

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

Return to an Address of the Honourable
the House of Commons dated 5 February 2026 for

The Cranston Inquiry

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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Foreword

In January 2024 the Secretary of State for Transport gave me the task of examining the events of 23 to 24 November 2021, when over 30 people died attempting to cross the English Channel in a small boat from France.

My team has been able to identify the names of 27 men, women and children, and those of a further four people whose bodies were not found. There were two survivors. Those on board that small boat came from different countries and for different reasons: a better life, family reunion and to escape political violence. They leave grieving relatives.

As explained in the report, I have concluded that some of those deaths were avoidable. This is for essentially three reasons.

Firstly, the people smugglers involved provided an unsuitable craft and inadequate safety equipment for the crossing. They then crowded at least 33 people onto the boat, putting them all at a high risk of harm which, in fact, occurred.

Secondly, the French Naval vessel, *Flamant*, failed to respond to a Mayday relay which HM Coastguard had issued about the small boat's plight, despite its proximity at the time.

Thirdly, the HM Coastguard staff involved in the planning and operation of the search and rescue on 23 to 24 November made a number of flawed decisions, culminating in the erroneous termination of the search early on 24 November. If the search had continued throughout that day, some of the deaths would have been avoided.

However, as detailed in the report, these members of HM Coastguard were placed in an intolerable position because of chronic staff shortages at Dover and other deficiencies. These were known about for some time, but no effective action had been taken to alleviate them. This represents a significant, systemic failure on the part of government.

Much has improved since November 2021 in terms of the personnel and the assets available to HM Coastguard. Nonetheless, the report contains a limited number of recommendations relating to search and rescue for small boats. In addition, it spells out recommendations relating to search and rescue more generally. These further recommendations are intended to provide for broader improvements in the UK's maritime search and rescue response.

The broader policy issue of preventing small boat crossings lies outside the Inquiry's Terms of Reference. However, the practice of small boat crossings must end. Apart from other reasons, it is 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.



Sir Ross Cranston

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.

Part 1:

Background to Inquiry

This part of the report explains how the Inquiry was established to consider and report on the events of 23 to 24 November 2021, when over 30 people died attempting to cross the Channel in a small boat, and sets out the UK's legal obligations to effect the search and rescue of those in distress at sea. Chapter 1 sets out the tasks the Inquiry was given and the work that it undertook. There were three aspects: firstly, to establish and when, where and in what circumstances these people came by their deaths, secondly, to ascertain who the deceased were, and thirdly, to consider any lessons that can be learned and to make recommendations to reduce the risk of a similar event occurring in future. Chapter 2 then outlines the UK's legal obligations for search and rescue at sea.

Chapter 1:

Establishment of the Inquiry

Introduction

- 1.1 On the evening of 23 November 2021, a group of people gathered on a beach near Dunkirk. They had walked largely in silence for about two hours to reach their departure point, where five smugglers waited with an inflated small boat. They were mainly men but there were also women and children. They had left their home countries for a variety of different reasons. Some had fled targeted political violence. Others were moving to start a new life or hoping to join relatives or loved ones. All were united in their determination to reach the UK. They had paid thousands of pounds to the smugglers, who promised them safe passage. Instead, they were about to embark on a harrowing journey, with more than 30 people crammed into the boat. Only two of them would survive the journey.
- 1.2 Unseaworthy and overcrowded, the boat set off towards the UK at around 21:00.¹ We cannot be certain what caused the boat to fail. Whatever the reason, around three hours into the journey, the boat began to take on a significant amount of water and later became swamped. The passengers tried in vain to bail out the water and made panicked mobile telephone calls for help. One called a smuggler who had arranged the journey and sent their location, but he did nothing to help. Just after 01:00 on 24 November 2021, HM 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, including 13 women and eight children. HM Coastguard called it incident ‘Charlie’.
- 1.3 Shortly afterwards, the French authorities transferred a mobile call from a 16-year-old on board. He spoke to HM Coastguard for around 20 minutes. He said they were “in the water” and required immediate assistance. Geolocation information was then sent to HM Coastguard which showed that the boat was in the Sandettie area of the Channel, close to the median line, but on the UK side. More calls were made and messages sent from the stricken small boat, though some calls and messages were missed. At around 02:25, a caller told HM Coastguard that the boat was sinking. At around 02:30, those on board made another desperate plea for help. HM Coastguard issued a Mayday relay broadcast, but a nearby French navy vessel did not respond.

1 All times are in Coordinated Universal Time (UTC) unless otherwise stated.

- 1.4 HM Coastguard had tasked a Border Force cutter, the Valiant, to respond at around 01:30. The Valiant did not leave the Port of Dover until 02:22 and took another hour to reach the last known location of incident ‘Charlie’. A helicopter was also tasked by HM Coastguard just before 03:00, while the Valiant was still en route. When the Valiant arrived in the Sandettie area at 03:24, it was unable to locate the boat. The co-ordinates had been given to Border Force more than an hour and a half earlier, so by the time the Valiant arrived it seems very likely that the small boat had drifted away. Between about 03:30 and 07:20, the helicopter and the Valiant located three small boats, rescuing 98 people in all. None of the boats found by the Valiant matched the description of incident ‘Charlie’.
- 1.5 Dawn came around 07:00. 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 boat. The bodies of their fellow passengers 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 had returned to Dover. No one in the UK was looking for the small boat, and no one came to their rescue.
- 1.6 Around 12:30 that day, 24 November 2021, a French fishing boat sailing approximately nine nautical miles off the coast of Calais found the first of the bodies floating in the water. HM Coastguard was notified at around 13:00, nearly 12 hours after it had received the first calls for help. Ultimately, the bodies of those who had been on the small boat associated with incident ‘Charlie’ were recovered to France and two survivors were rescued.
- 1.7 The Inquiry has been able to determine with confidence the identities of 26 of the 27 people who lost their lives and 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 cannot be conclusively ascertained, the Inquiry is able to suggest his identity. The Inquiry cannot be certain that there were no other people on board, including children, whose families may never know their fate.
- 1.8 Following the discovery of the mass casualty incident and the recovery operation, the Marine Accident Investigation Branch (MAIB) of the UK’s Department for Transport (DfT) started an investigation under its statutory powers to ensure the “prevention of future accidents through the ascertainment of its causes and circumstances”.² A MAIB investigation does not, and is not intended to, meet the requirements of Article 2 of the European Convention on Human Rights. Accordingly, in June 2022, the Secretary of State for Transport announced that an independent inquiry into the incident would take place following the conclusion of the MAIB investigation.

2 Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, Regulation 5(1). Available at: www.legislation.gov.uk/ukxi/2012/1743/contents (accessed 30 October 2025).

- 1.9** On 9 November 2023, the MAIB published its report into the incident. On the same day, the then Secretary of State for Transport, the Rt Hon Mark Harper MP, made a written ministerial statement to the House of Commons regarding the establishment of an independent non-statutory inquiry.³ The written ministerial statement explained the rationale for the formation of an Inquiry as follows:

“When events such as these occur, there is a legal obligation to investigate. While this would normally be the remit of a coroner, in this case, the bodies of the deceased were recovered to France and this does not allow for a coroner’s inquest. Therefore, I am announcing the establishment of an independent non-statutory inquiry into this incident.

The inquiry will be modelled on a coroner’s inquest and will allow a full and independent investigation into the circumstances of the deaths to take place, following the Marine Accident Investigation Branch’s report published yesterday (8 November 2023).

The inquiry will focus on investigating this individual incident, with the aim of ensuring the rights of those affected are upheld and allowing the survivors and family members of the deceased to be heard. Crucially, it will also examine the circumstances in which the deceased lost their lives and what lessons can be learned to prevent incidents like this in the future.”

- 1.10** On 11 January 2024, Mr Harper announced that I would chair the Inquiry.⁴ He stated that his thoughts were with the loved ones of those who died, with the survivors and with those who had responded to the extremely distressing event. Mr Harper added that the inquiry would be known as the ‘Cranston Inquiry’.

Terms of Reference

- 1.11** The Terms of Reference of the Inquiry are as follows:

“Scope and Purpose

1. The Inquiry will examine, consider and report on the events of 24 November 2021 when at least 27 people died attempting to cross the Channel in a small boat.
2. The Chair is to conduct an investigation into these events in order to:

³ House of Commons (2023), ‘Written statements for 9 November 2023’, Hansard, volume 740. Available at: <https://hansard.parliament.uk/commons/2023-11-09> (accessed 30 October 2025).

⁴ House of Commons (2024), ‘Written statements for 11 January 2024’, Hansard, volume 743. Available at: <https://hansard.parliament.uk/commons/2024-01-11> (accessed 30 October 2025).

- a. Ascertain who the deceased were and when, where and in what circumstances they came by their deaths.
 - b. 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.
3. The procedure and conduct of the Inquiry will be directed by the Chair.
 4. In conducting this inquiry, the Chair will consider the investigation already carried out by the Marine Accident Investigation Branch into the incident.

Timing

5. The Chair will report to the Secretary of State for Transport as soon as is practicable, taking into account any ongoing or future legal proceedings. The Secretary of State for Transport will be responsible for publishing the report.”
- 1.12 There are therefore three aspects to the Terms of Reference, which are addressed in Parts 3, 4 and 5 of this report: to establish when, where, and in what circumstances those in the small boat came by their deaths, to ascertain who the deceased were, and to consider any lessons which can be learned and make recommendations to reduce the risk of a similar event occurring.
 - 1.13 There are a number of important matters to note in relation to the Terms of Reference. Firstly, they focus specifically on the events of 23 to 24 November 2021. The Inquiry has had no wider remit to investigate the general and continuing issue of small boat crossings.
 - 1.14 Secondly, the Terms of Reference require answers to a set of questions (at paragraph 2 a) which resemble the four statutory questions which a coroner is required to answer in an inquest under section 5 of the Coroners and Justice Act 2009. However, the applicable legal framework is different. The Inquiry is not bound by the provisions of the Coroners and Justice Act 2009, its related rules and regulations, or case law applicable to inquests.
 - 1.15 Thirdly, this is a non-statutory inquiry. All questions as to the conduct of the Inquiry and the nature of its processes and procedures have been matters for me, as Chair, to determine, subject to applicable principles of law and, in particular, the over-riding duty of fairness. The Inquiry is independent of government and of the various public bodies which it has investigated during the course of its work.
 - 1.16 Fourthly, the Inquiry’s process is inquisitorial and not adversarial. Although, as explained shortly, some individuals and organisations have been accorded Full

Participant status, there have been no parties to the Inquiry. Moreover, the Inquiry has had no power to determine liability, whether civil or criminal. The Inquiry's purpose has been to find out the truth, and the role of all of those who engaged with the Inquiry in its investigation has been to assist it in ascertaining the truth of what happened on the night of 23 to 24 November 2021.

Structure of report

1.17 The report is structured as follows.

Part 1 gives an overview of the activities, processes and procedures which the Inquiry followed in its work, as well as the legal background to the UK's search and rescue obligations at sea.

Part 2 sets out the context of the events of 23 to 24 November 2021. It gives an account of small boat crossings, identifies the UK institutions and organisations which are responsible for meeting the UK's search and rescue obligations at sea, and sets out the steps which those organisations took to address small boats crossings before 23 to 24 November 2021, based on documentary evidence provided to the Inquiry.

Part 3 addresses the events of 23 to 24 November 2021 to answer the questions of when, where and in what circumstances the deaths occurred. In accordance with the Terms of Reference, it takes into account the investigation carried out by the MAIB. Part 3 includes a detailed chronology of events following the boat's departure from the coast of France on the evening of 23 November 2021. The factual, narrative account is followed by analysis of what occurred that night, focusing on the resources that were available, the search and rescue response, and the events that led to the mistaken conclusion that the small boat had been rescued.

Part 4 identifies the people who lost their lives. It sets out the information which the Inquiry has obtained about their lives and, where possible, describes the circumstances which led them to attempt a dangerous crossing of the English Channel.

Part 5 summarises the conclusions of the Inquiry and makes recommendations intended to reduce the likelihood of a similar mass casualty incident occurring in the future. The Inquiry's recommendations have been grouped into the following areas:

- recommendations specific to the issue of the preservation of life at sea in relation to small boat crossings
- recommendations relating to the response to mass casualty incidents at sea, the applicability of which is not limited to small boat crossings

- recommendations relating to the structure and capability of UK organisations involved in search and rescue activities at sea
- matters related to the publication of implementing measures in response to the MAIB's recommendations following an investigation.

Inquiry team and experts

- 1.18** On commencing my role as Chair of the Inquiry, I made a number of appointments to the Inquiry team. Mr Rory Phillips KC was appointed as Counsel to the Inquiry, Mr Stephen Brown as Solicitor to the Inquiry, and Mr Oliver Mulvey as Secretary to the Inquiry. Further counsel, solicitors and members of the secretariat worked as part of the Inquiry team during the course of its proceedings. A full list of members of the Inquiry team is in Appendix 4. I am very much in their debt for all of their hard work and dedication.
- 1.19** The Inquiry obtained three reports from independent, external experts in order to support its work. These were: Professor Michael Tipton MBE, Professor of Human and Applied Physiology at the University of Portsmouth, who reported on cold water survivability, Mr Iain Ivory, of Hermitage Comms, who advised on mobile communications networks, and Sytech Consultants, who analysed extracted data from the HM Coastguard mobile phone. The Inquiry also consulted Captain John Simpson (Associate Fellow of the Nautical Institute) of Solis Marine Consultants, a Master Mariner, on questions of maritime and marine practice. I am grateful to them all for their assistance.

Full Participants and the Funding Protocol

- 1.20** The Inquiry published its Initial Procedural Protocol on 28 February 2024. Under it, the Inquiry designated some individuals and organisations with a particular interest in the proceedings or outcome of the Inquiry as Full Participants. The protocol invited any other individual or organisation with a particular interest in the proceedings and/or outcome to apply for Full Participant status. No formal applications to be a Full Participant were made. The Full Participants were:
- a survivor, Mr Issa Mohamed Omar, and the families of the some of those who died, represented by Duncan Lewis Solicitors
 - the Maritime and Coastguard Agency (MCA)
 - the Home Office
 - the DfT.
- 1.21** As Full Participants, these individuals and organisations were permitted to:
- participate when the Inquiry consulted on its procedures

- receive the disclosure of material and witness statements identified as relevant by the Inquiry
- attend the Inquiry's public hearings and suggest lines of inquiry or questions to be put to witnesses by Counsel to the Inquiry at those hearings
- make written and oral opening and closing statements.

I am grateful to the Full Participants and their legal representatives – indeed to all those who engaged with us as witnesses, document providers, or in any other capacity – for the hard work which they undertook in order to assist us in our endeavours. The pace of our proceedings has been formidable, and it would not have been possible to make the progress we did without their co-operation and good will.

- 1.22** To enable those participating to obtain payment for legal advice and representation, the Inquiry published a Funding Protocol on 28 February 2024. Strict eligibility criteria were established. In practice, applications under the Funding Protocol were handled without difficulty and with expedition. Not all applications for funding were approved. In making an award, I not only had to determine eligibility under the protocol, but also have regard to the need to avoid any unnecessary cost, whether to public funds, witnesses or others.

Preliminary Hearing and List of Issues

- 1.23** The Inquiry held its Opening Hearing on 6 March 2024. At this hearing, I stressed that in all our work we would not lose sight of the fact that for those who lost their lives that day, and for their friends and loved ones, this was an immeasurable human tragedy. In particular I highlighted the Inquiry's independence, its limited remit, its inquisitorial and non-statutory character, and that I expected full co-operation from all those involved. In response, representatives of the Full Participants made brief oral submissions: Ms Phillippa Kaufmann KC for the bereaved families and a survivor, Mr James Maxwell-Scott KC for the MCA, Mr Prashant Popat KC for the Home Office, and Mr David Blundell KC for the DfT.
- 1.24** On 17 June 2024, following consultation with the Full Participants, the Inquiry published its List of Issues to help identify the detailed focus of the Inquiry's investigative work. The List of Issues contained over 30 questions grouped under six broad headings. It was kept under review over the lifetime of the Inquiry, but no changes proved necessary. The List of Issues is set out at Appendix 2. In summary, the issues fell under the following broad headings:
- the victims and survivors (Issue I)
 - the law of the sea and the applicable legal framework (Issue II)

- the operational systems in place on 23 to 24 November 2021 to respond to small boats attempting to cross the Dover Strait (Issue III)
- the events of 23 to 24 November 2021 (Issue IV)
- inspection and lesson learning before 24 November 2021 (Issue V)
- recommendations (Issue VI).

Meetings with families and a survivor

- 1.25** At the end of June 2024, I held initial, informal meetings with one of the survivors of the incident and with the family members of some of those on board the small boat, who were represented by Duncan Lewis Solicitors. In early December 2024, I held further informal meetings with one of the survivors of the incident and with family members. The meetings involved video links between the UK, France, Iraqi Kurdistan, Ethiopia and Somalia. I also held brief, informal meetings with members of the families in the margins of the full public hearings. For the families, the Inquiry was a long time coming after the tragedy, and I pay tribute to their patience and fortitude while waiting.

Visits

- 1.26** During the course of the Inquiry, my team and I undertook a number of site visits: to the MCA on 29 February 2024 (in Fareham) and 14 May 2024 (in Dover and Lydd), to Border Force on 22 April 2024 (in Dover and Ramsgate), and to the Royal National Lifeboat Institution (RNLI) on 12 April 2024 (in Poole) and 16 July 2024 (in Dungeness). The visits were not a formal evidence-gathering exercise but were invaluable in assisting us to understand the context of the events which the Inquiry was considering. I am grateful to those who facilitated these helpful visits.

The position of the French authorities

- 1.27** Following the events of 23 to 24 November 2021, the French authorities started a criminal investigation arising out of this 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 concerned in such investigations, with the result that the Inquiry has not had access to material relating to the ongoing French investigation. However, the Paris Prosecutor provided the Inquiry with a list of the identities of the deceased and those missing people who could have been on board the boat, relying on information gathered during the recovery operation. The Inquiry has kept the French authorities informed about the progress of its work.

Disclosure, witness statements and oral evidence

- 1.28** During the course of its proceedings, the Inquiry published a set of procedural protocols addressing every stage of its processes, up to and including the Full Hearings. It also published a privacy notice and appropriate policy relating to data protection matters. All were made available on the Inquiry's website.
- 1.29** Acting under the protocols, the Inquiry obtained thousands of pages of material relevant to the investigation, as well as audio files for transcription (inward disclosure). The material came from a wide range of individuals and organisations and was uploaded to the Inquiry's document management system. The material was subjected to close analysis and review for relevance. It led to the production of the List of Issues. Where appropriate, further disclosure was sought from the material providers and further sources of evidence were identified. I am grateful to the material providers, as the progress we made in a relatively short time would not have been possible without their co-operation.
- 1.30** In anticipation of what could be termed 'outward disclosure' of material to the Full Participants, the Inquiry team identified information in the disclosed material which it proposed to redact. The Inquiry team permitted material providers an opportunity to review and approve the proposed redactions and to identify any further redactions meeting the criteria set out in the formal Redaction Protocol. In October 2024, the Inquiry began to disclose tranches of material which we deemed relevant to the Full Participants, in accordance with the Disclosure Protocol. The Inquiry completed the majority of disclosure to Full Participants by the end of 2024, though some disclosure continued into early 2025.
- 1.31** In July 2024, following consideration of the material disclosed to the Inquiry, formal requests for the provision of witness statements were issued. Those requests sought evidence from organisations and also from individuals and families, including those who were directly involved with the incident of 23 to 24 November 2021.
- 1.32** Following receipt of the statements in draft format, the Inquiry team reviewed the disclosed material and, where appropriate, sought further information or clarification from those who provided statements. The Inquiry also identified a small number of additional people from whom it requested witness statements. All statements provided to the Inquiry in response to a request for evidence were disclosed to the Full Participants and were made available on the Inquiry's website. Not every person who prepared a witness statement was called to give evidence at the Full Hearings. Nonetheless, I am grateful to all of those who prepared witness statements. I recognise the considerable burden involved. In total, the Inquiry received witness statements from over 70 individuals and organisations. The list of those who were approached and provided witness statements is in Appendix 5.

- 1.33** On 24 October 2024, I held a Preliminary Hearing at which I set out the progress of the Inquiry to date and outlined the work that would be required so that the Full Hearings could take place in March 2025. In the course of my remarks, I underlined again my recognition that the loss of life on 23 to 24 November 2021 and the impact of the tragedy on the friends and families of those on the boat remained at the heart of the Inquiry's work.

Full Hearings

- 1.34** In January 2025, the Inquiry identified the individuals from whom it wished to receive oral evidence at the Full Hearings. The Inquiry provided its draft witness list and timetable to Full Participants in January and finalised these in February 2025. In accordance with the Witness Handling Protocol, the Inquiry produced evidence proposals for each of those witnesses. The evidence proposals set out the topics to be addressed in questioning as well as the documents to which reference could be made. Three applications were made under the Anonymity Protocol before the Full Hearings. I refused the applications and provided reasons for my decisions. I also received an application for special measures from one witness. I granted the application because, in my view, the applicant was a vulnerable witness and receiving evidence with special measures in place enabled me to obtain the best evidence and discharge the task conferred by the Terms of Reference.
- 1.35** The Inquiry's Full Hearings began on 3 March 2025 and ran for four weeks, concluding on 27 March 2025. To assist the Full Participants, the Inquiry made available to them written background material, including a detailed chronology of events leading up to the night, a note on the relevant legal framework, a list of acronyms, and outline descriptions of the main organisations with roles and responsibilities relevant to the night in question, along with charts (organograms) for understanding these.
- 1.36** Counsel to the Inquiry, Mr Phillips KC, opened the Full Hearings, outlining the tragedy, explaining the Inquiry's work, the legal framework, the small boats issue, and the relevant institutions and relationships, before detailing the events of the night when the incident occurred. After referring to post-event lesson learning and possible recommendations, he read the names of those who have been identified as dying in the tragedy, the name of an additional person whom the Inquiry believes to have also died, and the names of four men whom the Inquiry believes to have been on the boat but whose bodies have not been found. There were then opening statements by Ms Sonali Naik KC appearing for the bereaved families and a survivor, Mr Maxwell-Scott KC for the MCA, Mr Popat KC for the Home Office, and Mr Blundell KC for the DfT.

- 1.37** Over the course of 15 sitting days, the Inquiry heard evidence from 22 witnesses. These included a survivor of the incident, Mr Issa Mohamed Omar, an expert witness, Professor Tipton, and individuals from the MCA, Home Office, DfT, the RNLI, 2Excel Aviation Ltd and Bristow Helicopters Ltd. Witnesses were questioned (not cross-examined) on my behalf as part of the investigatory work of the Inquiry to ensure the clearest picture of what happened on the night in question, as part of the Inquiry's quest for the truth. All of the questioning was, in my view, appropriate. All the witnesses attempted, in my view, to assist the Inquiry with truthful answers, although it will be clear from the body of the report that I did not accept all of the evidence given.
- 1.38** On 26 and 27 March 2025, the Inquiry heard impact statements from the family members of some of the deceased. These statements were recorded in the family members' own languages and the recordings were played in the hearing room. A member of the Inquiry's legal team followed each recording with a reading of its English translation. I am enormously grateful for the evidence given by family members. It stands as a permanent record of their recollections of those who died or are missing. Part 4 of the report is dedicated to those who died in the tragedy and to the impact it has had on people's lives.
- 1.39** The Full Participants made oral closing statements, which were followed a fortnight later by full written closing statements. In preparing the report, I have benefitted from reviewing these statements, together with the other evidence available to the Inquiry, including the evidence given at the Full Hearings.

The report

- 1.40** Following the conclusion of the Full Hearings, the Inquiry began work on its report and recommendations. It requested further evidence from a number of parties as a result of matters raised during the Full Hearings. These additional statements were subjected to the Inquiry's usual redaction processes and were disclosed to the Full Participants.
- 1.41** There are a number of core principles to which I have had regard when producing this report. Firstly, there are no findings of civil or criminal liability. Secondly, the Inquiry is an inquisitorial process with no burden of proof and no fixed standard by reference to which findings of fact are to be made. I have adopted a flexible approach where conclusions are expressed 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 occurred. In other cases, my conclusion is that it is more likely than not that an event occurred, or alternatively that it is 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.

- 1.42** Thirdly, in reaching conclusions I have been mindful of the dangers of using hindsight when considering the actions of those involved in the events of the night. Although I have identified failings by people on the night, I have considered each of these in the context of what was known at the time, the resources available, the preparations made and the procedures in place. Overall, my conclusion is that even where failings are potentially attributable to individuals, the underlying causes were systemic in nature. Analysis of these in their full context provides the basis for the recommendations made in the report.
- 1.43** On 15 August 2025, the Inquiry undertook a process in respect of proposed criticisms in the draft report, in accordance with paragraph 32 of the Initial Procedural Protocol. On 19 August 2025, the Inquiry shared its draft recommendations with relevant organisations and invited comment on the practicability and deliverability of the recommendations. After reviewing the responses in both cases, I have in appropriate circumstances modified the original text to accommodate what I regard as helpful suggestions and justified responses to the provisional findings and recommendations. In mid October 2025, the report was handed over to Design102 for typesetting and preparation for publication.

Chapter 2:

Search and rescue at sea: legal framework

- 2.1** This chapter outlines the legal principles concerning the UK's obligations relevant to small boat search and rescue. The focus is on the relevant international obligations in respect of search and rescue at sea.
- 2.2** There are two broad legal obligations: firstly, the obligation on the UK to establish and maintain an adequate search and rescue capacity to protect life at sea, and secondly, the obligation on passing ships to render assistance to those in distress at sea, including those in small boats. After considering these obligations, the chapter turns to how the UK gives effect to them.

International obligations regarding search and rescue

- 2.3** Safety at sea, and in particular search and rescue, is addressed in a number of international treaties. These include:

- the 1982 United Nations Convention on the Law of the Sea (UNCLOS)¹
- the 1974 International Convention for the Safety of Life at Sea (SOLAS)²
- the International Convention on Maritime Search and Rescue (1979 SAR).³

The UK and France are Parties to all three Conventions and are bound by the obligations contained in them under international law.

- 2.4** The UK and France are also Member States of the International Maritime Organization (IMO), which is a specialised agency of the United Nations with responsibility for the safety and security of shipping, as well as the prevention of pollution by ships. SOLAS and the 1979 SAR were adopted under the auspices

1 United Nations (1982), 'United Nations Convention on the Law of the Sea (UNCLOS)', United Nations Treaty Series (UNTS), volume 1833, page 397. All subsequent references to UNCLOS relate to the same source, available at: <https://treaties.un.org/pages/showdetails.aspx?objid=0800000280043ad5> (accessed 30 October 2025).

2 United Nations (1974), 'International Convention for the Safety of Life at Sea (SOLAS)', UNTS, volume 1184, page 278. The Convention has been amended many times and subsequent references relate to SOLAS, as amended.

3 United Nations (1979), 'International Convention on Maritime Search and Rescue (SAR)', UNTS, volume 1405, page 97. The Annex to the Convention was amended in 1998 and 2004, and subsequent references relate to 1979 SAR, as amended.

of the IMO. The IMO has an ongoing role in amending and updating those Conventions.

- 2.5** The IMO has a Member State Audit Scheme, which became a treaty obligation in 2016. At that time, SOLAS was amended to provide that contracting States would be subject to periodic audits by the IMO to verify compliance with and to implement SOLAS. The IMO has adopted guidelines for the audits, and the Secretary-General of the IMO is responsible for administering the audit scheme. Periodically, the IMO secretariat prepares and publishes an anonymous consolidated audit summary report. Six of these have been published since the start of mandatory audits in 2016.
- 2.6** The IMO and the International Civil Aviation Organization jointly publish and periodically review and update the International Aeronautical and Maritime Search and Rescue (IAMSAR) Manual. This is a guide to Member States, set out in three volumes, for providing and organising a search and rescue service and executing their responsibilities under the applicable aviation and maritime conventions.

International obligations imposed on states

- 2.7** The duty to render assistance to those in peril at sea is a long-established norm of the law of the sea. It finds expression firstly in the obligations on coastal States to establish, operate and maintain adequate and effective search and rescue services. This duty now has force in international treaties. UNCLOS, SOLAS and the 1979 SAR each require States to establish, operate and maintain search and rescue services at sea.

UNCLOS and SOLAS

- 2.8** Article 98(2) of UNCLOS provides:
- “Every coastal State shall promote the establishment, operation and maintenance of an adequate and effective search and rescue service regarding safety on and over the sea and, where circumstances so require, by way of mutual regional arrangements cooperate with neighbouring States for this purpose.”
- 2.9** Regulation 7(1) of Chapter V of the Annex to SOLAS provides:

“Each Contracting Government undertakes to ensure that necessary arrangements are made for distress communication and co-ordination in their area of responsibility and for the rescue of persons in distress at sea around its coasts. These arrangements shall include the establishment, operation and maintenance of such search and rescue facilities as are deemed practicable and necessary, having regard to the density of the seagoing traffic and the navigational dangers and shall, so far as possible, provide adequate means of locating and rescuing such persons.”

1979 SAR

- 2.10** The most detailed provisions concerning search and rescue services are found in the 1979 SAR. It establishes a comprehensive international system for search and rescue operations. Paragraph 2.1.1 of Chapter 2 to the Annex of 1979 SAR provides:

“Parties shall, as they are able to do so individually or in co-operation with other States and, as appropriate, with the Organization, participate in the development of search and rescue services to ensure that assistance is rendered to any person in distress at sea. On receiving information that any person is, or appears to be, in distress at sea, the responsible authorities of a Party shall take urgent steps to ensure that the necessary assistance is provided.”

- 2.11** 1979 SAR goes on to provide for States to have responsibility for designated search and rescue regions, within which search and rescue services are provided. States are to establish search and rescue regions by agreement, and to notify these to the Secretary-General of the IMO.⁴ In the English Channel, the UK’s search and rescue region and France’s search and rescue region (for the purposes of maritime search and rescue) are divided along the territorial sea boundary. Where a State has accepted responsibility to provide search and rescue services, it “shall use search and rescue units and other available facilities and other available facilities for providing assistance to a person who is, or appears to be, in distress at sea”.⁵ It is also to arrange for its rescue co-ordination centre (and any rescue sub-centres) to receive distress alerts originating from within its search and rescue region.⁶
- 2.12** The 1979 SAR also provides for the rescue of people in distress to be co-ordinated by a search and rescue organisation. A common definition of search and rescue services appears in the 1979 SAR and SOLAS, which provides:

4 1979 SAR, Annex, Chapter 2, paragraph 2.1.4.

5 1979 SAR, Annex, Chapter 2, paragraph 2.1.9.

6 1979 SAR, Annex, Chapter 2, paragraph 2.3.2.

“The performance of distress monitoring, communication, co-ordination and search and rescue functions including provision of medical advice, initial medical assistance, or medical evacuation, through the use of public and private resources including co-opting aircraft, vessels, and other craft and other installations.”⁷

2.13 The 1979 SAR sets out the basic elements of search and rescue services in paragraph 2.1.2 of Chapter 2 to the Annex. It provides:

“Parties shall, either individually or, if appropriate, in co-operation with other States, establish the following basic elements of a search and rescue service:

1. legal framework;
2. assignment of a responsible authority;
3. organisation of available resources;
4. communication facilities;
5. co-ordination and operational functions; and
6. processes to improve the service including planning, domestic and international co-operative relationships and training.

Parties shall, as far as practicable, follow relevant minimum standards and guidelines developed by the Organization.”

2.14 It further provides that Parties shall “establish appropriate national procedures for overall development, co-ordination, and improvement” of search and rescue services, and to support search and rescue operations, ensure the co-ordinated use of available facilities and establish close co-operation between services and organisations that may contribute to improving search and rescue services.⁸ Parties must also, individually or in co-operation with other States, establish rescue co-ordination centres (and sub-centres, as they consider appropriate) for their search and rescue service. These centres are to arrange for the receipt of distress alerts originating from within its search and rescue region, and for communications with people in distress, search and rescue facilities, and other rescue co-ordination centres or sub-centres. They are to be operational on a 24-hour basis and to be constantly staffed by trained personnel with a working knowledge of English.⁹ Further, Parties must identify all facilities able to

7 1979 SAR, Annex, Chapter 1, paragraph 1.3.3. SOLAS, Annex, Chapter V, Regulation 2.5.

8 1979 SAR, Annex, Chapter 2, paragraph 2.2.1.

9 1979 SAR, Annex, Chapter 2, paragraph 2.3.

participate in search and rescue operations and provide each search and rescue unit with equipment appropriate to its task.¹⁰

- 2.15** Parties are obliged to provide information to the Secretary-General of the IMO on their search and rescue service.¹¹ They are also required to update this information “with respect to any alterations of importance”.¹² The Secretary-General is to transmit all the information received to all State Parties.¹³

1979 SAR and the Mancheplan

- 2.16** The 1979 SAR provides for co-operation between neighbouring States in respect of search and rescue operations, including where appropriate through agreements with other States.¹⁴ It requires States to co-ordinate search and rescue organisations and operations.¹⁵ It also indicates that Parties should:
- enter into agreements with neighbouring States, setting forth the conditions for entry of each other’s search and rescue units into or over their respective territorial seas or territory, providing for expediting entry with the least possible formalities¹⁶
 - authorise its search and rescue co-ordination centres to request assistance from other rescue co-ordination centres, to grant necessary permission for the entry of vessels, aircraft, personnel or equipment into or over its territorial sea or territory, to make arrangements with appropriate authorities with a view to expediting such entry, and to make necessary arrangements to identify the most appropriate place(s) for disembarking people found in distress at sea¹⁷
 - ensure its rescue co-ordination centres provide assistance to other centres, when requested¹⁸
 - authorise their responsible authority to make operational plans and arrangements for search and rescue co-operation and co-ordination with responsible authorities of other States.¹⁹
- 2.17** In the context of the English Channel, the UK and France have agreed the Anglo-French Joint Maritime Contingency Plan for the English Channel (Mancheplan). Chapter 2 of this is a regional search and rescue agreement within the meaning of the 1979 SAR. The 2018 Anglo-French Joint Maritime

10 1979 SAR, Annex, Chapter 2, paragraphs 2.5 and 2.6.1.

11 1979 SAR, Annex, Chapter 2, paragraph 2.1.11.

12 1979 SAR, Annex, Chapter 2, paragraph 2.1.11.

13 1979 SAR, Annex, Chapter 2, paragraph 2.1.11.

14 1979 SAR, Annex, Chapter 3, especially paragraph 3.1.8.

15 1979 SAR, Annex, Chapter 3, paragraph 3.1.1.

16 1979 SAR, Annex, Chapter 3, paragraph 3.1.5.

17 1979 SAR, Annex, Chapter 3, paragraph 3.1.6.

18 1979 SAR, Annex, Chapter 3, paragraph 3.1.7.

19 1979 SAR, Annex, Chapter 3, paragraph 3.1.8.

Contingency Plan for the English Channel provided the basis for the co-ordination and co-operation of search and rescue between the UK and French authorities as at November 2021.²⁰

1979 SAR and rescue co-ordination

- 2.18** Chapter 4 of the Annex to 1979 SAR sets out detailed provisions to guide the operations of rescue co-ordination centres and sub-centres. Each of these centres are to:
- have available, up-to-date information concerning search and rescue facilities and available communications relevant to search and rescue operations in its area
 - have ready access to information regarding the position, course and speed of vessels within its area which may be able to provide assistance, and regarding how to contact them
 - have detailed plans of operation for the conduct of search and rescue operations
 - be kept informed of the state of preparedness of search and rescue units.²¹
- 2.19** Parties are to ensure that they are capable of promptly and reliably receiving distress alerts from within their search and rescue regions, on a 24-hour basis.²² They are to ensure, where appropriate, that effective arrangements are in place for the registration of communication equipment and for responding to emergencies.²³
- 2.20** When a centre receives information concerning a person, vessel or other craft in a state of emergency, it is to evaluate such information and determine the phase of emergency and the extent of operations required.²⁴ If a search and rescue unit receives information of a distress incident, it is to take immediate action if in a position to assist and shall, in any case and without delay, notify the rescue co-ordination centre or sub-centre in whose area the incident has occurred.²⁵
- 2.21** Three emergency phases are identified in Chapter 4 of the Annex, as well as the procedures to be followed during these phases.

²⁰ See paragraph 7.63 to 7.65 on the Mancheplan.

²¹ 1979 SAR, Annex, Chapter 4, paragraph 4.1 (4.1.1 to 4.1.4).

²² 1979 SAR, Annex, Chapter 4, paragraph 4.2.1.

²³ 1979 SAR, Annex, Chapter 4, paragraph 4.2.2.

²⁴ 1979 SAR, Annex, Chapter 4, paragraph 4.2.4.

²⁵ 1979 SAR, Annex, Chapter 4, paragraph 4.3.

- a.** The ‘uncertainty phase’ is when a person has been reported as missing or a vessel or other craft is overdue, or where a person, vessel or other craft has failed to make an expected position or safety report.²⁶ The rescue co-ordination centre or sub-centre is to initiate inquiries to determine the safety of the person, vessel or other craft, or declare the ‘alert phase’.²⁷
- b.** The ‘alert phase’ is when, following the uncertainty phase, attempts to establish contact with the person, vessel or craft have failed and inquiries to other appropriate sources have been unsuccessful, or information is received indicating that the operating efficiency of a vessel or other craft is impaired, but not to the extent that a distress situation is likely.²⁸ The rescue co-ordination centre or sub-centre is to extend the inquiries for the missing person, vessel or other craft, alert appropriate search and rescue services, and initiate such action as is necessary in the light of the circumstances of the particular case.²⁹
- c.** The ‘distress phase’ is when:
 - i. positive information is received that a person, vessel or other craft is in danger and in need of immediate assistance
 - ii. following the alert phase, further unsuccessful attempts to establish contact and more widespread unsuccessful inquiries point to the probability that a distress situation exists
 - iii. information is received which indicates that the operating efficiency of a vessel or other craft has been impaired to the extent that a distress situation is likely.³⁰

The rescue co-ordination centre or sub-centre is to proceed as prescribed in its plans of operation for the conduct of search and rescue operations.³¹

2.22 Where the position of the search object is unknown:

- a.** the rescue co-ordination centre or sub-centre shall assume responsibility for initiating suitable action, unless it is aware that other centres are taking action, and shall confer with other centres with the objective of designating one centre to assume responsibility
- b.** unless otherwise agreed, the centre responsible for the area in which the search object was according to its last reported position is to be designated

26 1979 SAR, Annex, Chapter 4, paragraph 4.4.1.

27 1979 SAR, Annex, Chapter 4, paragraph 4.5.1.

28 1979 SAR, Annex, Chapter 4, paragraph 4.4.2.

29 1979 SAR, Annex, Chapter 4, paragraph 4.5.2.

30 1979 SAR, Annex, Chapter 4, paragraph 4.4.3.

31 1979 SAR, Annex, Chapter 4, paragraph 4.5.3.

- c. after the declaration of the distress phase, the centre co-ordinating the search and rescue operations shall, as appropriate, inform other centres of all the circumstances of the emergency and of all subsequent developments.³²

- 2.23** Whenever possible, the rescue co-ordination centre or sub-centre shall forward information on the search and rescue operations that it has initiated to the person, vessel or other craft for which an emergency phase has been declared.³³ Where search and rescue operations involve more than one State, each shall take appropriate action in accordance with the plans of operation when requested by the rescue co-ordination centre.³⁴ The activities of search and rescue units and facilities are to be co-ordinated on scene to ensure the most effective results. Where there are multiple facilities about to engage, the most capable person should be designated as on-scene co-ordinator.³⁵
- 2.24** Search and rescue operations are to continue, when practicable, until all reasonable hope of rescuing survivors has passed.³⁶ The decision to discontinue will normally be taken by the rescue co-ordination centre or sub-centre, or if no centre is involved, by the on-scene co-ordinator.³⁷ Search and rescue operations shall be terminated where the centre considers, on the basis of reliable information, that the operation has been successful, or that an emergency no longer exists. It will inform any authority, facility or service which has been activated or notified.³⁸ If a search and rescue on scene becomes impracticable and the centre concludes that survivors might still be alive, on-scene activities may be temporary suspended, and resumed when justified on the basis of information subsequently received.³⁹
- 2.25** The rescue co-ordination centre or sub-centre is to initiate the process of identifying the most appropriate place(s) for disembarking people found in distress at sea, and shall inform the ship, ships and other relevant Parties concerned.⁴⁰

32 1979 SAR, Annex, Chapter 4, paragraph 4.5.4.

33 1979 SAR, Annex, Chapter 4, paragraph 4.5.5.

34 1979 SAR, Annex, Chapter 4, paragraph 4.6.

35 1979 SAR, Annex, Chapter 4, paragraph 4.7.

36 1979 SAR, Annex, Chapter 4, paragraph 4.8.1.

37 1979 SAR, Annex, Chapter 4, paragraph 4.8.2.

38 1979 SAR, Annex, Chapter 4, paragraph 4.8.3.

39 1979 SAR, Annex, Chapter 4, paragraph 4.8.4.

40 1979 SAR, Annex, Chapter 4, paragraph 4.8.5.

International requirements for vessels to render assistance

- 2.26** Each of UNCLOS, SOLAS and 1979 SAR contain provisions which address requirements for vessels to render assistance to people in danger or distress. They do so in slightly different terms.
- 2.27** Article 98(1) of UNCLOS provides that:
- “Every State shall require the master of a ship flying its flag, in so far as he can do so without serious danger to the ship, the crew or the passengers:
- (a) to render assistance to any person found at sea in danger of being lost;
- (b) to proceed with all possible speed to the rescue of persons in distress, if informed of their need of assistance, in so far as such action may reasonably be expected of him...”
- 2.28** Although Article 98 appears in Part VII of UNCLOS, which deals with the high seas, it is generally accepted that it applies to all areas of the sea, because of the general wording included in Article 98(1)(a), referring to “to any person found at sea”.⁴¹ The application of the duty to provide assistance to the territorial sea is also consistent with Article 18(2) of UNCLOS (in Part II on the territorial sea and contiguous zone), which provides that foreign vessels may temporarily stop or anchor in another State’s territorial sea for the purpose of rendering assistance to people, ships or aircraft in danger or distress.⁴²
- 2.29** Article 98(1) of UNCLOS does not impose obligations directly on vessels or their masters: rather, it imposes an obligation on States to require that certain action be taken by masters of its flagged vessels.
- 2.30** By contrast, SOLAS imposes obligations directly on masters of a ship to provide assistance in response to distress messages. Regulation 33(1) of Chapter V of the Annex is key, and provides as follows:

⁴¹ For example: F. G. Attard (2020), ‘The Duty of the Shipmaster to Render Assistance at Sea under International Law’, Brill, page 42. B. H. Oxman (1997), ‘Human Rights and the United Nations Convention on the Law of the Sea’, Columbia Journal of Transnational Law, volume 36, pages 399, 414 to 415.

⁴² United Nations (1982), ‘UNCLOS Article 18(2)’, UNTS, volume 1833: “Passage shall be continuous and expeditious. However, passage includes stopping and anchoring, but only in so far as the same are incidental to ordinary navigation or are rendered necessary by force majeure or distress or for the purpose of rendering assistance to persons, ships or aircraft in danger or distress.”

“Distress messages: obligations and procedures

The master of a ship at sea which is in a position to be able to provide assistance on receiving a signal from any source that persons are in distress at sea, is bound to proceed with all speed to their assistance, if possible informing them or the search and rescue service that the ship is doing so. If the ship receiving the distress alert is unable or, in the special circumstances of the case, considers it unreasonable or unnecessary to proceed to their assistance, the master must enter in the log-book the reason for failing to proceed to the assistance of the persons in distress, taking into account the recommendation of the Organization, to inform the appropriate search and rescue service accordingly.”

Regulation 33(1-1) adds:

“Contracting Governments shall coordinate and cooperate to ensure that masters of ships providing assistance by embarking persons in distress at sea are released from their obligations with minimum further deviation from the ships’ intended voyage, providing that releasing the master of the ship from the obligations under the current regulations does not further endanger the safety of life at sea. The Contracting Government responsible for the search and rescue region in which such assistance is rendered shall exercise primary responsibility for ensuring such coordination and cooperation occurs, so that survivors assisted are disembarked from the assisting ship and delivered to a place of safety, taking into account the particular circumstances of the case and guidelines developed by the Organization. In these cases, the relevant Contracting Governments shall arrange for such disembarkation to be effected as soon as reasonably practicable.”

- 2.31** Under both UNCLOS and SOLAS, the duty to provide assistance applies regardless of the legal status of the person in distress. The 1979 SAR expressly confirms that assistance is to be provided regardless of the nationality or status of the person in distress. Article 2.1.10 of Chapter 2 of the Annex to the 1979 SAR provides:

“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 person or the circumstance in which that person is found.”

European Convention on Human Rights, Article 2

- 2.32** Article 2 of the European Convention on Human Rights, given effect in UK domestic law by section 6 of the Human Rights Act 1998, imposes a range of positive duties on UK public authorities to safeguard life. It is well established that this can include both procedural and substantive duties.

UK implementation of its international obligations

- 2.33** In evidence to the Inquiry, the DfT accepted its responsibility to ensure the UK's implementation of its obligations in relation to small boats under UNCLOS, SOLAS, 1979 SAR, and Article 2 of the European Convention on Human Rights. In terms of specific legal obligations, the DfT:
- a.** accepted that the Secretary of State has responsibility for establishing, operating, and maintaining an adequate and effective civil maritime and aeronautical search and rescue, which it fulfils through the MCA, HM Coastguard, and the Aviation Airspace Division⁴³
 - b.** pointed to the Secretary of State's designation under the Civil Contingencies Act 2004 as a Category 1 responder, which imposes responsibilities regarding maritime emergencies, met through the MCA and its 24-hour maritime search and rescue emergency response service
 - c.** explained the Secretary of State's determination of 1992, pursuant to the Coastguard Act 1925, as the basis of her statutory responsibility to initiate and co-ordinate the civil search and rescue response within the UK search and rescue region, including the search and rescue response to small boats in the English Channel.⁴⁴
- 2.34** The requirement for vessels to render assistance in case of distress is incorporated in UK domestic law through the Merchant Shipping Act (Safety of Navigation) Regulations 2020, SI 2020 No 673. The Regulations apply to any UK ships, and any non-UK ships while they are within UK waters.⁴⁵ A violation of Regulation 33(1), Chapter V of the Annex to SOLAS, is an offence by the master of a ship, punishable on summary conviction in England and Wales by a fine, or on conviction on indictment by imprisonment for a term not exceeding two years or a fine, or both.⁴⁶ The operation of these provisions is addressed later in the report.⁴⁷

⁴³ See paragraphs 4.2 and 7.2.

⁴⁴ House of Commons (1992), 'Written answers for 9 March 1992', Hansard, volume 205. Available at: <https://hansard.parliament.uk/commons/1992-03-09> (accessed 30 October 2025). See paragraph 4.16.

⁴⁵ Merchant Shipping Act (Safety of Navigation) Regulations 2020, Regulation 3(1). Available at: www.legislation.gov.uk/uksi/2020/673/contents (accessed 30 October 2025).

⁴⁶ Merchant Shipping Act (Safety of Navigation) Regulations 2020, Regulation 9(2) and (5). Available at: www.legislation.gov.uk/uksi/2020/673/contents (accessed 30 October 2025).

⁴⁷ See paragraphs 7.58 and 17.60 to 17.64.

PART 2:

Context of the events of 23 to 24 November 2021

Chapter 3 outlines the history of small boat crossings since they first rose to prominence in 2018 and the challenges small boats present for a search and rescue response. Chapter 4 then describes the key UK and French organisations involved in responding to small boats. In Chapters 5 to 7, the report turns to the government response to the challenges posed by small boats, and the specific systems and processes in place to meet them before 23 to 24 November 2021.

Chapter 3:

Small boat crossings and search and rescue

Introduction

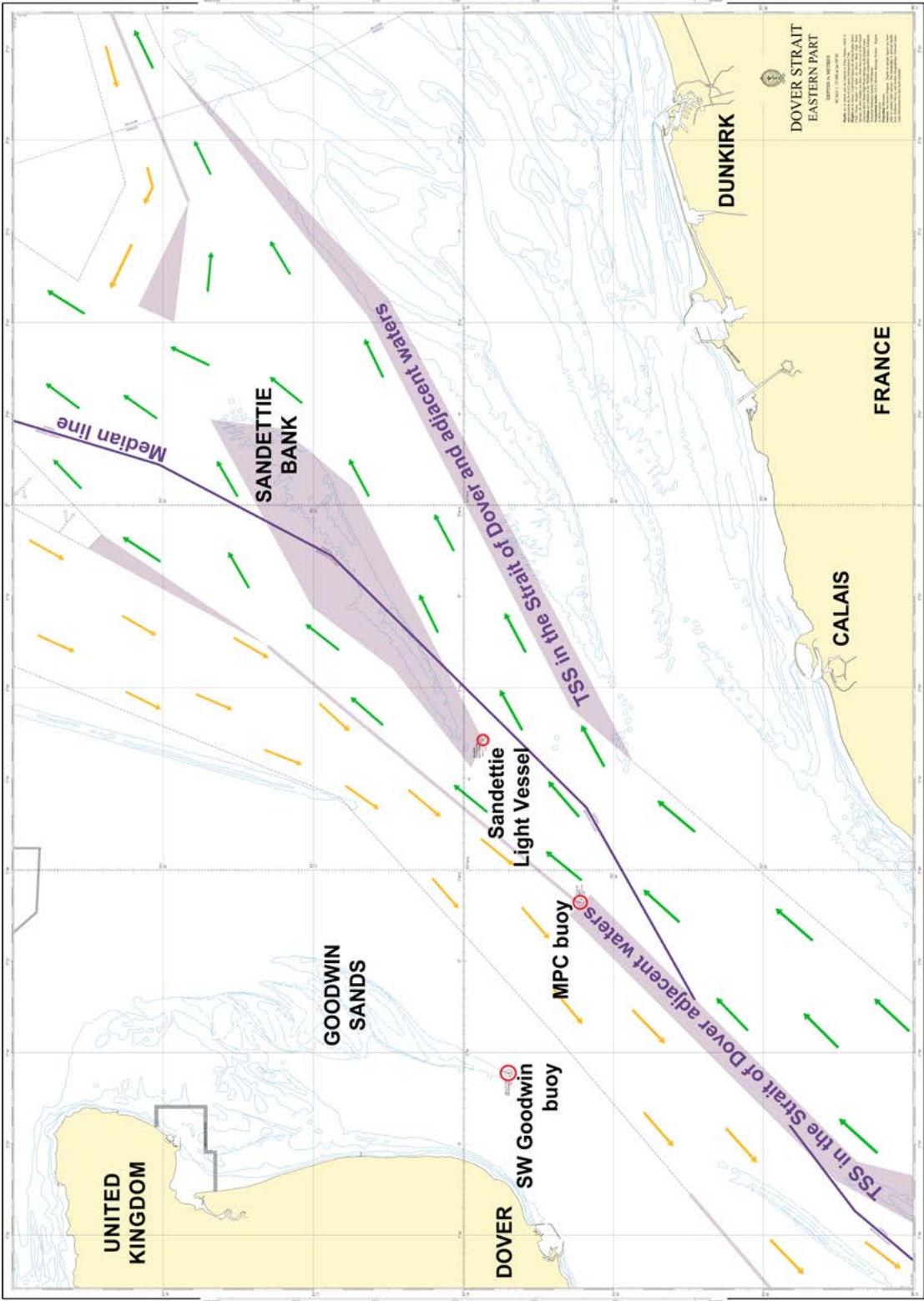
- 3.1** This chapter sets out part of the wider context to the events of the 23 to 24 November 2021. It explores, in outline form, the small boats issue. It starts by describing the English Channel, where small boat crossings have occurred, and then considers the increase in small boat crossings in the years leading to 2021 (including the role of people smugglers) and the challenges small boats present for a search and rescue response. The Terms of Reference do not require me to make any firm or conclusive findings about these matters, and I do not do so.

The English Channel

- 3.2** The English Channel is 300 nautical miles (nm) long and 130nm wide at its widest point. However, most small boat crossings take place in an area between England and France known as the Dover Strait, which is the narrowest point in the Channel and measures some 18nm (see Figure 1). The territorial waters of France and the UK in this area are separated by what is known as the median line. There are no international waters in the Dover Strait, although vessels of all nations have a right of transit passage under Article 38(1) of the UN Convention on the Law of the Sea.¹
- 3.3** There is a high volume of commercial and recreational marine traffic in the Channel. Over 400 vessels transit the Dover Strait every day, including some of the largest ships in the world. To manage this traffic, the International Maritime Organization (IMO) has approved a Traffic Separation Scheme (TSS), which is managed and controlled by the Channel Navigation Information Service. The scheme separates the marine traffic in the Channel so that it flows in two ‘lanes’.

¹ United Nations (1982), ‘United Nations Convention on the Law of the Sea’, United Nations Treaty Series, volume 1833, page 397.

Figure 1: Extract from nautical chart of the Dover Strait



Reproduced from Admiralty Chart 0323 by permission of the UK Hydrographic Office.

- 3.4** One lane of the Traffic Separation Scheme is on the English side of the Channel, with vessels travelling south-westerly. The other is primarily on the French side, with vessels travelling north-easterly, although around the area of the Sandettie Light Vessel the traffic flowing in this direction divides, with one stream crossing into UK territorial waters and the other continuing on the French side of the median line. The English side of the Channel falls within the UK search and rescue region and the French side falls within the French search and rescue region.
- 3.5** As well as being required to follow these ‘lanes’, a Mandatory Reporting Scheme is in place whereby large vessels (over 300 gross tonnes) are required to contact HM Coastguard when they enter and exit the area. The Traffic Separation Scheme has been described as being like an invisible, but very busy, motorway at sea.

Small boat crossings

Increase in the number of small boat crossings

- 3.6** Before 2018, there were isolated cases of clandestine small boat arrivals in the UK. A Home Office operation related to illegal migration threats from ‘small craft or yachts’ in July 2016, Operation Tuxes, found that nine instances of small boat crossings had taken place between 2014 and 2016.
- 3.7** However, in the last two months of 2018, there was a ‘surge’, and 248 people crossed the Channel in small boats. From May to July 2019, the numbers arriving by small boat continued to rise, reaching a new monthly high in August 2019 when 342 people made the crossing. It was also in August 2019 that the first reported fatality linked to a small boat crossing was recorded.² Over the autumn of 2019 and early part of 2020, instances of crossings stayed at relatively stable levels. However, in April 2020, the number of people crossing the Channel by small boat began to increase substantially, peaking for a third time in September 2020 when 1,949 people crossed.
- 3.8** From May 2021, the number of crossings began to increase significantly again. In November 2021, 6,971 people crossed in 209 small boats. This was the third highest monthly total of people to cross the Channel in small boats, and the highest number of boats in a month. See Figure 2 for the number of people detected arriving in the UK by small boat between 2018 to 2024, and Figure 3 for the number of small boats detected between 2018 to 2024.

2 INQ006143/par4. Please see Appendix 7 for guidance on how Inquiry document references are formatted.

Figure 2: Number of people detected arriving in the UK by small boat per month: January 2018 to September 2024

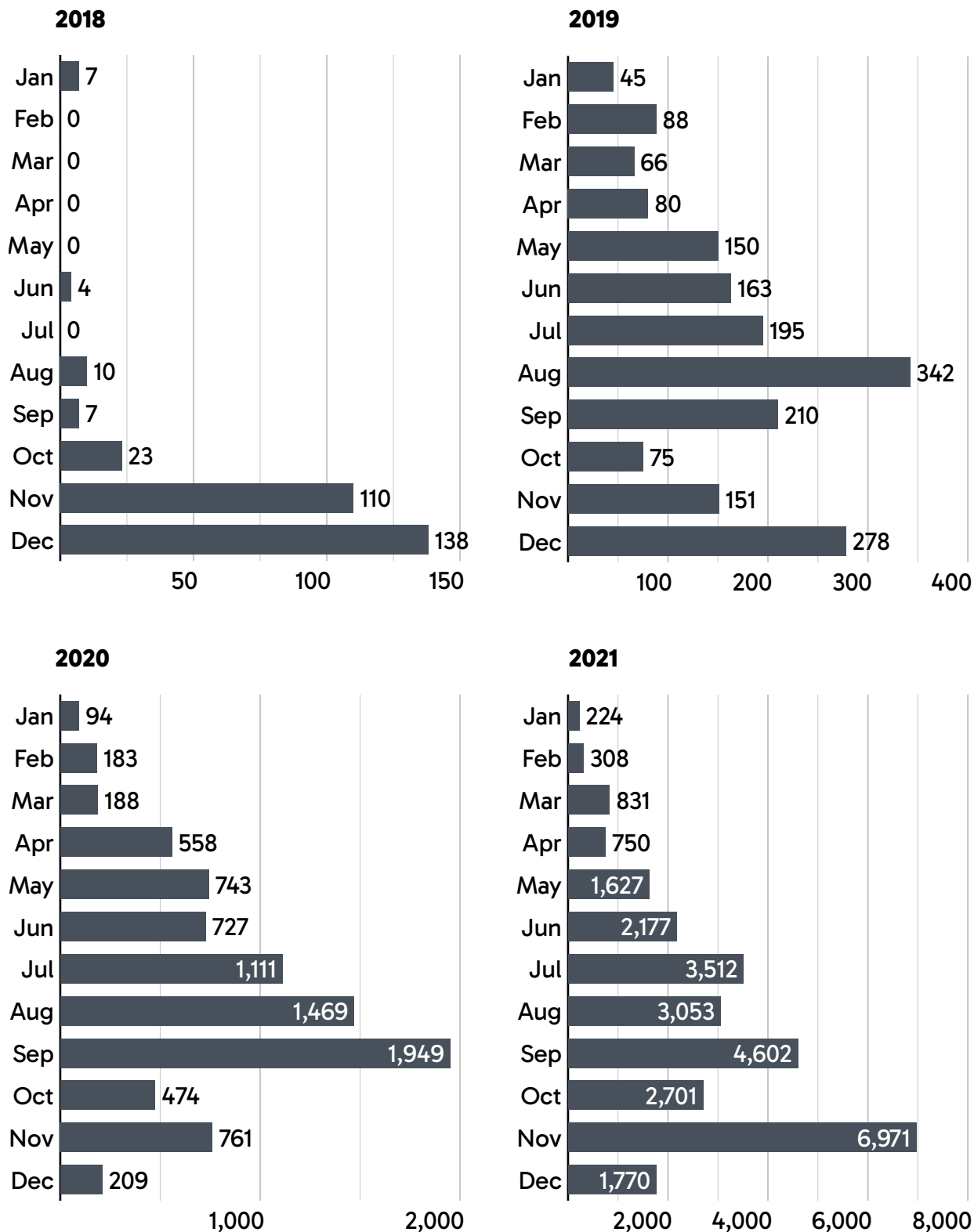


Figure 2: Number of people detected arriving in the UK by small boat per month: January 2018 to September 2024 (continued)

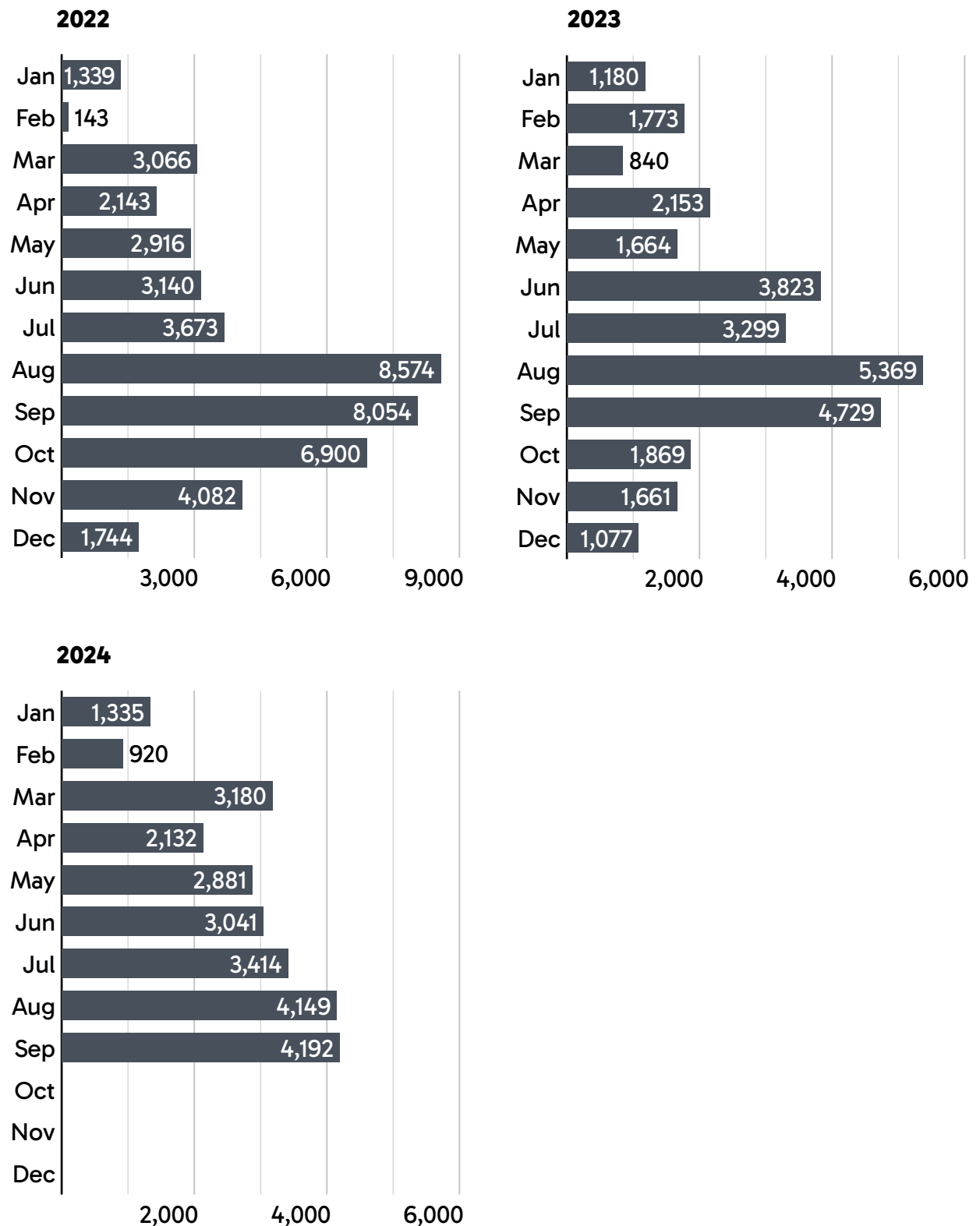


**Figure 3: Number of small boats detected per month:
January 2018 to September 2024**

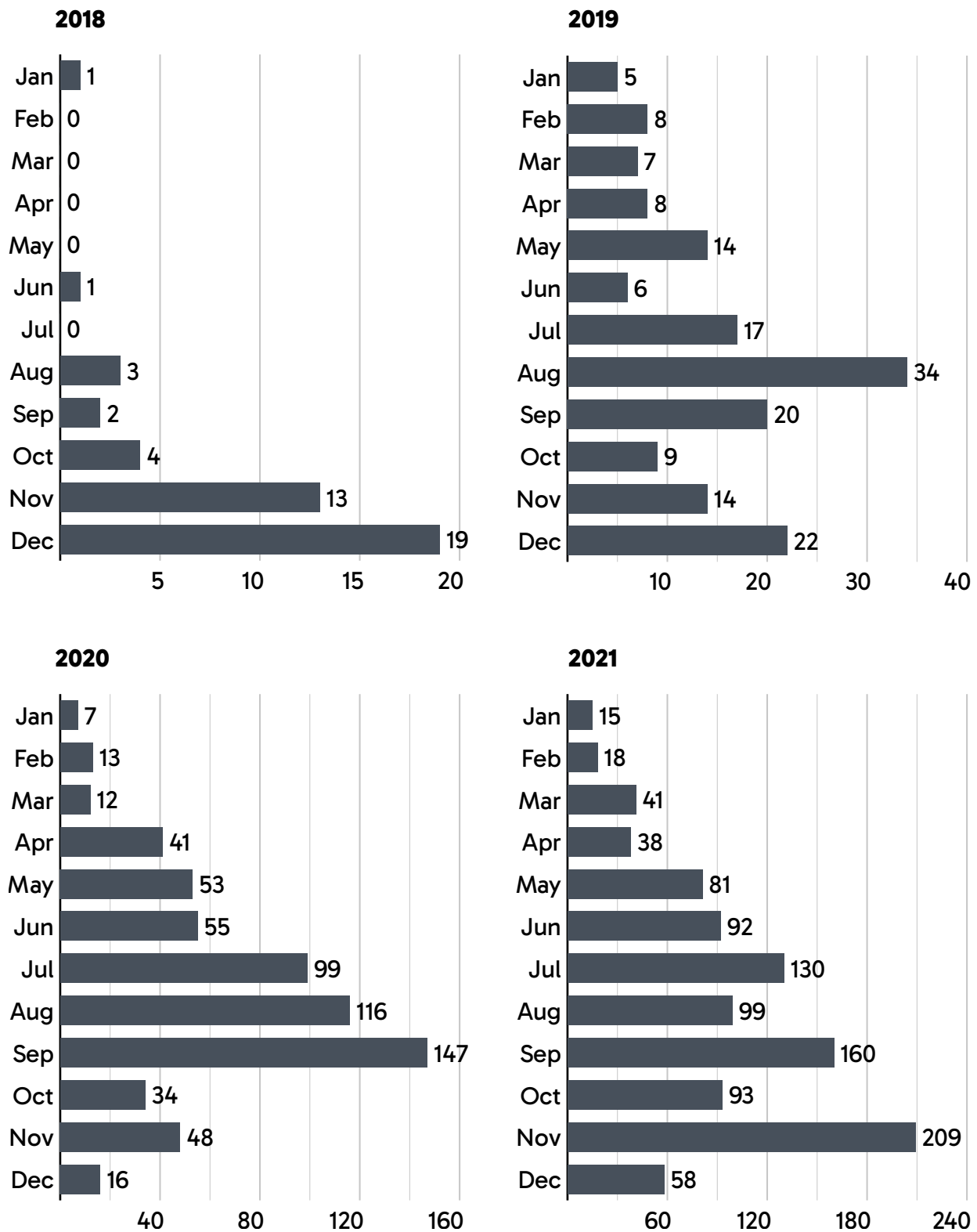
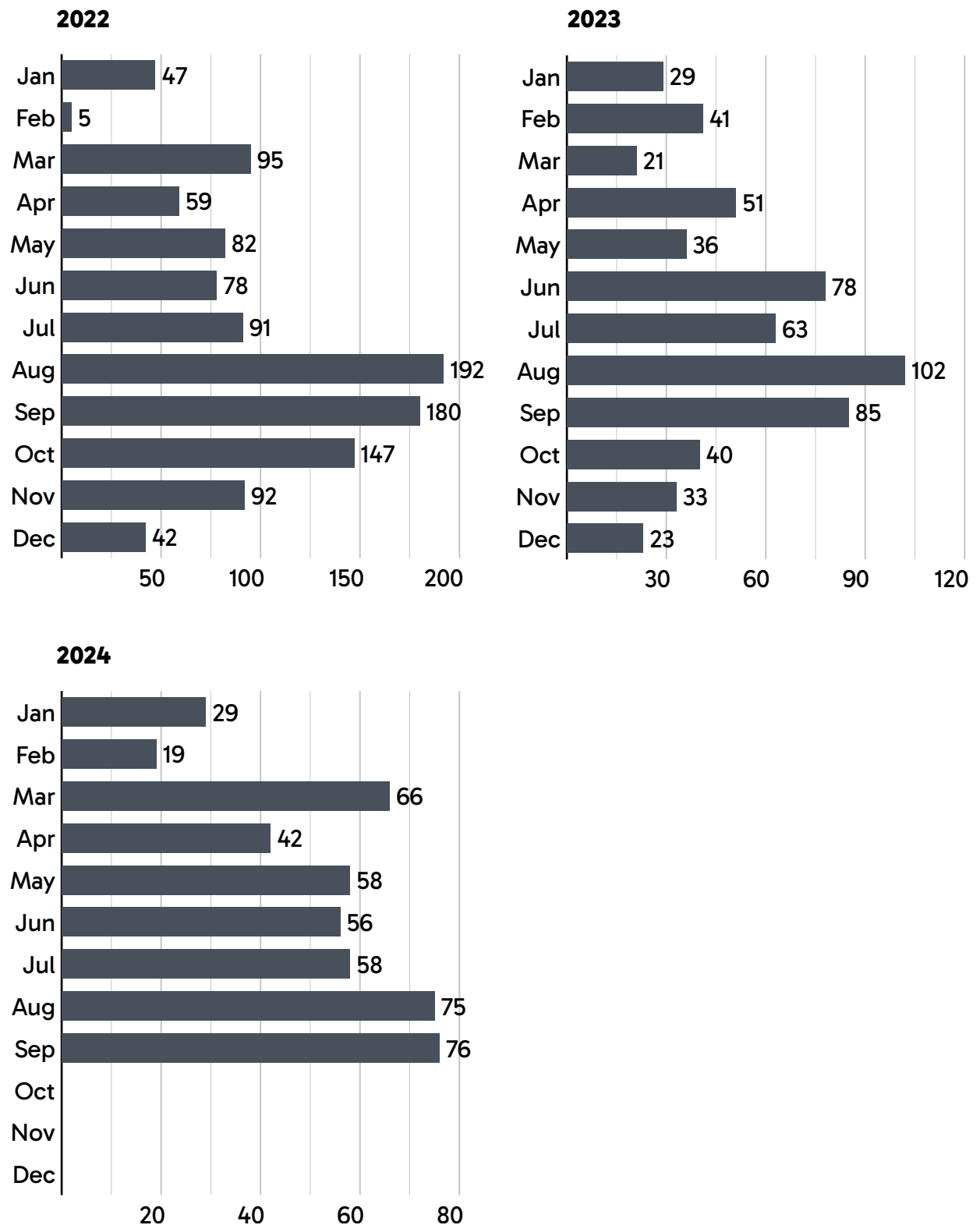


**Figure 3: Number of small boats detected per month:
January 2018 to September 2024 (continued)**



- 3.9** November 2021 is, for obvious reasons, of particular interest to the Inquiry. On 24 November 2021 itself, 757 people arrived in 17 small boats. This was not a particularly large number of boats for that month. For example, on 3 November 2021, 853 people crossed in 25 small boats, on 11 November 2021, 1,250 people crossed in 36 small boats, on 16 November 2021, 1,168 people crossed in 33 small boats, and on 20 November 2021, 886 people crossed in 28 small boats.
- 3.10** Since November 2021, crossings have continued in large numbers. The implications of the continuing increase in crossings for search and rescue are addressed later.³

Why people make the journey

- 3.11** The reasons that people migrate to the UK are complex and likely to vary considerably from person to person. The University of Oxford's Migration Observatory describes a combination of 'pull factors' which attract people to a particular destination, and those which 'push' people to leave wherever they may be.⁴ The Migration Observatory also acknowledges that there is limited academic evidence of why people decide to come to the UK specifically.⁵ The material which the Inquiry has received, including from non-governmental organisations and charities whose work concerns small boat crossings, refers to a number of potential reasons why people choose to migrate irregularly to the UK. The factors set out here are not intended to be exhaustive.
- 3.12** Among the factors which may be considered to 'pull' people to the UK are:
- the perception that the labour market is easy to access⁶
 - strong existing diasporas in the UK due to its history of immigration⁷
 - the English language⁸
 - Britain's imperial history⁹
 - the perception that the UK is a tolerant country which guarantees individual rights.¹⁰

3 See Chapters 5, 6 and 7.

4 The Migration Observatory (2025), 'Unauthorised migration in the UK'. Available at: <https://migrationobservatory.ox.ac.uk/resources/briefings/unauthorised-migration-in-the-uk> (accessed 30 October 2025).

5 The Migration Observatory (2025), 'People crossing the English Channel in small boats'. Available at: <https://migrationobservatory.ox.ac.uk/resources/briefings/people-crossing-the-english-channel-in-small-boats> (accessed 30 October 2025).

6 INQ009645/27/par39.3.

7 INQ009645/26/par39.2, INQ009647/13/par41.

8 INQ009647/13/par42.

9 INQ009647/13/par43.

10 INQ009647/14/par44.

- 3.13** There are also factors commonly cited which ‘push’ people to migrate irregularly (both initially and to continue to migrate further once their journey has started). These include:
- conflict, persecution and poverty¹¹
 - a cultural expectation of migration¹²
 - ill treatment by State and non-State actors on a migration route¹³
 - difficult conditions on the migration route, including in Calais.¹⁴
- 3.14** There is no consensus on the cause of the sharp increase in small boat arrivals since 2018. It is likely that there is no single causative factor. However, three factors can be highlighted: blockages with other routes of entry, the ramifications of the COVID-19 pandemic and the role of people smugglers.¹⁵
- 3.15** As to the first factor, the increase in security at the Port of Calais and the Channel Tunnel is often cited as a possible cause of the increase in small boat arrivals.¹⁶ The increase in security reduced the viability of entry into the UK via ferry or stowing away in lorries. Related to this are also the efforts to secure areas surrounding the port, including the removal of the area in Calais referred to as ‘the Jungle’ in 2016. This was home to approximately 6,000 people, living there on an informal basis and intent, in many cases, on migration to the UK. Small boats offered another route for the people smugglers.
- 3.16** The reduction in air, ferry and Channel tunnel traffic in 2020 as a result of the travel restrictions introduced in response to the COVID-19 pandemic is also thought to have contributed to the increase in small boat crossings, as this further reduced the viability of stowing away in lorries as a means to reach the UK. Small boats could avoid the pandemic restrictions. The people smugglers met the need.

11 INQ008208/3, 4 and 9, INQ008219, INQ009647/7-13/par27-39.

12 INQ002985/20/par4.1.3.

13 INQ009647/9-10/par30, 12/par38, INQ008187, INQ008188.

14 INQ009644/4/par12, INQ009647/14-23/par47-75, INQ008201, INQ008205. See also: The Migration Observatory (2025), ‘People crossing the English Channel in small boats’. Available at: <https://migrationobservatory.ox.ac.uk/resources/briefings/people-crossing-the-english-channel-in-small-boats> (accessed 30 October 2025).

15 For example, INQ010134/23-24/par61-63. See also: Home Affairs Committee (2022), ‘Channel crossings, migration and asylum: First report of session 2022-23’. Available at: <https://publications.parliament.uk/pa/cm5803/cmselect/cmhaff/199/report.html> (accessed 30 October 2025). See also: The Migration Observatory (2025), ‘People crossing the English Channel in small boats’. Available at: <https://migrationobservatory.ox.ac.uk/resources/briefings/people-crossing-the-english-channel-in-small-boats> (accessed 30 October 2025).

16 INQ008265/36-40, INQ009644/5-7/par14 -15, 8/par19, 10/par28, INQ004467/60/par8.2. See also: The Migration Observatory (2025), ‘People crossing the English Channel in small boats’. Available at: <https://migrationobservatory.ox.ac.uk/resources/briefings/people-crossing-the-english-channel-in-small-boats> (accessed 30 October 2025).

The role of people smugglers

- 3.17** ‘People smuggling’ is a term used to describe a transactional relationship between an individual and a facilitator to enter a country illegally. It is distinct from ‘people trafficking’, in which the objective is for the trafficker to exploit the victim for gain or other benefit, generally after their entry into the UK. That can be through their work or service, typically in the form of forced labour or sexual exploitation.
- 3.18** People smugglers play an inextricable role in the small boats issue. Notwithstanding the push and pull factors mentioned above, they are largely responsible for the industrialisation and commercialisation of small boat Channel crossings. People smuggling is often carried out by organised, transnational criminal networks. It generates vast profits.
- 3.19** In 2024, the Global Initiative Against Transnational Organized Crime suggested that the small boat smuggling networks across the English Channel are controlled by Iraqi Kurdish organised crime groups, with other groups co-operating and collaborating with them.¹⁷ There exists a network of recruiters in origin countries and a series of intermediary roles between the leader of the group and those on the ground, a sophisticated and established supply chain for boats, and ever-innovative techniques to avoid detection and apprehension by law enforcement. This includes the establishment of waiting posts further inland, from which people are brought to the coast at short notice and launched in small boats in multiple cycles with considerable efficiency. It also includes the use of so-called ‘water taxis’, where people wade short distances inshore to board a small boat which has been launched elsewhere, to prevent authorities intercepting the boat’s launch.
- 3.20** Successive UK governments have sought to disrupt the activities of people smuggling gangs. Some of the measures taken include increased co-operation with European police forces, co-operation arrangements with countries such as Iraq to tackle smuggling routes, a new Border Security Command to co-ordinate investigations, and a sanctions regime targeted at people smuggling gangs.¹⁸

17 Global Initiative Against Transnational Organized Crime (2024), ‘Small boats, big business: The industrialization of cross-Channel migrant smuggling’, page 11. Available at: <https://globalinitiative.net/wp-content/uploads/2024/02/Small-boats-big-business-The-industrialization-of-cross-channel-migrant-smuggling-GI-TOC.Feb-2024.pdf> (accessed 30 October 2025).

18 Home Office (2024), ‘UK/Iraq border security pact to target smuggling gangs’. Available at: www.gov.uk/government/news/uk-and-iraq-border-security-pact-to-target-smuggling-gangs (accessed 30 October 2025). Home Office (2024), ‘Home Secretary launches new Border Security Command’. Available at: www.gov.uk/government/news/home-secretary-launches-new-border-security-command (accessed 30 October 2025). Foreign, Commonwealth and Development Office (2025), ‘UK brings forward world’s first sanctions regime to smash the gangs responsible for irregular migration’. Available at: www.gov.uk/government/news/uk-brings-forward-worlds-first-sanctions-regime-to-smash-the-gangs-responsible-for-irregular-migration (accessed 30 October 2025).

Challenges for search and rescue presented by small boats

- 3.21** Small boat crossings present particular challenges for a search and rescue response. Firstly, there is the dangerous environment of the English Channel, where small boat crossings take place. Secondly, there are the characteristics of the small boats, their flimsy structure and the lack of navigation equipment available to people on board. Finally, there are the vulnerabilities of the people on board, both before they embark on the journey and during the voyage.

The Channel environment

- 3.22** The many large vessels which transit the Dover Strait present significant risks for small boats. Big ships may struggle to see unilluminated small boats or detect them by radar. Large vessels are also unable to change course quickly to avoid small boats due to their size, which increases the likelihood of collision, particularly if a small boat's engine fails and it is left to drift. Big ships also create large, turbulent wakes as they travel through the water. These are capable of swamping small boats. Small boat crossings usually take place in the Channel at night, when it is very dark. There is little light, except perhaps for the moon or passing ships. This makes it even more difficult for small boats to be seen.
- 3.23** The weather in the Dover Strait can also increase the danger of making the crossing, especially in winter months. Temperatures can get very low, presenting a risk of hypothermia. The water itself is also very cold. If someone enters the water, they might suffer cold water shock. More generally, low temperatures can have profound consequences on a person's ability to survive in the water.¹⁹ The misty and foggy conditions which are often present in the Channel can also make it more difficult to detect small boats.

Characteristics of small boats

- 3.24** The small boats used in crossing the Channel present a number of risks by virtue of their construction.
- 3.25** The Inquiry received evidence that the vessels used to cross the English Channel are now typically 8 metres to 10 metres in length.²⁰ In November 2021, the average length of vessels used was 7.5 metres, and they would carry around 32 people on average. The boats are made of a rubber material, similar to that used to make children's bouncy castles. They are generally comprised of a large inflatable tube with what appear to be two chambers (one on the boat's

¹⁹ This is considered in paragraphs 15.4 to 15.7.

²⁰ INQ010137/14/par28. When small boat crossings first began to increase, the boats used were small (4 metres to 6 metres) rigid hull inflatable boats, such as those used for yacht tenders. These boats would be overloaded to carry around 16 people. There were also instances of improvised craft being used such as inflatable paddling pools, rowing boats with makeshift paddles, or water sports equipment such as kayaks.

port side, the other on its starboard side). When inflated, they are barely half a metre tall.

- 3.26** Some boats have rubber patches along the top of the inflated tube, through which a length of rope had been threaded to give the impression of a lifeline. They have at their stern a plyboard or wooden transom, to which an outboard motor can be mounted. Often, these transoms are fixed to the boat with duct tape. They have a thin rubber membrane for a deck, which is often reinforced with wood or metal to allow more people to be carried. Boats often have a small outboard motor capable only of slow speeds, and their speed is likely to be reduced by overcrowding or choppy seas.
- 3.27** The boats are not built to any recognised EU or UK standard.
- 3.28** The risks posed to those on board by the poor construction of small boats seem to include the following.
- a.** Their low height in the water means they are prone to taking on water and any waves over 1 metre are likely to swamp a small boat entirely. This can cause people on the boat to get wet and increase the risk of hypothermia.
 - b.** Even if reinforced with floor panels and a transom, small boats have very little stability in the water. This instability means that if occupants on the boat stand, the small boat will likely capsize. Standing may also cause the floor of the small boat to give way.
 - c.** The use of sharp materials to reinforce the boats floors can damage the inflatable parts of the boat. If the inflatable part is punctured, the absence of a compartmentalised design means the entire boat will deflate and therefore the risk of sinking is extremely high.
- 3.29** The fact that the wooden transom is affixed with duct tape could lead to the entire transom falling off. Similarly, the wood of the transom may be untreated which can lead to significant warping and to the outboard motor falling off or, again, the entire transom becoming detached from the boat.
- 3.30** Fuel may leak from the engine, mix with seawater in the vessel and cause burns to boat occupants.
- 3.31** As well as creating risks to its occupants, the construction of small boats may also directly impact the search and rescue effort. Their rubber material and low height in the water, which are compounded by overcrowding of the vessel, mean that small boats have a minimal radar signature. The boats also do not have strong points to support towing or attaching lines to a search and rescue vessel.

Equipment on board small boats

- 3.32** People on small boats often have no lifesaving equipment, such as life jackets, or if they do have them, they are unsuitable. Life jackets worn by those onboard small boats are often filled with layers of foam material which provide little or no buoyancy and are liable to disintegrate if they come into contact with seawater and spilt petrol.²¹ The stitching and other construction is also poor. This, along with the fact that wearers are often given the incorrect size life jacket, means the devices do not stay in place.²² In fact, they can roll the wearer on to their front and make it more difficult for them to return to a position flat on their back in the water. This would make it more difficult for someone to keep their airways away from the water.²³ Often, other unsuitable items are provided for buoyancy including inflatable recreational rubber rings and inner tubes of tyres.
- 3.33** Finally, whereas conventional vessels have Automatic Identification System very high frequency (VHF) radio, radar and other vital equipment, small boats have no communication, location or navigation systems on board, except perhaps for the occupants' mobile phones. In other words, those on small boats do not have the equipment to know where they or other vessels are, or to readily call for help. Further, unlike conventional vessels, small boats are not named and need to be distinguished from other maritime traffic by characteristics such as their colour or the number of occupants.

Vulnerability of people on small boats

- 3.34** People aboard small boats are unlikely to have any maritime experience. They are unaware of the rules and regulations of the sea. Those steering the boat will not have proper training to do so. The overcrowding of vessels and exposure to the elements during the crossing can be physically demanding due to the cold and adverse sea conditions.
- 3.35** In addition, in some instances, highly vulnerable people such as unaccompanied children, pregnant women and people with disabilities are on board. Finally, English is almost always not the occupants' first language, which creates difficulties in seeking rescue.

21 INQ003460.

22 INQ003460.

23 INQ003460.

Chapter 4:

Search and rescue: organisations

Introduction

- 4.1** This chapter provides an overview of the main organisations and individuals involved in responding to small boats in the UK and in France on 23 to 24 November 2021. It addresses how these organisations and individuals related to, and worked with, one another at the time of the incident at an institutional, corporate or policy level, their relevant operational arrangements, and the operational roles and responsibilities of key individuals.¹

The Department for Transport

- 4.2** The Department for Transport (DfT) is a UK government department. The Secretary of State for Transport has responsibility for maritime security and search and rescue including by “establishing, operating and maintaining an adequate and effective civil maritime and aeronautical search and rescue service”.² In addition, the Secretary of State for Transport is a Category 1 responder pursuant to the Civil Contingencies Act 2004, which places a statutory duty on them to “assess, plan and advise” in relation to, among other things, “an event or situation which threatens serious damage to human welfare in a place in the United Kingdom”.³
- 4.3** The following organogram (Figure 4) has been provided by the DfT setting out the Civil Service roles relevant to small boats within the DfT at the time of the incident.⁴

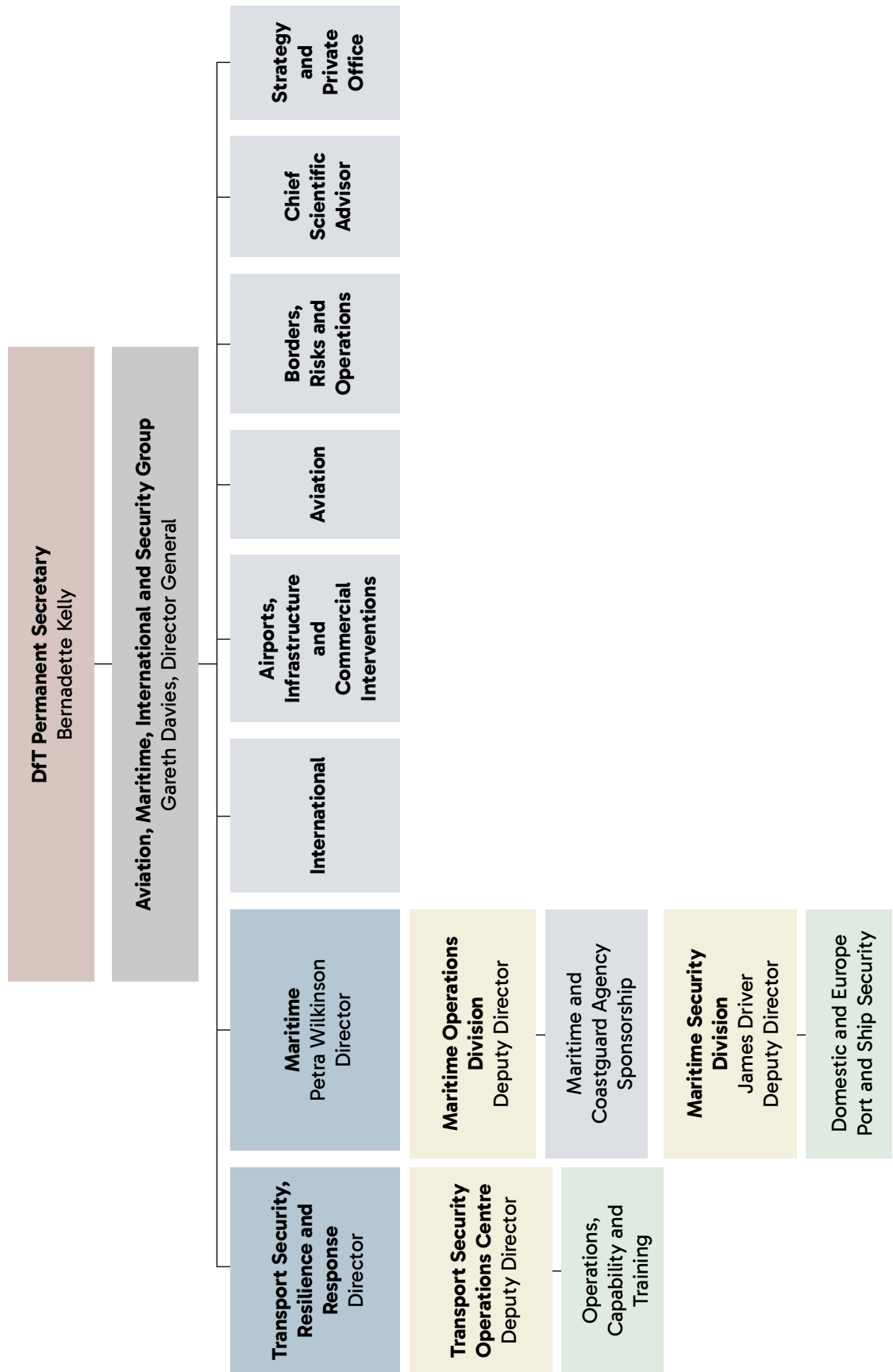
¹ Where this chapter uses the present tense, it is referring to the position as it was in November 2021, where the evidence before the Inquiry is that the position remains unchanged today. Where the past tense is used (unless qualified), the chapter refers only to the position as it was in November 2021.

² INQ003756/par 1.

³ INQ010337/9/par22h, 9/par23b. Civil Contingencies Act 2004, sections 1 and 2 and Schedule 1(12). Available at: www.legislation.gov.uk/ukpga/2004/36/contents (accessed 30 October 2025).

⁴ INQ008176.

Figure 4: Organisation chart showing the teams and individuals within the DfT relevant to small boats at the time of the incident



The DfT's relationship with other government departments

- 4.4** At the administrative level, the DfT is responsible for co-ordinating maritime interests across government. At the time of the incident, together with the Foreign, Commonwealth and Development Office, it liaised with the Home Office in relation to illegal migration policies to ensure that they did not infringe the UK's international obligations and ability to save lives at sea.⁵ The DfT also represented the Maritime and Coastguard Agency (MCA), and maritime interests generally, across Whitehall.⁶
- 4.5** From 2019, the DfT participated in a 'Small Boats Planning Group' which was convened and chaired through the Joint Maritime Operations Coordination Centre.⁷ The Joint Maritime Operations Coordination Centre was established in October 2017 to co-ordinate the deployment of seagoing government assets in contexts other than search and rescue.⁸ It was physically located in Portsmouth, together with the National Maritime Information Centre, which was established between 2010 and 2012 to gather intelligence.⁹
- 4.6** In 2019, the Joint Maritime Security Centre (JMSC) was created to act as an umbrella organisation for the National Maritime Information Centre and Joint Maritime Operations Coordination Centre.¹⁰ For administrative purposes it sits under Border Force and is therefore described in greater detail below.¹¹
- 4.7** From July 2021, DfT officials met with HM Coastguard representatives on a regular basis, specifically to discuss the small boats issue, co-ordinate any policy activity and keep abreast of operational matters.¹²

The Maritime and Coastguard Agency

- 4.8** The MCA is an executive agency of the DfT. It was formed on 1 April 1998 when the Marine Safety Agency and Coastguard Agency were merged to form the MCA.¹³ The MCA's purpose is to discharge the DfT's international obligations and statutory duties in respect of search and rescue and civil contingency.¹⁴ At an operational level, the MCA does this through HM Coastguard, with the MCA providing corporate governance.¹⁵

5 INQ010337/19-20/par45, 22/par53, 79/par241.

6 INQ010337/56/par158b.

7 INQ010337/78-79/par238.

8 INQ010445/41-42/par1.9.1, INQ009128/1/par3, INQ006156/1, INQ000003/1/par4, INQ000426/2.

9 INQ001119, INQ009128/4/par16, INQ000441/1, INQ000003/1/par3, INQ000441/2.

10 See paragraph 4.70.

11 INQ010337/24/par60, INQ004290/2.

12 INQ010337/57/par160, 88/par269, 90/par273.

13 INQ010413/6/par4, INQ000168/53.

14 INQ010337/10/par24.

15 INQ010337/10/par24, INQ010098/2/par1.1.

- 4.9** At the time of the incident, the MCA's Chief Executive was responsible for the overall "risk management and maritime governance, improvement and assurance" of the MCA.¹⁶ The MCA Board was the highest decision-making entity within the MCA and was responsible for (among other things) ensuring that it was informed of any concerns about MCA activities.¹⁷
- 4.10** The detail of the relationship between the DfT and the MCA was set out in the framework document for the MCA in November 2017 (the MCA Framework).¹⁸ Under the MCA Framework, the Secretary of State for Transport was accountable to Parliament for all matters concerning the MCA, for the policy framework in which it operated, and for agreeing the MCA's strategic objectives, but was not expected to become involved in day-to-day operational matters.¹⁹
- 4.11** The DfT Director of Maritime was also the MCA agency owner and agency sponsor, and was "responsible on behalf of the Agency Owner, the Minister and the Permanent Secretary for holding the MCA to account and gaining assurance on the body's governance, risk management, and internal control processes".
- 4.12** Under the terms of the MCA Framework, the MCA was generally required to report regularly its financial and non-financial performance to the agency sponsor and to inform them of any changes which may impact the achievement of the MCA's objectives. In a similar way, the agency owner was required to ensure that there were arrangements in place to monitor the MCA's activities, address significant problems, periodically assess risks, and bring concerns about the MCA's activities to the MCA and DfT boards.²⁰

HM Coastguard

- 4.13** As explained above, at an operational level, the MCA discharges the DfT's obligations and duties in respect of search and rescue and civil contingency through HM Coastguard.²¹ HM Coastguard has six functions: search and rescue, vessel traffic monitoring, maritime security, pollution response, maritime safety, and disaster and emergency response.²² In respect of search and rescue specifically, HM Coastguard provides 24-hour emergency search and rescue services for incidents at sea and in the coastal, or 'littoral', areas of the UK.²³

16 INQ000168/50,52.

17 INQ010337/60/par170, INQ000955/11/par40.

18 INQ000955.

19 INQ000955/4-5/par11-15.

20 INQ000955/6/par21, 20/par88.

21 INQ010337/10/par24, INQ010098/2/par1.1.

22 INQ010098/3/par1.5.

23 INQ009632/13/par28, INQ009634/9/par18, INQ010098/2/par1.1, INQ000379/9, INQ000412/8.

- 4.14** At the time of the incident, at a corporate level the discharge of HM Coastguard's six functions was the responsibility of the Director of HM Coastguard, who was part of the executive directorship of the MCA.²⁴
- 4.15** HM Coastguard became the responsibility of the Secretary of State for Transport in 1983.²⁵ Immediately before that, it was under the control of the Board of Trade as a "coast-watching force for the performance of the duties hitherto performed by the coastguard on behalf of the Board, and of such other duties as may be determined by the Board".²⁶
- 4.16** In 1992, following a period of ambiguity around HM Coastguard's role, the then Secretary of State for Transport clarified HM Coastguard's search and rescue role and the duty on it to provide search and rescue services pursuant to the Coastguard Act 1925.²⁷ The determination said:
- "Her Majesty's Coastguard is responsible for the initiation and co-ordination of civil maritime search and rescue within the United Kingdom search and rescue region. This includes the mobilisation, organisation and tasking of adequate resources to respond to persons either in distress at sea, or to persons at risk of injury or death on the cliffs or shoreline of the United Kingdom."²⁸
- 4.17** HM Coastguard primarily discharges its search and rescue duty by co-ordinating assets which are declared or contracted to it. It has not had its own fleet of maritime surface assets (sea-going vessels) since the 1970s. The assets HM Coastguard co-ordinates are either 'declared search and rescue facilities' or 'additional facilities'. A declared search and rescue facility is a facility which has been designated as being available for maritime search and rescue according to a specific standard or set criteria – for example, the Royal National Lifeboat Institution (RNLI) and contracted air operators. An additional facility is one which may be available from time to time but which is not of a specific standard (for example, vessels in the vicinity of an incident).²⁹ Due to its use of RNLI assets for search and rescue purposes, HM Coastguard's systems necessarily involve a significant degree of reliance on voluntary organisations and volunteers.

24 INQ000168/51, 54, INQ010203, INQ002301.

25 INQ010337/10/par24b.

26 When HM Coastguard was initially formed in 1822, its role was to prevent smuggling by patrolling the coast of the UK. It then spent a brief period under the control of the Admiralty, before being returned to civilian control under the Board of Trade. See also: Coastguard Act 1925, section 1. Available at: www.legislation.gov.uk/ukpga/Geo5/15-16/88/contents (accessed 30 October 2025).

27 INQ010337/10/24b, INQ010411.

28 INQ010411.

29 INQ010098/46-47/par2.73-2.77, INQ001347. For the status of Border Force as additional or declared facility, see paragraph 7.31.

Operational arrangements within HM Coastguard

- 4.18** At the time of the incident, to deliver its functions in respect of search and rescue within the UK, HM Coastguard operated a ‘national network’ comprised of the Joint Rescue Coordination Centre (JRCC), a series of Maritime Rescue Coordination Centres (MRCC), and the Aeronautical Rescue Coordination Centre (ARCC).³⁰ There was also a Maritime Rescue Sub-Centre in London.³¹ These co-ordination centres covered 36 search and rescue zones across the UK.³² The Dover Strait lay in zone 14.³³
- 4.19** There were 10 MRCCs within the UK including MRCC Dover (11 if the Maritime Rescue Sub-Centre in London was also counted), each of which had a defined, geographical maritime area of responsibility.³⁴ MRCCs were used to co-ordinate all maritime search and rescue activities within their area of responsibility.³⁵ Each MRCC had an operations room.³⁶
- 4.20** The JRCC, MRCCs and Maritime Rescue Sub-Centre were, and are, linked through two data centres, which means that all routine and emergency telephone lines and 166 radio communications sites are available to all MRCCs, the Maritime Rescue Sub-Centre and the JRCC.³⁷ In addition, all MRCCs operate the same systems, policies and procedures.³⁸ Access to these lines of communication and having common policies and procedures in place allow staff within each MRCC to co-ordinate the search and rescue missions of other MRCCs throughout the UK. At the time of the incident, ‘zone flexing’ was used to manage staffing levels within the network by allowing remote support to be provided to MRCCs like MRCC Dover which had insufficient staff.³⁹ By contrast, being physically present in the operations room was sometimes referred to as being ‘on station’.⁴⁰

30 INQ000427/1, INQ010098/3/par1.5, INQ008905/9/par2.1.1.

31 INQ010098/24/par1.63, INQ008933/6, INQ000073/6/par2.3.

32 INQ008905/11/par2.1.7, INQ001459.

33 INQ010138/7/par27, 9/par40a, INQ007274/2, INQ007276/1, INQ001459, INQ000411, INQ010142/14/par37.

34 INQ009632/13/par29, INQ010138/2-3/par8, INQ001459.

35 INQ010098/24/par1.62, INQ009632/13/par29.

36 INQ009632/2/par6.

37 INQ008905/11/par2.1.7, INQ010138/2-3/par8, INQ004106/10/par2.1.3.

38 INQ009634/10/par21.

39 INQ000456, INQ010138/2-3/par8, INQ009632/13/par29, INQ010142/par17, INQ009634/9-10/par19-21. For zone flexing, see paragraph 6.6.

40 INQ009632/2/par6, 14/par32, INQ009634/11/par22.

The Joint Rescue Coordination Centre

- 4.21** At the time of the incident, the JRCC at Fareham had two functions. Firstly, it was the UK Mission Control Centre for HM Coastguard, which co-ordinated and organised the MRCCs and ensured each had adequate resources available for search and rescue missions.⁴¹ Secondly, the JRCC housed the ARCC for tasking and co-ordinating aviation assets across the entire HM Coastguard network.⁴² The JRCC was also the primary fall-back station for any MRCC requiring remote assistance under the 'zone flexing' system.⁴³
- 4.22** The ARCC did not receive calls directly from members of the public but instead received requests for assistance from 'recognised coordinating authorities', which were the three main emergency services, HM Coastguard and foreign search and rescue providers.⁴⁴ The ARCC would sift these calls and then task aerial asset providers and (exceptionally) Ministry of Defence (MOD) assets to conduct aerial search and rescue operations.⁴⁵

Maritime Rescue Coordination Centre Dover

- 4.23** MRCC Dover usually covered search and rescue zones 11, 13 and 14.⁴⁶ Zone 11 covered an area approximately from Felixstowe to Bradwell-on-Sea, zone 13 covered an area approximately from Bradwell-on-Sea to Margate, and zone 14 covered an area from Margate to Camber Sands.⁴⁷ However, in the lead up to the incident, under a temporary operating instruction, responsibility for search and rescue zones had been reallocated so that MRCC Dover was only responsible for zone 14.⁴⁸
- 4.24** As well as being responsible for search and rescue missions in its designated area(s), MRCC Dover was also responsible for the Vessel Traffic Service, which was a radio and radar service monitoring the movement of commercial vessels within the Dover Strait, 24 hours a day.⁴⁹

Joint Control Room

- 4.25** MRCC Dover was also the physical location of the Joint Control Room – sometimes referred to as the CTC [Clandestine Threat Command] Control Room.⁵⁰ This was a body controlled by the Clandestine Channel Threat

41 INQ010138/2/par6, INQ006716/1.

42 INQ009628/1/par2, INQ010098/24-25/par1.64, INQ006716/1.

43 INQ009634/9-10/par19-21, INQ009632/13/par29, INQ000456.

44 INQ009628/5/par12b, 7/par15.

45 INQ009628/7/par15, 11-17/par26-41. See also paragraph 4.99.

46 INQ001459, INQ000411, INQ010142/14/par37, INQ010138/9/par40a.

47 INQ001459, INQ010142/14/par37.

48 INQ010343/2, INQ000411, INQ010138/7/par28, 9/par40a, INQ006193, INQ010142/14/par37.

49 INQ010138/10/par40c, INQ009634/11-12/par24.

50 INQ000619/23, INQ010137/21-22/par54.

Command (CCTC) and established in late 2020 to early 2021.⁵¹ In response to the increase in small boats, from 2019 onwards, Border Force Liaison Officers were placed in MRCC Dover on days when high numbers of crossings were anticipated.⁵² The Joint Control Room formalised this arrangement and was intended to enable closer working and information sharing between Border Force Maritime Command (BFMC) and HM Coastguard in respect of small boat activity.⁵³

- 4.26** The Joint Control Room had a role in co-ordinating the arrival and disembarkation of BFMC vessels which had rescued people from small boats, tasking Border Force assets, and sharing Home Office drone imagery.⁵⁴ However, at the time of the incident, the Joint Control Room generally only operated during day-time hours.⁵⁵

Operational systems

ViSION

- 4.27** HM Coastguard used an incident management software called ‘ViSION’ to record details and information relevant to a particular search and rescue incident.⁵⁶ Each incident log would receive a ‘global incident number’.⁵⁷ The information recorded included names of casualties or first informants, location of the incident, resource taskings and search instructions to assets.⁵⁸
- 4.28** In the context of small boats, a new incident log on ViSION would be created by the relevant MRCC (usually MRCC Dover) when a call about a small boat crossing was received (either directly to HM Coastguard or transferred from another emergency service or body), or when incidents were communicated by the French authorities or recorded in the French tracker document.⁵⁹ A new log would be created unless a call could be immediately correlated with a previous incident – for example, if the phone number used was identical and could be recognized by the ViSION system.⁶⁰ Sometimes a further incident would be created but would later be merged with a previous incident number once it became clear that both calls in fact related to the same incident.⁶¹

51 INQ000182/2, INQ010134/13/par37, 24/par65, INQ010137/16-17/par40, INQ010098/29/par2.14, INQ005229.

52 INQ010137/17/par41.

53 INQ010098/29/par2.14, INQ010134/13/par37, 24/par 65, INQ010137/16-17/par39-41.

54 INQ010445/45/par1.10.4, INQ010098/29/par2.14, INQ010137/17/par41.

55 INQ010134/13/par38, INQ010137/17/par41, INQ010135/8-9/par20.

56 INQ010098/62/par3.71.

57 INQ010098/62/par3.71, INQ010142/8/par20.

58 INQ010098/62/par3.71.

59 INQ010098/62/par3.72, INQ009634/16/par41. See also paragraph 7.72.

60 INQ010098/62/par3.73, INQ000435, INQ009634/18/par45c.

61 INQ010098/62/par3.73, INQ000435.

- 4.29** As well as opening a ViSION log for each individual incident, MRCC Dover would also open a daily incident log within ViSION titled ‘admin’, which was used to record and account for all small boat operations for the day. The log would cover a 24-hour period, from midnight to midnight, and was known as the migrant administration log.⁶²
- 4.30** Some features of ViSION require further explanation. Firstly, if an asset was tasked to a particular incident, the ViSION system would automatically update.⁶³ Automatic updates are indicated by lower case text in the ViSION log, whereas manual entries appear in capital letters.⁶⁴ Secondly, ViSION had a grading system for incidents. For example, ‘I’ stands for ‘information’, ‘N’ for ‘non-search and rescue’, ‘M’ for ‘monitoring’ and ‘D’ for ‘distress’.⁶⁵

C-Scope

- 4.31** A further system used by HM Coastguard to co-ordinate search and rescue was ‘C-Scope’.⁶⁶ This was used to simulate the projected course of a given small boat, once its initial position was known, so that vessels in or around its path which might be able to locate it or provide further information could be identified.⁶⁷

HM Coastguard tracker

- 4.32** HM Coastguard used a tracker spreadsheet to co-ordinate the search and rescue response to small boats. In the report, this is referred to as the ‘HM Coastguard tracker’. It was used to develop situational awareness and obtain a recognised maritime picture, as well as to reconcile calls which were received from small boats.⁶⁸ The phrase ‘recognised maritime picture’ in this context refers to an awareness of the number and location of small boats within the Channel, their situation (in particular their level of distress), and the number of people on board.
- 4.33** The HM Coastguard tracker was an Excel spreadsheet created by HM Coastguard. The Inquiry was provided with 182 iterations of this tracker for 23 to 24 November 2021.⁶⁹ The Inquiry was also provided with a document referred to as an ‘index of versions’, which identifies who made changes to the document and when.⁷⁰ This document was used only by the maritime arm of HM Coastguard and was not made available to the ARCC.⁷¹

62 INQ009634/17/par45a, INQ008904/16, INQ010138/11-12/par44, INQ000235.

63 INQ010715/154/ln14-22, INQ010720/162-163/ln12-10.

64 INQ010715/72/ln18-24.

65 INQ010715/72/ln23-24, INQ010715/79/ln11-19.

66 INQ000437.

67 INQ010098/54/par3.36.

68 INQ010098/60-61/par3.60-3.70.

69 INQ010098/60/par3.64, INQ006771-INQ006952.

70 INQ007058.

71 INQ010718/110/ln11-17.

- 4.34** The tracker was developed through experience in dealing with small boat incidents, and the intention was to try and keep a summary of information that may be required or requested on a single sheet.⁷²
- 4.35** HM Coastguard allocated a unique identifier to each incident, in addition to the ‘global incident number’ attributed to the incident by the ViSION system.⁷³ The reference consisted of a phonetic alphabet code-word (such as Alpha, Bravo or Charlie) being attributed to the incident.⁷⁴ Calls would be attributed to one of these references in alphabetical order, in line with the order in which calls were received, and it was not uncommon for HM Coastguard to go through the alphabet multiple times in a shift.⁷⁵ Where this happened, a number would also be attributed (such as Alpha 1, Foxtrot 2 or Delta 3).⁷⁶
- 4.36** The HM Coastguard tracker included a row for each unique reference.⁷⁷ It also included columns to record various information about the boat, including its co-ordinates (if known), the number of people on board and any distinguishing features. Each row was given a coloured red, amber or green rating, relating to whether the incident was ongoing or closed. This was a determination made by HM Coastguard.⁷⁸

Systems for communicating with search and rescue incidents

- 4.37** There were various systems for communications with HM Coastguard in relation to search and rescue incidents. Calls could be made to report search and rescue incidents using the UK emergency call numbers, 999 or 112. The call handling agent would route a 999 or 112 call to the appropriate co-ordination centre.⁷⁹
- 4.38** Where calls were made through the emergency calls system, a system known as the Enhanced Information Service for Emergency Calls could be used to obtain the caller’s location automatically. However, there were limitations to this, which are addressed in Chapter 6.

72 INQ010097/5/par16.

73 INQ010098/62/par3.71, INQ010142/8-9/par20-21.

74 INQ010142/9/par21.

75 INQ010142/9/par21, INQ010135/8-9/par20.

76 INQ010142/9/par21.

77 INQ006834, INQ010142/9/par22.

78 INQ010135/11-12/par25.

79 INQ005192/2.

- 4.39** Calls could also be made directly to HM Coastguard or through other means. HM Coastguard training directed staff to get as much information as possible from a caller. If they had called through a non-emergency number, and once all information had been obtained, the caller was asked to hang up and call back using an emergency number, in the hope of obtaining their location.⁸⁰
- 4.40** MRCC Dover also had a dedicated mobile phone which could be used for communicating with small boats. This is addressed in more detail in Chapter 6.

Roles and responsibilities: MCA and HM Coastguard line management structure

- 4.41** Figure 5 is an organogram showing the MCA and HM Coastguard line management structure as at 23 to 24 November 2021.

Key leadership roles and responsibilities in HM Coastguard

- 4.42** HM Coastguard is led by the Chief Coastguard, who is responsible for setting the strategic direction of HM Coastguard operations. The Chief Coastguard is also responsible for ensuring that HM Coastguard is adequately structured and resourced to deliver on the UK's coastal State responsibilities, the requirements of the Civil Contingencies Act 2004, as well as the MCA's and HM Coastguard's business strategy and plans. The Chief Coastguard has a role in establishing and representing the interests of HM Coastguard at a national level to other key stakeholders such as the DfT, Home Office, RNLI and other international coastguard services.⁸¹
- 4.43** The Deputy Chief Coastguard is the deputy head of the profession and is responsible to the Chief Coastguard for delivering the strategic operational direction for HM Coastguard, as well as its business objectives. They are also responsible for ensuring that HM Coastguard delivers on the UK's international and domestic responsibilities and obligations.

Operational roles and responsibilities

- 4.44** The organogram at Figure 6 shows the HM Coastguard command structure as at 23 to 24 November 2021.

80 INQ010746/148/ln4-18.

81 INQ010098/12/par1.33-1.35, INQ010205.

Duty Strategic Maritime Commander

- 4.45** Operationally, the role of the Duty Strategic Maritime Commander was to oversee and support the JRCC Maritime Tactical Commanders.⁸² This was a role shared between five Grade 7 coastguard staff, each of whom would be on call for a week at a time.⁸³ The Duty Strategic Maritime Commander would provide advice, re-assurance, assistance with decision-making, and support for routine and major coastguard operations, to those beneath them in the command structure, if required.⁸⁴

JRCC Tactical Commanders

- 4.46** The role of Maritime Tactical Commanders within the JRCC was to ensure the efficient running of the Coastguard network.⁸⁵ This necessarily involved maintaining oversight of ongoing search and rescue missions to ensure that there was a proper plan in place, and sufficient resources were available.⁸⁶ In practical terms, this was achieved through the 'RAG' procedure, which stands for 'review, assess, guidance'.⁸⁷ This process required JRCC Maritime Tactical Commanders to periodically review ongoing search and rescue incidents and record their assessments briefly in the ViSION system.⁸⁸
- 4.47** JRCC Maritime Tactical Commanders were required to work in shifts to ensure that there was a tactical-level officer overseeing the Coastguard network 24 hours a day.⁸⁹

Maritime Tactical Commanders

- 4.48** Outside the JRCC, each MRCC had an officer at Maritime Tactical Commander level.⁹⁰ This was generally a non-operational role with responsibility for managing an MRCC station as part of the national network.⁹¹ However, they could assume Search and Rescue Mission Co-ordinator (SMC) duties if needed.⁹² They were required to work a rota as Duty On-Call Tactical Commanders to provide out-of-hours network support in addition to, or in the absence of, the JRCC Maritime Tactical Commander who was on duty.⁹³

82 INQ003766/4.

83 INQ010094/6/par23, INQ010098/14/par1.42, INQ007230.

84 INQ003766/4-6, INQ010094/6/par26, 7/par28-29, INQ010098/14/par1.42.

85 INQ010138/2/par7, 3/par9.

86 INQ010138/3/par10, INQ003775.

87 INQ010138/3/par10, INQ003775, INQ010098/108/par6.38.

88 INQ003775.

89 INQ010098/14-15/par1.43, INQ003766, INQ000390, INQ010212/5/par13-14, INQ009634/8/par14, 9/par18, INQ000410/tab'C&C', INQ000404/1-2, INQ004764/12/par4.3.3.

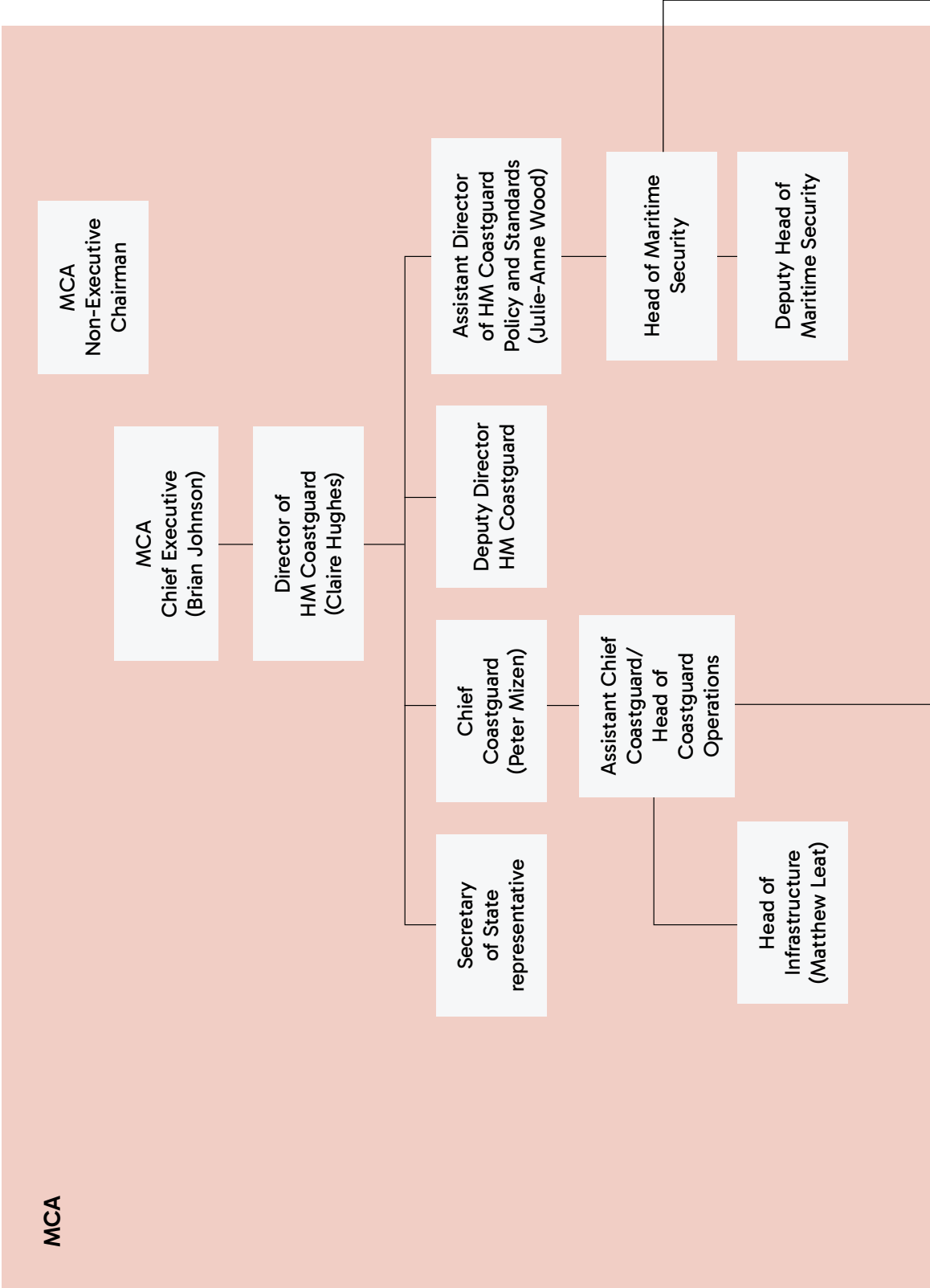
90 INQ003766/1-2, INQ004550.

91 INQ010212/8/par23, INQ000402/1.

92 INQ000446/2.

93 INQ003766/2, INQ010212/8/23, INQ000402/1.

Figure 5: MCA and HM Coastguard line management structures as at 23 to 24 November 2021



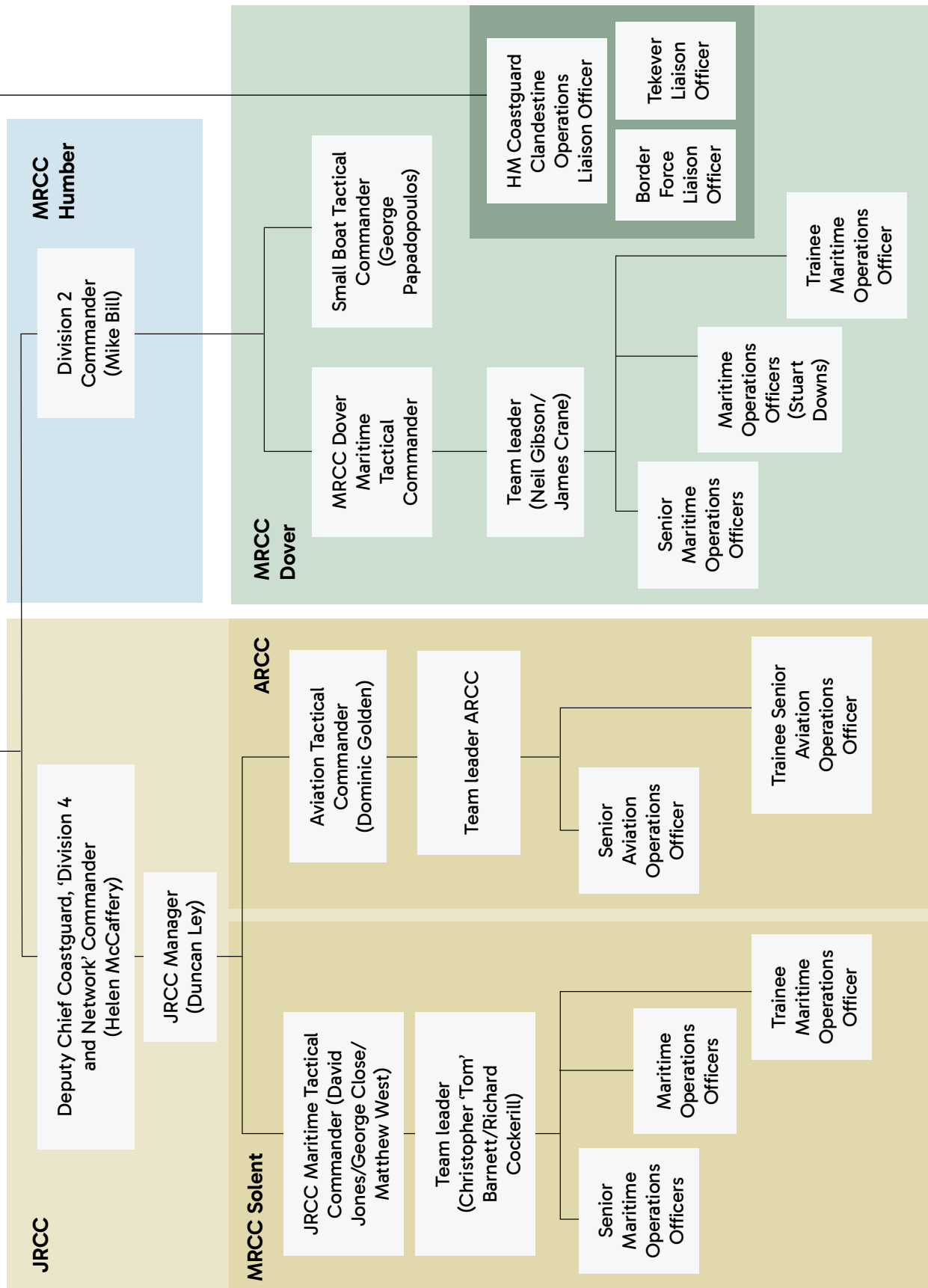


Figure 6: HM Coastguard command structure at 23 to 24 November 2021

HM Coastguard command structure in relation to MRCC Dover on the night shift of 23 to 24 November 2022

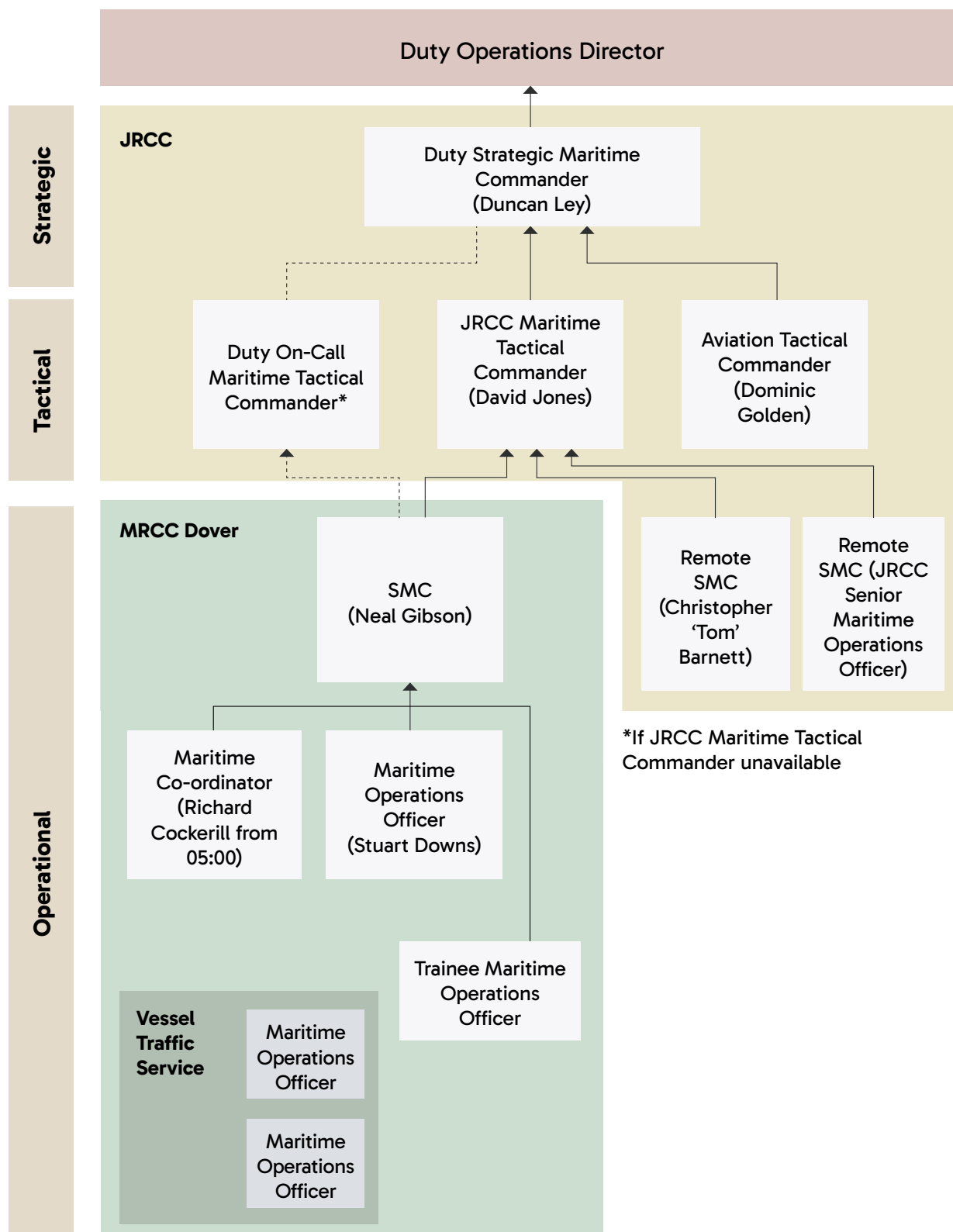
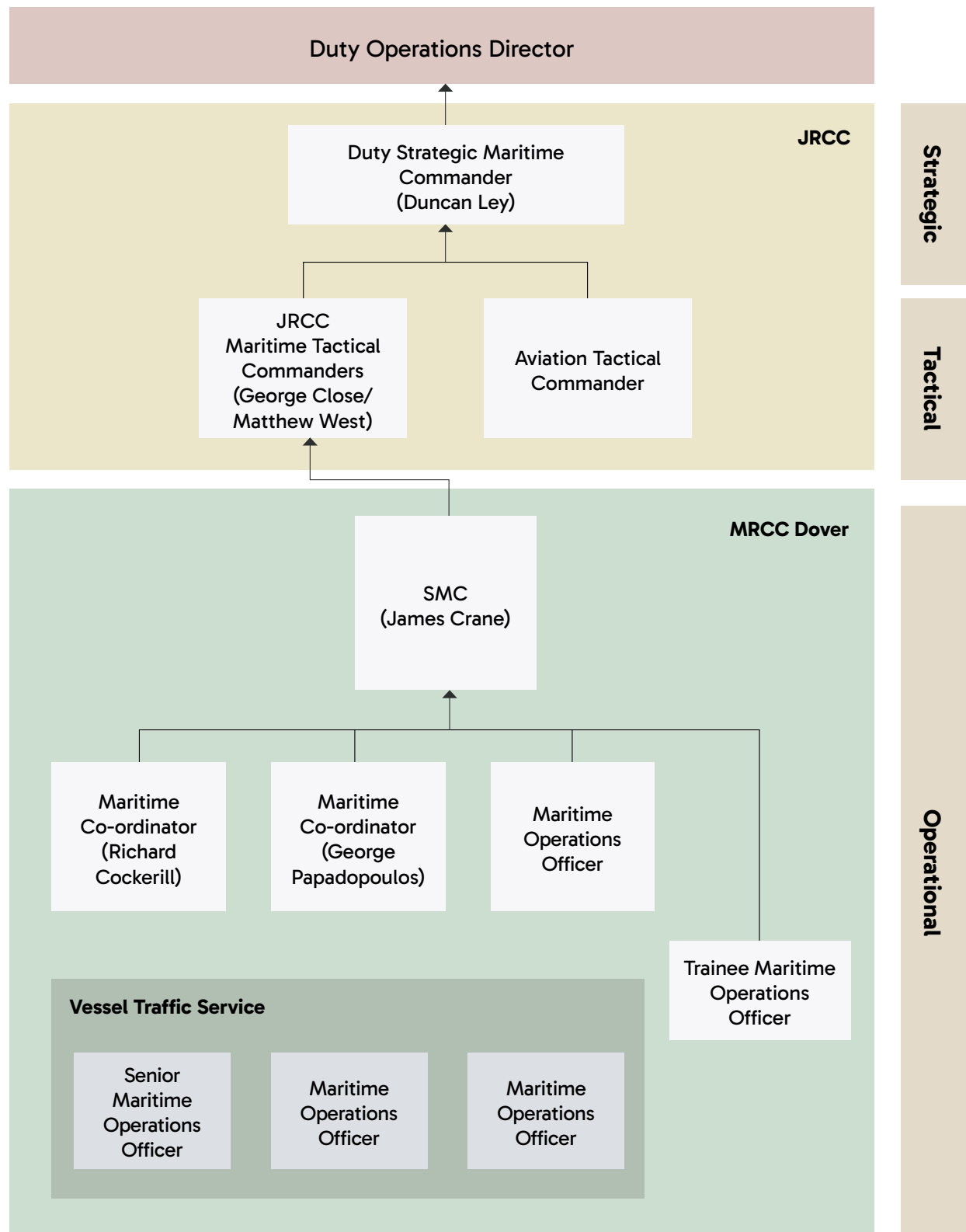


Figure 6: HM Coastguard command structure at 23 to 24 November 2021

HM Coastguard command structure in relation to MRCC Dover on the day shift of 24 November 2021



Aviation Rescue Co-ordination Centre/Aviation Tactical Commander

- 4.49** The Aviation Tactical Commander was responsible for the co-ordination of the aviation response to search and rescue incidents and for ensuring that sufficient air assets were available to respond to search and rescue incidents across the network.⁹⁴ The Aviation Tactical Commander did not have responsibility for search planning, which was the responsibility of the maritime team.⁹⁵
- 4.50** The Aviation Tactical Commander sits within the ARCC.⁹⁶ The Aviation Tactical Commander and team leader manage a team of Senior Aviation Operations Officers.⁹⁷ Team leaders had oversight of a team within their rescue co-ordination centre and had line management, pastoral and leadership responsibilities.⁹⁸ They dealt with the vast majority of search and rescue taskings, which were usually routine requests for search and rescue helicopters, without input from the Aviation Tactical Commander or team leader.⁹⁹ The Aviation Tactical Commander was supported operationally by the Duty Strategic Maritime Commander.¹⁰⁰ In November 2021, the Aviation Tactical Commander and Maritime Commander were based in the same room at the JRCC.¹⁰¹

Small Boats Tactical Commander

- 4.51** The original purpose of the Small Boats Tactical Commander role was to provide a designated lead in relation to small boat search and rescue, due to the volume and concentration of crossings around Dover.¹⁰² The Small Boats Tactical Commander had a training role in relation to small boats matters.¹⁰³ In periods with fewer small boat crossings, they also had a role in supporting the general management of MRCC Dover.¹⁰⁴ However, by 23 September 2021:

94 INQ009628/5-6/par11-12.

95 INQ010718/96/ln4-5.

96 INQ010201, INQ009628/1/par2.

97 INQ009628/6/par12c, 6/par13.

98 INQ010204, INQ010140/2/par4, 6/par19, INQ010098/16/par1.46, INQ010212/7-8/par20-21, INQ009632/4/par12, INQ009634/8/par14, INQ002709.

99 INQ009628/8/par16, INQ010718/106.

100 INQ009628/10/par22, INQ003766/4.

101 INQ010718/141/ln16-20, INQ010715/70-71/ln25-2.

102 INQ009632/5/par14, INQ003195.

103 INQ009632/12/par25-26, INQ008621, INQ000449, INQ000428, INQ000434.

104 INQ009632/6-7/par16.

“[The Small Boats Tactical Commander’s] main function is to act as tactical commander in the Dover ops room on Red days when he will release the network commanders from the requirement to oversee the migrant incidents and take over the [red, amber, green assessment] function for those incidents...if he considers it necessary, he may play a more hands on role as the [SMC] handing back the tactical command to the network commander.”¹⁰⁵

- 4.52** When the role was created, there was an intention to recruit a second Small Boats Tactical Commander. This had not come to fruition by November 2021.¹⁰⁶

Search and Rescue Mission Co-ordinators

- 4.53** The concept of an SMC derives from the International Aeronautical and Maritime Search and Rescue (IAMSAR) Manual which requires an SMC to be in place in respect of each search and rescue mission. Where there are multiple incidents taking place at once, the SMC role may also be delegated to a suitably qualified person.¹⁰⁷

- 4.54** As an operational role, an SMC is effectively the on-the-ground decision maker for an individual search and rescue mission. SMCs provide oversight to officers beneath them in the command structure and are responsible for providing effective leadership to the operational team.¹⁰⁸ An SMC is in charge of a search and rescue operation until either:

- a rescue is effected
- it has become apparent that further efforts will be unsuccessful
- they are relieved by another SMC
- responsibility for co-ordinating the rescue has been accepted by another MRCC.¹⁰⁹

The person undertaking the function of SMC for a particular search and rescue incident could be located in a different geographical location from the MRCC within whose area of responsibility the incident was taking place.¹¹⁰

105 Red days are days on which crossings were highly likely to take place (see paragraph 7.36). INQ009632/6-8/par16-17, INQ008621/2, INQ010740/4-9/ln2-6.

106 INQ009632/5/par14; INQ010740/2-3/ln23-2.

107 INQ010445/47/1.11.2.

108 INQ010140/3/par8, INQ010138/2/par5.

109 INQ010098/22/par1.54, INQ000401.

110 INQ000446, INQ000445.

- 4.55** At the time of the incident, the SMC qualification was a prerequisite to becoming both a team leader and a Senior Maritime Operations Officer.¹¹¹

Senior Maritime Operations Officers, Maritime Operations Officers and trainees

- 4.56** At the time of the incident, a Senior Maritime Operations Officer was a member of the watch keeping team who exercised delegated leadership and supervision functions in respect of the operations team at a JRCC or MRCC but who did not have line management duties.¹¹² A Senior Maritime Operations Officer could have delegated responsibility to act as an SMC.¹¹³
- 4.57** A Maritime Operations Officer was a member of the watch keeping team in the JRCC or MRCC who was responsible for operating HM Coastguard control room systems and communications.¹¹⁴ Maritime Operations Officers had to complete modules on mission conduct, maritime search and mission co-ordination.¹¹⁵ They were sometimes referred to as Maritime/Mission Co-ordinators.¹¹⁶

The Joint Control Room at MRCC Dover and Clandestine Operations Liaison Officer

- 4.58** The Joint Control Room at MRCC Dover was staffed by both HM Coastguard and Border Force Maritime Command Centre staff, but was led by a Tactical, or Silver, Commander from the CCTC.¹¹⁷ A key HM Coastguard role within the Joint Control Room was the Clandestine Operations Liaison Officer.¹¹⁸ They were based within the Joint Control Room to facilitate communication between HM Coastguard and the CCTC.¹¹⁹
- 4.59** Also within the Joint Control Room was a BFMC Liaison Officer, also referred to as a Maritime Command Liaison Officer.¹²⁰ At the time of the incident, the BFMC Liaison Officer's role was to support the BFMC, who retained overall command and control, in tasking and co-ordinating BFMC assets.¹²¹

111 INQ002709/4, INQ010098/16/par1.46, INQ010392/4-5/par12, INQ010140/2/par4, INQ000366, INQ000359, INQ002346/4, INQ002763/4, INQ004045/4 cf, INQ000377.

112 INQ010098/16/par1.47.

113 INQ004045/1.

114 INQ010098/16/par1.51, INQ003256/1.

115 INQ010040/3, INQ006710, INQ006711, INQ006717, INQ006713.

116 INQ009634/31/par28, INQ009632/15/par35, 16-17/par40, 17/par41, 17/par42, INQ006713/2, INQ006717/2.

117 See Paragraph 4.25. INQ002761, INQ002764/4, INQ010134/13/par38, 19/par51, INQ010445/45/par1.10.4.

118 INQ010134/13/par38, INQ007168/1. This role was also sometimes referred to as the 'Joint Control Room (Dover) Liaison Officer' (INQ009632/26/par69), the 'MCA LO' or 'CG LO' (INQ002761).

119 INQ010134/13/par38.

120 INQ010098/29-30/par2.15, INQ002266/3, INQ010098/28-29/par2.11, INQ000619/24, INQ010137/21-23/par54.

121 INQ010137/17/par41, INQ000619/23, INQ000619/24.

HM Coastguard training

- 4.60** This section sets out, at a very high level, the general qualification requirements and assessment methods for each rank in HM Coastguard, up to the level of SMC. Each of those with an operational role in the events of 23 to 24 November 2021 has set out, in their witness statements to the Inquiry, the training which they personally had received. Where it is relevant to the events concerning the small boat on 23 to 24 November 2021, this is referred to later in the report.
- 4.61** The entry level position within HM Coastguard at the relevant time was the role of Maritime Operations Officer.¹²² Maritime Operations Officers completed training on search planning, mission co-ordination, nautical knowledge, communications and use of HM Coastguard systems, such as VISION.¹²³ The course comprised 10 weeks of tuition over a period of 10 months.
- 4.62** The next most senior rank was the Senior Maritime Operations Officer.¹²⁴ As at July 2021, to become a Senior Maritime Operations Officer there was a three-week training period followed by a week-long assessment, delivered over a three-month period.¹²⁵ The training contained two broad topics: incident co-ordination (including effective decision-making and managing teams) and search planning.
- 4.63** The next rank in HM Coastguard is that of SMC. To achieve this rank, a coastguard needed to complete the SMC qualification. This was a three-week course followed by a week of assessments.¹²⁶ The course covered search planning (including refreshing the trainee's knowledge of IAMSAR Manual search models), and search and rescue theory (with topics including survivability and termination of incidents).¹²⁷ The final week was a week of practical incident simulation where trainees were observed.¹²⁸

The Home Office

- 4.64** The Home Office is a UK government department. Among other responsibilities, the Secretary of State for the Home Department (Home Secretary) and their department are responsible for immigration and law enforcement within the UK.¹²⁹ The Home Office comprises a wide range of directorates and bodies,

122 INQ010094/3-2/par7, 5-6/par19.

123 INQ010098/18/par1.51.

124 INQ010098/16/par1.47.

125 INQ010098/16/par1.48, INQ010040/4, INQ006736, INQ006719, INQ006761, INQ006731, INQ010040.

126 INQ006762, INQ000364, INQ000365.

127 INQ006762, INQ000364, INQ000353, INQ000355, INQ000359, INQ006753, INQ000379, INQ000387, INQ006587.

128 INQ006762, INQ006587.

129 INQ010134/16/par17.

but the main ones relevant to the Inquiry's work are UK Visas and Immigration, Border Force, and Immigration Enforcement.¹³⁰ Together, these directorates represent the three key stages in the UK's immigration system.¹³¹

- 4.65** At the time of the incident, UK Visas and Immigration was responsible for “decision-making about who has the right to visit or stay within the [UK] (including asylum and the provision of accommodation) with a firm emphasis on national security”.¹³² Border Force was “responsible for securing the UK border by carrying out immigration and customs controls for people and goods entering the UK”.¹³³ Immigration Enforcement was responsible for enforcing immigration laws and policies, preventing abuse of the immigration system, and “protecting the vulnerable”.¹³⁴
- 4.66** The Home Office was not responsible for search and rescue policy or its provision which sat with the DfT.¹³⁵ However, through Border Force (and specifically BFMC), the Home Office has had an “enduring” role in search and rescue arrangements in the UK, including UK waters, since 2018.¹³⁶

Border Force Maritime Command

- 4.67** BFMC within Border Force operates the UK's national maritime law enforcement capability in UK and adjacent territorial waters. It is responsible for preventing and disrupting organised crime from exploiting the UK's territorial waters for illegal purposes including drug trafficking, illegal migration and modern slavery.
- 4.68** The Head of BFMC was Mr Stephen Whitton OBE, who gave evidence to the Inquiry on behalf of the Home Office. BFMC operated from the Border Force Maritime Command Centre (Border Force MCC), which was located in Portsmouth together with the JMSC, National Maritime Information Centre and Joint Maritime Operations Coordination Centre. BFMC's top priority is law enforcement, and it is not responsible for co-ordinating search and rescue in the UK. That is the duty of HM Coastguard.¹³⁷

130 INQ010134/6-7/par18, INQ010135/2/par5.

131 INQ009671/16.

132 INQ010134/6-7/par18.

133 INQ010137/3/par7, INQ010134/6-7/par18.

134 INQ010417/170, INQ010134/6-7/par18.

135 INQ010134/4-5/par10, INQ010137/5/par12.

136 INQ010137/3-4/par8, 6/par14.

137 INQ010137/1-2/par1, 3-4/par8, 4-5/par9, 5-6/par12-13, 16/par37, INQ010207.

Joint Maritime Security Centre

- 4.69** The JMSC was established in 2019 as the “umbrella organisation” or “collective title” for the National Maritime Information Centre and the Joint Maritime Operations Coordination Centre.¹³⁸ The JMSC was the UK’s cross-government organisation for maritime security.¹³⁹ Its assets and personnel came from a range of government departments and agencies, including the Royal Navy, Border Force, and the MCA.¹⁴⁰
- 4.70** Its operational mandate stated that the JMSC provided “expert, independent advice and support to government, including the Devolved Administrations and Crown Dependencies on maritime security, including maritime related threat, operational capability and response mechanisms”.¹⁴¹ The JMSC produced operations briefs which provided a broader overview of the UK maritime picture.¹⁴² These were circulated on a daily basis to a number of stakeholders.¹⁴³ Small boats were only one interest of JMSC – it did not have a command-and-control function in relation to small boat search and rescue.¹⁴⁴
- 4.71** The JMSC operations room was physically located within the Joint Maritime Operations Coordination Centre.¹⁴⁵ Mr Daniel O’Mahoney, who gave evidence (on behalf of the Home Office) to the Inquiry, was the founding director of the JMSC until his appointment as Commander and Director of the CCTC in August 2020.

Clandestine Channel Threat Command

- 4.72** The CCTC was established in August 2020 to lead and unify the government response to small boats, providing a “whole of route, whole of government” approach.¹⁴⁶ The CCTC’s purpose was to render the Channel crossing migration route to the UK unviable.¹⁴⁷ As well as seeking to control the maritime environment, the CCTC also had a role in establishing and managing migrant reception facilities and disembarkation facilities.¹⁴⁸ The CCTC’s work was guided by an operational campaign plan and was overwhelmingly described as ‘Operation ALTAIR’.¹⁴⁹

138 INQ010445/42/1.9.2, INQ000426, INQ007060/12, INQ000441, INQ010337/24/par60, INQ000442, INQ000003/1/par2, INQ005282/5-6. See also paragraph 4.6.

139 INQ000003/1/par1.

140 INQ010134/7/par19,20, INQ007947/13.

141 INQ000003/1/par1.

142 INQ000606, INQ000607, INQ000609, INQ000610, INQ000614, INQ000615.

143 INQ010134/19/par50, INQ010136/20-21/par57, INQ000609.

144 INQ010337/24-25par60-61, INQ010134/7/par19-20.

145 INQ002091/2.

146 INQ010134/8/par22, 7-8/par21-22, INQ000017/1, INQ008370/2, INQ001108.

147 INQ001960, INQ001108.

148 INQ010134/12/par36.

149 INQ008370/3, INQ010134/25.

- 4.73** The delivery of the operational campaign plan was overseen by the CCTC Delivery Board, which was chaired by Mr O'Mahoney and attended by multiple stakeholders, including the DfT, Border Force and the MCA.¹⁵⁰ Mr O'Mahoney led the CCTC from its creation until December 2022. He reported to the Director General of Immigration Enforcement who, in turn, reported to the Second Permanent Secretary. Mr O'Mahoney also had a direct reporting line to the Home Secretary.¹⁵¹

Operational arrangements of Border Force

Border Force Maritime Command Centre

- 4.74** Border Force MCC was a 24-hour facility based within the JMSC at Royal Naval Command, Portsmouth. It was responsible for overseeing the deployment and co-ordination of Border Force maritime assets across the UK and provided the overarching command, control and support to maritime operations involving BFMC vessels. At the time of the incident, Border Force MCC's functioning in respect of small boats was determined according to the Operation DEVERAN Operational Order.¹⁵² Operation DEVERAN was established in May 2019 and led Border Force's maritime response to small boats from then on.¹⁵³ The Operation DEVERAN Operational Order set out the particulars of Border Force's small boats response.

Border Force resources

- 4.75** At the time of the incident, Border Force MCC had a range of maritime assets available to it.¹⁵⁴ The standard deployment as part of Operation DEVERAN was one cutter and two coastal patrol vessels. A surge cutter could be deployed at 12 hours' notice. On 'red days' (days on which crossings were highly likely to take place), it was anticipated that additional rigid hull inflatable boats would be deployed.¹⁵⁵ Border Force MCC also had access to systems such as 'Telesto', 'Marine Traffic', 'Vessel Finder' and 'Geoplanner', on which they received in-house training, to help them understand the co-ordinates given to them by HM Coastguard.¹⁵⁶
- 4.76** MRCC Dover was made aware of which assets were available through the Operation DEVERAN asset emails.¹⁵⁷

150 INQ010337/23/par56, INQ001052, INQ001108.

151 INQ010134/8/par 23, INQ001960, INQ010414/columnK/row8, INQ010415/columnK/row5, INQ000017/1.

152 INQ010137/15/par31, 16/par36, 16/par 39, 17-18/par42, 21-23/par54, INQ010098/30/par2.17, INQ000619.

153 See paragraph 5.10.

154 INQ010137/40/par102-106.

155 See paragraph 7.36. INQ000619/14.

156 INQ010135/7/par17.

157 INQ000566, INQ010135/10/par23.

4.77 The Border Force vessel HMC Valiant (the Valiant) was tasked on the night of 23 to 24 November 2021.

- a. The Valiant was a 42.8-metre Damen Stan Patrol 4207-type vessel, also known as a cutter or fast patrol boat, which was designed to conduct anti-smuggling operations.¹⁵⁸ It had a top speed of 26 knots, could cruise at a speed of 20 knots and had a total endurance of 890nm.¹⁵⁹ The Valiant required a crew of 12. The maximum survivor capacity was 100 people, although if necessary to save life, this could be exceeded and life rafts, the rigid hull inflatable boats carried on board and a man overboard boat could be used.¹⁶⁰
- b. Cutters including the Valiant were equipped with marine VHF radio, Airwave and satellite communications. They also carried a Global Maritime Distress Safety System which allowed the boat to communicate with other vessels and onshore installations, as well as transmitting emergency and distress messages. They were also equipped with radar, flood lights, thermal night vision and regular cameras. The Valiant carried a rigid hull inflatable boat at its stern, two 20-person life rafts, and personal floatation devices such as life rings and life jackets.¹⁶¹

4.78 Border Force MCC did not triage distress calls from small boats themselves, but instead received asset tasking requests by telephone from HM Coastguard. Border Force MCC would then call the Commander of the vessel to determine the correct course of action. Precisely when the vessel would deploy would depend on the location of the small boat (whether it was in UK territorial waters or, alternatively, when it was predicted to enter them). Once the vessel and crew were ready, the Valiant would proceed to leave the Port of Dover. Once out at sea, the Valiant would communicate directly with HM Coastguard over VHF radio, and HM Coastguard would have oversight of the Valiant's movements via the Automatic Identification System or radar.¹⁶² However, Border Force MCC continued to support vessel Commanders tasked to search and rescue since they remained under Border Force command.¹⁶³

158 INQ007224/2, INQ010136/5/par 15.

159 INQ007224/2.

160 INQ010136/5/par15, INQ010137/11-12/par23, INQ007224/2, INQ010717/26-27/ln24-13.

161 INQ007224/2, INQ010136/5-6/par17, 6-7/par19-2020.

162 INQ010135/6-7/par16, 7-8/par18, 9-10/par21-22, 12-13/par27, INQ010136/8-9/par24-26, 10/par29-30.

163 INQ010137/17-18/par42, 21-23/par54, INQ000619/23.

Border Force operational roles and responsibilities

Strategic command of Border Force Maritime Command

- 4.79** As we have seen, BFMC was led by Mr Whitton. He (or a member of BFMC's senior leadership team acting as his deputy) was responsible for BFMC's strategic operational command, but he also line managed the Head of Operations and Planning and the Head of Operational Support.¹⁶⁴ In turn, the Head of Operational Support line managed four Senior Executive Officers: two had responsibility for technical and logistical support, one had responsibility for training, and one had responsibility for Border Force MCC.¹⁶⁵
- 4.80** Reporting to the Senior Executive Officer in Border Force MCC were five Higher Officers.¹⁶⁶ It was the role of the Border Force Higher Officers to manage requests for Border Force maritime assets from HM Coastguard and deploy them across the UK. The Border Force Higher Officers worked shifts to provide 24-hour coverage.¹⁶⁷

Tactical command within Border Force: the Commander of the Valiant

- 4.81** The Head of Operations and Planning oversaw three Senior Executive Officers and the Commander and crew of Border Forces vessels.¹⁶⁸ The tactical-level command for an Operation DEVERAN deployment was the Cutter Commander, or the Coastal Patrol Vessel Officer in charge, depending on which vessel was deployed. There was also a Duty Senior Executive Officer on call to provide tactical command for an incident or operation.¹⁶⁹
- 4.82** The Commander of the Valiant was responsible for its overall command, as well as the crew.¹⁷⁰ The Valiant's activities and key information would be recorded in the vessel's logbook and its Commander's daybook.¹⁷¹ Its Commander was also required to provide a situation report, or 'sit rep', to Border Force MCC every 24 hours on the vessel's activity.¹⁷² At the end of a patrol, its Commander would also produce a report of the entire 15-day period for his superior to review.¹⁷³ After small boat incidents, the Commander would also conduct an informal crew debrief if he considered it worthwhile, which would involve an evaluation of what had happened and how its crew could develop as a team.¹⁷⁴

164 INQ000619/24, INQ010137/17-18/par42, INQ010207.

165 INQ010207, INQ010137/2/par4.

166 INQ010207.

167 INQ010135/1-2/par4, 3/par7, 4-5/par12-13, 12/par26, 14-15/par31, 16-17/par37, 17-18/par38, 19-20/par43, INQ010136/8-9/par25.

168 INQ010207.

169 INQ010137/17-18/par42, 21-23/par54, INQ000619/24.

170 INQ010136/3/par7.

171 INQ010136/3/par9, INQ002054.

172 INQ010136/3-4/par10.

173 INQ010136/3/par8, 4/par12.

174 INQ010136/4/par12.

National Crime Agency

- 4.83** The National Crime Agency was formed on 7 October 2013 and replaced the Serious Organised Crime Agency.¹⁷⁵ It operates under the direction and control of the Director General.¹⁷⁶ Its relationship to the Home Office is set out in a framework document.¹⁷⁷ The functions and remit of the National Crime Agency are set out in detail in section 1 of the Crime and Courts Act 2013. In broad terms, it leads the UK's operational response to serious organised crime, one example of which is organised immigration crime via small boat crossings.¹⁷⁸ It does not monitor routine traffic in the English Channel and has a limited role in relation to safety of life at sea.¹⁷⁹
- 4.84** Following the establishment of the CCTC and Operation ALTAIR, the National Crime Agency contributed intelligence to 'gold'-level meetings of the CCTC to inform its approach.¹⁸⁰

Police

- 4.85** Police forces have two primary relevant responsibilities in the context of small boat crossings:
- to co-ordinate land-based search and rescue operations¹⁸¹
 - to investigate associated criminality – other than organised immigration crime which is generally a matter for the National Crime Agency – on land, or at sea.¹⁸²

They also assist the National Crime Agency, in respect of incidents at sea, in co-operating with French authorities for suspected criminal offences in French territorial waters.¹⁸³

175 Crime and Courts Act 2013. Available at: www.legislation.gov.uk/ukpga/2013/22/contents (accessed 4 November).

176 Crime and Courts Act 2013, section 1(2). Available at: www.legislation.gov.uk/ukpga/2013/22/contents (accessed 4 November).

177 INQ010435.

178 INQ010100/2/par5, 3/par9.

179 INQ010100/3/par7.

180 See paragraph 5.19. INQ010100/5-6/par16-19.

181 INQ000412/7, INQ008911/1/par1.3.

182 Police Act 1996, section 30. Available at: www.legislation.gov.uk/ukpga/1996/16/contents (accessed 4 November 2025). Territorial Sea (Limits) Order 1989. Available at: www.legislation.gov.uk/uksi/1989/482/contents (accessed 20 November 2025). INQ010098/36/par2.35, INQ008998/2-3/par4.

183 INQ008998/2-3/par 4.

Kent Police

- 4.86** Kent Police covers the area along the Dover Strait. A large proportion of policing responsibilities in respect of small boat Channel crossings falls to Kent Police, although they are supported by Sussex Police or the (privately funded) Port of Dover Police, if necessary.¹⁸⁴ Kent Police also receives phone calls from occupants of small boats due to its location.¹⁸⁵ In respect of search and rescue responsibilities, Kent Search and Rescue, a voluntary organisation, can provide further search and rescue resources to Kent Police.¹⁸⁶

Metropolitan Police

- 4.87** The Metropolitan Police Service (Met Police) is responsible for policing the 32 boroughs of Greater London, excluding the City of London.¹⁸⁷ They are led by the Metropolitan Police Commissioner.¹⁸⁸ With some exceptions, the Met Police only has responsibility for matters within its geographical boundary: it is not a coastal police force, and its Marine Support Unit polices only the River Thames.¹⁸⁹ However, the Met Police occasionally (and atypically) receives calls to its control room about small boat incidents. Generally, these are made by people who are based within the geographical area of the Met Police. Any such calls are referred on to HM Coastguard.¹⁹⁰

The Royal National Lifeboat Institution

- 4.88** The RNLI, founded in 1824, is a charitable organisation headquartered in Poole. It is separate from HM Coastguard, independent of government and raises its own finance with no government support. It is governed according to its Royal Charter and bye-laws as amended over time.¹⁹¹ The RNLI's charitable aim is to end preventable drowning through rescue, lifeguarding and water safety education.¹⁹² The RNLI is staffed overwhelmingly by volunteers, many of whom have full time jobs. It receives 94% of its funding from charitable donations.¹⁹³
- 4.89** The RNLI operates 238 lifeguard units and a 24-hour search and rescue lifeboat service across the UK, Channel Islands, Isle of Man and Ireland.¹⁹⁴ The Dover Strait was served by Ramsgate, Walmer, Dover, Littlestone, Dungeness,

184 INQ010437, INQ008998/2-3/par 4.

185 INQ008998/6-8/par14.

186 INQ0089983/par5.

187 INQ010426/1.

188 INQ010425.

189 INQ009680/3/par9.

190 INQ008995, INQ009680/3/par 11, 4/par15.

191 INQ010101/2/par 5.

192 INQ010101/2/par 4.

193 INQ010101/2/par4, 4/par12.

194 INQ010101/2-3/par7, 4-5/par13.

Hastings, Eastbourne and Newhaven RNLI stations. These stations were supported by a support centre based in Poole which operated 24 hours a day. The support centre was not a tasking or co-ordinating authority but responded to queries via a duty system which had an executive, strategic and tactical level person on call.¹⁹⁵

- 4.90** The RNLI has an executive team led by a Chief Executive who is accountable to the charity’s trustees.¹⁹⁶ The executive team manages the RNLI support centre in Poole which supports the delivery of the RNLI’s lifesaving work.¹⁹⁷ In 2021, the RNLI had Area Lifesaving Managers who were responsible for the safe, efficient and effective delivery of the RNLI’s policies, standards within a defined geographical region, and compliance.¹⁹⁸ The RNLI’s current structure includes a Head of Lifeboats. This role is held by Mr Simon Ling, who reports directly to the Lifesaving Operations Director.¹⁹⁹ Mr Ling gave evidence to the Inquiry.

The RNLI’s relationship to HM Coastguard

- 4.91** The RNLI is a declared search and rescue facility to HM Coastguard and can be tasked by HM Coastguard to conduct search and rescue.²⁰⁰ The RNLI does not make decisions about how to deploy assets, and while it is able to self-deploy it generally does not do so.²⁰¹ Its relationship with HM Coastguard at the time of the incident was governed by a memorandum of understanding (MoU) signed on 1 October 2020 (the HM Coastguard MoU). Its object was to formalise the RNLI’s assistance to HM Coastguard as a declared facility.²⁰²
- 4.92** Pursuant to the HM Coastguard MoU, the RNLI was to provide lifeboats on a “best endeavours” basis, “when and where practicable”, with the ultimate decision to launch being made by the RNLI launch authority according to a range of dynamic factors, such as the nature of the tasking, fuel and weather conditions.²⁰³ There was no transfer of funds from the MCA to the RNLI for this service.²⁰⁴

195 INQ010101/10/par30, 30/par68.

196 INQ010101/2/par6.

197 INQ010439/78.

198 INQ010101/3/par8.

199 INQ010101/1/par 2.

200 See paragraph 4.17. INQ010101/8-9/par22, INQ010098/par 2.32-2.33.

201 INQ010101/8-9/par22, 13/par36.

202 INQ000096/2/par2.2.

203 INQ000096/2/par 2.3-2.4, 4/par 5.5, 9/Annex 2.

204 INQ000096/5/par 7.1.

Royal National Lifeboat Institution assets

- 4.93** The RNLI primarily operated two classes of lifeboat: all-weather lifeboats and inshore lifeboats.²⁰⁵ The all-weather lifeboats were capable of achieving speeds of 25 knots and were designed to operate in all weather, day or night.²⁰⁶ They were self-righting in the event of capsize and carried a wide range of communication and search and rescue equipment.²⁰⁷ On the other hand, inshore lifeboats were operated closer to shore and in shallower waters, or near cliffs and rocks. They were quick and agile boats but were subject to weather limitations. These were B and D class lifeboats.²⁰⁸
- 4.94** The RNLI's lifeboats have different capacities to accommodate individuals rescued (described by the RNLI as 'survivors') depending on whether the self-righting capability of the lifeboat was retained. Where self-righting capability was retained, the survivor capacity ranged from 5 to 44. It ranged from 46 to 96 when the self-righting capability was not retained.²⁰⁹
- 4.95** At the time of the incident, sometimes lifeboats were declared 'off service' if they were unable to safely launch or operate due to damage, defect, crew availability or fatigue, or if undergoing repair.²¹⁰ A lifeboat may also have been placed on 'restricted service' if it was able to launch but with operational constraints.²¹¹ A lifeboat station was responsible for communicating the available assets in real time to HM Coastguard, other flanking RNLI stations and the RNLI operations room.²¹²

Tasking the Royal National Lifeboat Institution

- 4.96** At the time of the incident, to request that a lifeboat be launched, HM Coastguard would usually first contact the relevant lifeboat station's designated launch authority with details of the tasking.²¹³ The designated launch authority was the specially trained operational volunteer leader within a station.²¹⁴
- 4.97** On receiving the request, the designated launch authority would consider the tasking based on their knowledge of the crew, available assets, conditions and local knowledge to determine whether it was "compliant, appropriate and achievable".²¹⁵ They would also consider if back-up from other RNLI stations

205 INQ010101/4-5/par13.

206 INQ010101/4-5/par13.

207 INQ010101/4-5/par13.

208 INQ010101/4-5/par13.

209 INQ010739/6/par14.

210 INQ010101/10/par27.

211 INQ010101/10/par28.

212 INQ010101/10/par28.

213 INQ010101/9/par23-24, INQ005206/1, INQ005208.

214 INQ010101/9/par23.

215 INQ010101/9/par23, INQ005206/1.

or aircraft was required.²¹⁶ If they agreed that a lifeboat should be launched, then they would give authority to the search and rescue unit Commander, who was the vessel's coxswain or helm, and instruct HM Coastguard to contact the wider RNLI crew.²¹⁷ Once the crew had been contacted, the designated launch authority would brief the crew.²¹⁸ If the search and rescue unit Commander did not feel it was safe for the lifeboat to launch, they were able to override the decision made by the designated launch authority.²¹⁹ If a lifeboat was deployed, the vessel would communicate directly with HM Coastguard via VHF radio.²²⁰

Private aerial asset providers

4.98 HM Coastguard does not 'own' any search and rescue assets. However, it does have contracts with commercial organisations to provide aerial search and rescue resources in the form of fixed-wing aircraft, helicopters and drones. At the time of the incident, aerial search and rescue taskings were deployed proactively by the MCA pursuant to Operation EOS.²²¹ Operation EOS had been established in or around May 2020 to keep track of the MCA budget commitment of these taskings and to differentiate them from Operation DEVERAN taskings.²²²

Fixed-wing aircraft: 2Excel

4.99 2Excel Aviation Limited (2Excel) is a private company regulated by the UK Civil Aviation Authority.²²³ As at the date of the incident, 2Excel held a single contract, known as the aerial surveillance and verification contract, to provide the MCA with two types of fixed-wing aircraft: the Piper PA31 Panther and the King Air B200.²²⁴ 2Excel was awarded the contract on 19 March 2019.²²⁵ It was subsequently amended a number of times.²²⁶ A further contract was in the process of being negotiated at the time of the incident pursuant to Operation CAESAR, an MCA project to obtain greater aerial asset capability in response to the projected number of small boat crossings in 2022.²²⁷ Operation CAESAR did not go live until 1 March 2022.²²⁸

216 INQ010101/9/par25, INQ005203.

217 INQ010101/9/par24, INQ005206/1.

218 INQ010101/9/par25.

219 INQ010101/9/par25.

220 INQ010101/9/par25, 13/par36.

221 INQ005198, INQ010098/34-35/par2.29, INQ009632/11/par23c, INQ000459.

222 As to Operation DEVERAN, see paragraph 5.10.

223 INQ010335/1/par1, 2/par5, 6/par18, 7/par23.

224 INQ010098/38/par2.44-2.45, INQ010335/3/par8, 18/par79.

225 INQ010335/3/par 8, INQ006325.

226 INQ010335/3/par 9-11, INQ006328, INQ006327, INQ006326, INQ006324, INQ006323.

227 INQ010098/31/par2.20.

228 INQ010098/31-32/par2.22, 38/par2.44, 75-76/par5.2, 91/par5.61.

2Excel operational arrangements

- 4.100** At the date of the incident, 2Excel operated from Doncaster Sheffield Airport.²²⁹ At an operational level, the pilots of 2Excel's aircraft reported to a head of division according to the type of aircraft which they flew. The heads of division each then reported to the Head of Surveillance, who was overseen in turn by the Director of Special Missions.

2Excel assets

- 4.101** The Piper PA31 Panther and the King Air B200 aircraft were modified with a range of technology, which can be broadly summarised as follows.
- a.** All aircraft were equipped with Automatic Identification System, GPS systems, VHF radio and, with the exception of one Panther aircraft, satellite communications systems.²³⁰
 - b.** Both Panther and King Air aircraft were equipped with gimbal-mounted electro-optical and infrared cameras. The King Air was additionally equipped with a multifunction radar which could detect maritime targets.²³¹
 - c.** The King Air was also equipped with a drop tube, which could deploy small items of survival equipment from air to surface, as well as technology to detect electronic distress signals.²³²

Tasking 2Excel

- 4.102** All taskings for 2Excel were received from the ARCC based at the JRCC at Fareham.²³³ The 2Excel operations team would confirm whether the aircraft and crew were available and then complete and return the tasking request form either by 'acceptance' or by 'qualification', identifying any risks or issues.²³⁴ Once airborne, the pilot and HM Coastguard would communicate directly with each other via VHF radio.²³⁵

229 INQ010335/2/par4.

230 INQ010335/12/par44.

231 INQ010335/12/par44.

232 INQ010335/12/par44.

233 INQ010335/5/par15.

234 INQ010335/5/par16.

235 INQ010335/10/par36.

Fixed-wing aircraft: RVL Aviation Limited

- 4.103** RVL Aviation Limited (RVL) is a private company based in Leicestershire.²³⁶ It provides a wide range of specialist aviation services to private and public sector clients, including the MCA and Home Office.²³⁷ RVL contracted with the MCA to provide an aircraft for aerial dispersant spray services on 1 February 2012 for use with incidents of oil pollution.²³⁸
- 4.104** Through its relationship with the MCA, in late 2021, the Home Office was able to secure the use of a Beech B200 King Air asset from RVL (the RVL asset) to test an enhanced surveillance capability. The Home Office's use of the RVL asset was the subject of an MoU between the MCA and the Home Office. Alongside the MoU, the MCA signed a contract change notice with RVL which provided confirmation that the Home Office could task the RVL asset. Both documents confirmed that MCA retained the ability to override any Home Office tasking and that MCA could use the enhanced surveillance capability.²³⁹

Tasking RVL

- 4.105** RVL was tasked by the CCTC depending on the weather conditions and the likelihood of small boat activity.²⁴⁰ Once the CCTC identified a requirement for a RVL flight, a tasking form would be submitted to the ARCC, who would formally allocate the tasking.²⁴¹
- 4.106** The RVL asset operated at a higher altitude than the search and rescue helicopter and the Tekever drone.²⁴² It was equipped with VHF radios for both aerial and maritime communications, an Automatic Identification System receiver and satellite communications.²⁴³ While on task, RVL and the CCTC would liaise directly, without the involvement of the ARCC, via satellite communications.²⁴⁴

236 INQ010102/1-2/par2.

237 INQ010102/1-2/par2, 2-3/par4-5.

238 INQ000097/4, 25.

239 INQ010409/3-4/par10.

240 INQ010102/7-8/par19.

241 INQ010102/7-8/par19, INQ010409/4/par 11, 6/par17, INQ003876.

242 See paragraphs 8.8 and 8.37. As to the Tekever drone generally, see paragraph 4.112.

243 INQ010102/2-3/par 5, INQ010409/5-6/par 16-17.

244 INQ010102/7-8/par 19, INQ010409/6-7/par18.

Helicopters: Bristow Helicopters Limited

4.107 Bristow Helicopters Limited (Bristow) is a private limited company based in Surrey.²⁴⁵ In 2013, Bristow contracted with the DfT under the search and rescue helicopter contract to provide and operate all HM Coastguard search and rescue helicopters.²⁴⁶ The contract began in 2015.²⁴⁷ As part of this contract, Bristow provided a fleet of Sikorsky S-92A and Leonardo AW189 helicopters which bore the HM Coastguard logo.²⁴⁸ As well as search and rescue taskings, Bristow helicopters were also deployed to conduct safety of life at sea surveillance.²⁴⁹

R163 helicopter capabilities and tasking

4.108 R163, the helicopter used on the night of 23 to 24 November 2021, was an AW189 aircraft. The AW189 is a twin engine ‘modern generation’ helicopter which was equipped with a forward-looking infrared camera, a search and weather radar, night vision goggles to be worn by crew, a distress beacon homing system, VHF and high frequency long-range radios, and TETRA, the UK emergency services end-to-end encrypted communications network. While the aircraft’s radio transmissions were recorded, they were overwritten after a time.²⁵⁰

4.109 Bristow’s AW189 helicopters were based at Lydd and Lee-on-Solent, while their Sikorsky S-92A helicopters were based in Humberside.²⁵¹ The former were most frequently deployed for small boat search and rescue incidents as they were geographically closer to the Dover Strait.

4.110 Bristow was tasked by the ARCC by a phone call to the closest Bristow base to a given search and rescue incident.²⁵² Once a tasking was accepted, the crew would ready themselves within the agreed readiness times pursuant to the search and rescue helicopter contract.²⁵³ These were 15 minutes by day (08:00 to 22:00) and 45 minutes at night (22:00 to 08:00).²⁵⁴ Once airborne, the helicopter could communicate directly with the controlling authority.²⁵⁵ Helicopter pilots would be trained in relation to search planning.

245 INQ010336.

246 INQ010098/37-38/par 2.41, INQ001157/2.

247 INQ010336/3/par 2.2, 3-4/par3.1.

248 INQ010098/37-38/par 2.41, 38/par2.42.

249 INQ010336/13/par5.5.

250 INQ009651/3/par3.1, 3-6/par3.3, 13/par4.3.5, INQ010336/18/par 6.11.

251 INQ010336/18/par3.11, INQ000115.

252 INQ010336/6/par3.9.

253 INQ010336/6/par3.10.

254 INQ010336/6/par3.10.

255 INQ009651/11/par4.3.1-4.3.2.

Bristow operational roles and responsibilities

- 4.111** R163 ordinarily requires four crew: two pilots, a winch operator, and a paramedic.²⁵⁶ The captain of R163 was responsible for the safe operation of the shift, correct operation of the aircraft and overall management of the crew, and reported to the Bristow UK search and rescue Chief Pilots.²⁵⁷

Drones: Tekever

- 4.112** Tekever Limited (Tekever) is a private company based in Lydd.²⁵⁸ Tekever was contracted by the CCTC and Home Office to provide unmanned aerial vehicles on five out of every seven days for surveillance over the Dover Strait to locate small boats and produce images of boats, suspected facilitators and boat occupants.²⁵⁹ By November 2021, Tekever drones were available to the MCA and were used as an extra layer of support in the event that fixed-wing aircraft were unable to be tasked.²⁶⁰

Ministry of Defence

- 4.113** The MOD is a UK government department constituted by the Ministry of Defence Act 1946 to unify the policy development of the Armed Forces.²⁶¹ Its purpose is “to protect the people of the United Kingdom, prevent conflict, and be ready to fight [its] enemies”.²⁶² The MOD is led by the Secretary of State for Defence (Defence Secretary). Its overarching policy framework is provided by the National Security Council.²⁶³
- 4.114** Generally, the MOD has no direct policy responsibilities in relation to small boats but is able to support other government departments through the military aid to the civil authorities process.²⁶⁴ Military aid to civil authorities activity is co-ordinated by the Standing Joint Command (UK), which focuses on the delivery of land resilience and security operations in the UK.²⁶⁵ The power to deploy military resources to civilian tasks derives from the prerogative power, Defence Council orders under the Emergency Powers Act 1964, and Part 2 of the Civil Contingencies Act 2004, depending on the nature of the required deployment.²⁶⁶

256 INQ009651/3/par3.2.

257 INQ009651/8-9/par4.1.3, INQ008981.

258 INQ009628/16/par38.

259 INQ010134/26-27/par70-71, INQ010098/39/par2.47.

260 INQ009628/16/par38.

261 INQ010427/10/par1.2.2.

262 INQ010427/6/par1.1.1.

263 INQ010427/9/par1.1.11.

264 INQ009649/2/par1.6-1.7, 3/par2.1-2.2.

265 INQ009649/par 2.9, 8/par2.14, INQ010430.

266 INQ008935/40/par2.12.

4.115 Military aid to civil authorities will be deployed if:

- there is a need to act and the task requested is clear
- other options such as commercial and voluntary assistance have been discounted, and either:
 - a. the civil authority lacks the necessary capability to fulfil the task and it is unreasonable or prohibitively expensive to expect it to develop one
 - b. the civil authority has all or some of the capability or capacity but it may not be immediately available or to the required scale, and the urgency of the task requires rapid external support from the MOD.

These criteria may be waived by MOD ministers temporarily if the needs of the event in question so require.²⁶⁷

Ministry of Defence involvement in small boat activity before the incident

4.116 MOD vessels are exempted from the 1974 International Convention for the Safety of Life at Sea (SOLAS), although there is an expectation that they will behave consistently so far as is reasonable and practicable, and their duties under the 1982 United Nations Convention on the Law of the Sea are qualified.²⁶⁸ However, between January 2019 and July 2021, the MOD provided support to the Home Office through the military aid to civil authorities process, which included providing extra cutter crew, CCTC liaison, intelligence aircraft, defence estate for migrant reception facilities, planning expertise, and assistance in developing turnaround tactics.²⁶⁹

4.117 At the time of the incident, the MOD had staff (Royal Navy personnel) embedded in the JMSC who would have been aware of when crossings took place, but the clear division of responsibilities between the CCTC and the JMSC meant that Royal Navy personnel and the JMSC would have had no role in responding to small boats.²⁷⁰ Then between April 2022 and January 2023, 'primacy' for the operational maritime response to small boats was transferred to the MOD pursuant to Operation ISOTROPE and the policy of 'military primacy'.²⁷¹

267 INQ008935/4/par 1.4, 36-37/par2.5.

268 INQ009649/4/par 2.5, 4-5/par2.7, 5/par2.8.

269 INQ009649/3/par2.3, 5-6/par2.10-2.10.9, 11/par3.6-3.7, INQ008962.

270 INQ009649/11/par3.7, INQ010337/24-25/par 61, 25/par63.

271 INQ010134/20/par 52, INQ001009. See also paragraph 16.12.

The French authorities

4.118 In France, ‘government action at sea’ is based on interministerial co-ordination.²⁷² The Prime Minister chairs the Interministerial Maritime Committee which “brings together all ministers concerned” and “sets the government’s maritime policy guidelines”.²⁷³ The General Secretariat of the Sea (Secrétariat général de la Mer) is responsible for leading and co-ordinating maritime policy development, and for co-ordinating the action of maritime prefects (préfet maritime) and delegates of the overseas French government regarding State action at sea.²⁷⁴ Around France, there are three coastal regions with maritime prefects appointed in respect of each. They are the Atlantic (Atlantique), the Mediterranean (Méditerranée), and the Channel and North Sea (Manche et Mer du Nord).²⁷⁵ Operations in the Dover Strait fall to the latter, whose prefecture is based in Cherbourg, France.²⁷⁶

4.119 Co-operation between the UK and France is addressed in Chapter 7.

French Coastguard/Navy and operational arrangements

4.120 The Inquiry has been provided with limited information about the operational details of the French Navy. The Maritime Operations Command in Cherbourg was the overarching command and control facility for all French assets deployed at sea.²⁷⁷ However, search and rescue operations were co-ordinated by one of the seven Centres Régionaux Opérationnels de Surveillance et Sauvetage (CROSS) stations, which broadly equates to HM Coastguard’s system of MRCCs in the UK.²⁷⁸ The relevant CROSS station in relation to the Dover Strait was CROSS Gris-Nez.²⁷⁹ MRCC Dover could make direct contact with CROSS Gris-Nez.

French search and rescue assets

4.121 French maritime deployments generally consisted of French Naval patrol boats (Cormoran, Pluvier and Flamant) and Gendarmerie Maritime patrol boats (Athos, Aramis, Scarpe and Escault).²⁸⁰ The Société Nationale de Sauvetage en Mer, the French equivalent of the RNLI, had lifeboats based at Dunkerque, Gravelines, Calais and Boulogne.²⁸¹ As well as maritime assets, the French authorities also had helicopters and, in terms of technology, operated an iPad to communicate with small boats via WhatsApp.²⁸²

272 INQ010420/2.

273 INQ010420/2, INQ010422.

274 INQ010422, INQ010421/1, 3.

275 INQ010419/2.

276 INQ010419/2.

277 INQ000619/24, INQ009700/6/par 2.4.

278 INQ010423, INQ009700/6/par 2.3.

279 INQ010423.

280 INQ000619/17-18.

281 INQ010098/133-134/par 7.41, INQ000217/2.

282 INQ009700/7/par 2.5.3, INQ000217/2.

Chapter 5:

Government response to small boats: 2018 to November 2021

Introduction

- 5.1** This chapter sets out the government response to the increasing number of small boat crossings. It focuses on how the overall policy response developed as the number of small boats increased. It is set out mainly in chronological order and should be read in conjunction with Appendix 3 (the pre-incident chronology).

Initial response: November to December 2018

- 5.2** During November 2018, Border Force assets were increasingly tasked by HM Coastguard to respond to small boat crossings. Three key developments took place at the end of November 2018.
- 5.3** Firstly, on 23 November 2018, the Centre Conjoint d'Information et Coordination, located at the port of Coquelles, became operational (though it was not formally opened until later, in February 2019). The Centre Conjoint d'Information et Coordination was part of a £45 million commitment by the UK pursuant to the Sandhurst Treaty (concerning the reinforcement of co-operation for the co-ordinated management of the shared border).¹ The Sandhurst Treaty was signed by the UK and France on 18 January 2018. While the Centre Conjoint d'Information et Coordination was not established specifically to deal with small boats, it came to hold a key operational function for the UK and French authorities' response to the issue. Border Force and French law enforcement officers were stationed at the Centre Conjoint d'Information et Coordination, and this location became the main operational centre for planning and co-ordinating French deployments to prevent crossings.
- 5.4** Secondly, from late November 2018, the Home Office convened meetings with other government departments to discuss illegal crossings. This included meetings on 27 November 2018 and 4 December 2018. At the 4 December meeting, among other things it was resolved that the UK and France should review their surveillance provision. The Minister for Immigration was tasked with writing to her French counterpart.

1 INQ010134/10-11/par29.

- 5.5** Finally, on 30 November 2018, a meeting of the UK-French Migration Committee took place in London. At this meeting, the UK authorities offered further assistance to the French authorities pursuant to the Sandhurst Treaty. This included providing surveillance equipment, sharing communications campaign experience and deploying a Border Force cutter in French territorial waters.
- 5.6** The UK government activity in this period resulted in a list of actions to address small boat crossings. These covered a wide range of matters including intelligence sharing, diplomatic engagement, development of a possible ‘returns to France’ policy, provision of equipment to the French authorities, and increasing maritime aerial surveillance capabilities.² In relation to the latter, the list of actions recorded that HM Coastguard was able to deploy fixed-wing aircraft and could absorb the costs of any missions involving a search and rescue element. However, the costs for engaging commercial suppliers or the MOD were significant, and Border Force did not believe that the detection benefits merited those costs. In its view, the most effective option was for the French to monitor their shoreline.³

Major incident declared by the Home Secretary: 28 December 2018

- 5.7** Following the increase in activity over the Christmas period, on 28 December 2018 the Home Secretary declared a major incident regarding small boat crossings in the Channel. A major incident is a situation which has a range of serious consequences, and which requires special arrangements to be implemented by multiple emergency responder agencies.⁴
- 5.8** The Home Secretary then took further steps, including ordering the redeployment to the Channel of vessels assisting operations in the Aegean Sea. He also made a request of the MOD under the military aid to civil authorities process for immediate assistance in countering illegal migration in the Channel, including by the deployment of a Royal Navy vessel until Border Force vessels had returned from the Aegean Sea.

² INQ006188.

³ INQ006188/3-4.

⁴ On the other hand, a critical incident is often a recognition within an organisation that a significant event or situation is occurring.

Gold Command: January 2019

- 5.9** By 2 January 2019, a Gold Command structure (or Gold Group) had been established within Border Force.⁵ The purpose of this group was to “direct and coordinate the response to the migrant crossing issue”, and it was agreed between Border Force and HM Coastguard that Border Force assets would be available to HM Coastguard for search and rescue taskings.⁶ In January 2019, the Home Office created the Clandestine Threat Board to “set the operational and tactical response to clandestine entry into the UK”, and input into a Strategic Co-ordination and Oversight Group.⁷ The Gold Command officially ended in April 2019.⁸

Operation DEVERAN: May 2019

- 5.10** On 15 May 2019, Operation DEVERAN was established. Border Force’s maritime response to small boats from then on fell under Operation DEVERAN.⁹ Its aim was to deliver the key aspects of a joint action plan agreed between the UK and France in January 2019.¹⁰ Operation DEVERAN formalised the provision of one cutter and two coastal patrol vessels for search and rescue in the Channel.¹¹ Operation DEVERAN was the centrepiece of the Home Office response to small boats until Operation ALTAIR was introduced in December 2020 to bring the land and maritime aspects of the government response together.¹²

Operation BOWTHORPE and returns at sea: June 2019 to March 2020

- 5.11** In June 2019, the results of a Home Office ‘lessons learned review’, which had been commissioned in March 2019, were published.¹³ The review recommended, among other things, that a strategic decision should be made regarding Border Force’s overarching aim in relation to small boats, and specifically whether safety of life at sea “[will] always outweigh law enforcement”.¹⁴ The report also noted difficulties with the capacity of the RNLI due to fatigue, and described how Border Force vessels were a “useful addition to Coastguard’s capability”.¹⁵

5 INQ004467/57/par8.10 and fn87. ‘Gold’ is a term used to denote a strategic level of decision-making, in contrast to the tactical (‘silver’) or operational (‘bronze’) level.

6 INQ004467/57/par8.10, INQ010098/80/par5.16.

7 INQ004467/28/par6.29.

8 INQ006136/10/par3.6.1.

9 INQ010137/14/par29 and 19/par49, INQ000619/1.

10 INQ004467/par8.73, INQ005215. See also paragraph 7.69.

11 INQ010137/14/par29.

12 See paragraph 5.19.

13 INQ004467/57-58/par8.14, INQ006136.

14 INQ006136/51/ln14.

15 INQ006136/19/par6.4.2-6.4.3.

- 5.12** The Cabinet Office convened a cross-Whitehall meeting on small boats on 5 July 2019. In a briefing document for the meeting, Border Force recognised that their current approach was “failing”, that the risk to life posed by small boat crossings was “significant”, and that the potential for a fatality at sea was said to be “highly likely”.¹⁶ As a result of the meeting, Mr James Driver (Deputy Director of Maritime Security at the DfT, who attended the meeting on behalf of the DfT) was required “to enlist JMOCC [the Joint Maritime Operations Coordination Centre] to discuss co-ordinating [search and rescue] response with [MCA]/ Border Force”.¹⁷
- 5.13** On 24 July 2019, the Joint Maritime Operations Coordination Centre convened the first Small Boats Planning Group meeting, which was attended by members of Border Force, the MCA, the Joint Maritime Operations Coordination Centre and the DfT.¹⁸ While emails circulated beforehand stated that the purpose of the meeting was to discuss “responsibility for [search and rescue]”, the minutes of the meeting recorded that its purpose was to “set out what transitioning into [business as usual] will look like, both on the water and in terms of the whole of the [HM Government] piece, should [Border Force] Maritime draw down on their assets to re-task to other work”.¹⁹
- 5.14** A fortnight later, following a meeting of the Small Boats Strategic Steering Group, Mr Daniel O’Mahoney (who at the time was the Director of the JMSC) was designated to lead on alternative multi-agency tactics to effect returns at sea and determine to what extent government maritime resources could be better deployed.²⁰
- 5.15** In relation to returns at sea, there was discussion as to whether a policy known as Operation BOWTHORPE could be implemented.²¹ Operation BOWTHORPE had been developed by Border Force a few months earlier. It was a policy whereby people rescued from small boats would be returned back to France, rather than be taken to the UK.²²

16 INQ008159/1. See also INQ008158.

17 INQ004161/3.

18 INQ001131.

19 INQ001119, INQ001131/1.

20 INQ009210.

21 INQ001939.

22 INQ006132.

Operation SOMMEN and turnaround tactics: March 2020 to April 2022

- 5.16** By spring 2020, the Home Office had reiterated its desire to develop a returns at sea policy.²³ However, the policy this time would go beyond returning people on board small boats once rescued, and would instead involve the development of tactics to turn small boats around at sea to prevent them reaching the UK in the first place.²⁴ This policy was known as Operation SOMMEN.²⁵
- 5.17** Around 30 March 2020, a strategic briefing was prepared which set out “tactical options to interdict migrant vessels”.²⁶ Among other things, it stated that the lead agency for any interdictions would be Border Force, that the priority was saving lives at sea, and that the purpose of any interdiction under the current legal framework was search and rescue.²⁷
- 5.18** From around May 2020, the DfT began to raise concerns in internal meetings regarding the development of turnaround tactics and sought to ascertain the implications of the policy, particularly as regards the search and rescue remit of HM Coastguard.²⁸ Over the summer of 2020 and in the months that followed, there were discussions between the DfT and Home Office regarding the development of turnaround tactics.²⁹ At the end of June 2021, the Home Secretary chaired a meeting regarding the operationalisation of turnaround tactics, and a timeline was set for their roll-out.³⁰

Operation ALTAIR: December 2020

- 5.19** On 21 December 2020, the CCTC launched Operation ALTAIR.³¹ Operation ALTAIR covered both the maritime and land-based aspects of the Home Office’s strategy, such as reception facilities and communications campaigns upstream in migration routes.³² This strategy became the overarching operational response up to 23 November 2021, although reference continued to be made to Operation DEVERAN in relation to the maritime aspects of Operation ALTAIR activity.³³

23 INQ001084.

24 INQ002387/2.

25 INQ010137/23-24/par56-58.

26 INQ002350.

27 INQ002350/1-2/par1.3.

28 INQ001947, INQ001163.

29 For example, see INQ001171.

30 INQ004299, INQ001089.

31 As to the CCTC, see paragraph 4.73.

32 INQ010134/13/par39.

33 INQ010134/13/par39.

Implementation of Operation SOMMEN: summer 2021

- 5.20** In early July 2021, the Home Office made a series of further military aid to civil authorities requests to the MOD in the form of planning, development of tactics, assets and personnel to support the CCTC's safety of life at sea operation. In September 2021, further steps were taken to implement turnaround tactics including a workshop at the CCTC, which aimed to review the procedures for Operation SOMMEN and HM Coastguard to terminate search and rescue in respect of small boats.³⁴
- 5.21** The use of the turnaround tactics was approved by the Prime Minister on 25 September 2021.³⁵ They remained available for use until April 2022, when the Home Secretary withdrew them, although they were not used on the night in question and were never used with small boats.³⁶

³⁴ INQ010098/65/par3.87-3.88.

³⁵ INQ003490.

³⁶ INQ010137/24/par57.

Chapter 6:

Operational response: 2018 to November 2021

Introduction

- 6.1** The chapter concerns the operational response to small boat crossings, primarily by HM Coastguard. It considers the position in relation to resources (in particular, staffing and assets available to effect search and rescue) and HM Coastguard's operational systems. It addresses HM Coastguard's awareness of the pressure on resources (including as a result of the increase in small boat crossings) and the challenges with its operational systems. It also considers the adequacy of HM Coastguard's response to the issues.
- 6.2** This chapter and the following chapter are primarily concerned with the position up to 23 November 2021.

Resources: HM Coastguard staffing

Recommended staffing level

- 6.3** A July 2019 review of staffing levels by HM Coastguard suggested that seasonal staffing numbers for 'medium' demand periods (defined to include 23 September to 24 November) for MRCC Dover were three operational officers for both day and night shifts, on weekdays and weekends.¹ These staffing levels related to search and rescue only, with Vehicle Traffic Service personnel responsible for commercial and other maritime traffic in the Dover Strait being additional to this figure. The MCA did not consider the suggested seasonal requirement to be a minimum staffing requirement for each MRCC. Instead, it relied on having a minimum number of staff across the national network, with the use of 'zone flexing' as necessary.²
- 6.4** There was a further review of staffing across the HM Coastguard network in 2020. This extended the 'medium' demand period to include the whole of November.³ The review included a staffing recommendation for Dover (search and rescue excluding small boat activity), which remained at three for both

¹ INQ001176, INQ007223, INQ001329.

² See paragraph 6.6.

³ INQ001329/4.

day and night shifts on medium weekdays and weekends. It appears that there was an additional recommendation for staffing for a ‘migrants requirement’, which was noted to be subject to confirmation and which was also three for both day and night shifts for the same period.⁴ The review was completed and dated 8 November 2021, but it remained in draft.⁵ It would seem that it was not revisited until March 2022, and that the recommendations were not implemented until August 2022.⁶

- 6.5** Finally, with regard to staffing at the JRCC, it was considered preferable to have two Maritime Tactical Commanders on each watch to improve oversight, reduce mental fatigue and ensure adequate rest breaks were in place.⁷

Remote staff, zone flexing and network flexing

- 6.6** As explained earlier in the report, HM Coastguard allocated specific zones to be overseen by each MRCC. However, it operated a system referred to as ‘zone flexing’ or ‘network flexing’, whereby staff within a given MRCC or the JRCC at Fareham were able to co-ordinate the search and rescue missions of other MRCCs throughout the UK.⁸ Under zone flexing, the role of an SMC could be undertaken remotely.⁹ Zone flexing was intended to manage staffing levels within the network by providing remote support to a particular MRCC which had insufficient staff.

HM Coastguard awareness of staffing and other operational issues

- 6.7** By 23 November 2021, MRCC Dover had longstanding issues with staffing levels, which “had been low for some time”.¹⁰ The staffing of MRCC Dover was said to have been regularly discussed at divisional management team meetings.¹¹ The MRCC Dover Commander would report about staffing to the Divisional Commander, Mike Bill, who was well aware of staff shortages at MRCC Dover.¹² Staff retention was a key issue and impacted the experience and competence of those at MRCC Dover.¹³
- 6.8** In March to April 2021, seven new trainee coastguards were recruited at Dover, though only five of those stayed on.¹⁴ As boat crossing numbers began to rise over the spring and summer of 2021, HM Coastguard was notified by the Home

4 INQ001329/9.

5 INQ001329/1.

6 INQ007223, INQ010014.

7 INQ010138/4/par13. See also paragraphs 8.15 and 9.20.

8 INQ010098/106/par6.31.

9 INQ000446, INQ000456.

10 INQ010392/11/par28.

11 INQ010719/8/ln22-25.

12 INQ010719/13/ln4, 15-16/ln17-7.

13 INQ010719/19/ln13-22.

14 INQ010719/33/ln15-16.

Office that as of 1 August 2021 predictions of crossings for 2022 could reach 60,000 people.¹⁵ In light of this prediction, HM Coastguard determined that additional staff were required.¹⁶ This led to a recruitment campaign taking place in August 2021 for a further 24 operational staff at MRCC Dover.¹⁷ It was also determined that a second Maritime Operations Controller should be recruited for MRCC Dover.¹⁸

- 6.9** However, staffing shortages continued throughout the summer of 2021. Appeals were made to existing coastguards to make themselves available to support MRCC Dover until October, by which time new staff would have been trained.¹⁹
- 6.10** In August 2021, two HM Coastguard reviews identified resourcing and other operational issues affecting HM Coastguard's search and rescue response.
- 6.11** Firstly, on or around 4 August 2021 (a particularly busy day for crossings), there was a review of migrant incident activity conducted by the HM Coastguard Clandestine Operations Liaison Officer.²⁰ The review recorded a number of staffing issues which had arisen in the course of the operational response that night.
- There was low and possibly inadequate staffing. In particular, the watch for search and rescue had been made up of one qualified Maritime Operations Officer and two trainee Maritime Operations Officers.
 - Problems with zone flexing were identified. The SMC for the day had been remotely located at MRCC Humber. As the apparent number of migrant vessels in distress had increased, there had been a loss of effective communication with the remote SMC, which had consequences for shared situational awareness and joint understanding of risk. Due to the loss of situational awareness and effective communications, the remote SMC elected to stand down and a new SMC and 'support cell' was provided by the JRCC at Fareham.
 - Maritime Operations Officers on shift that night were seen to be visibly struggling with the amount of information, logging and analysing it, and communication with the remote SMC. They also did not have adequate time for breaks. These were not new observations. Border Force colleagues had also raised the issue that previous red days had seen staff at MRCC Dover "displaying signs of tiredness bordering on exhaustion with a consequent drop in performance", particularly when there had been multiple red or amber

15 INQ010098/9/par1.24, INQ004304/37, INQ007064/34.

16 INQ010098/9/par1.24, INQ010746/65/ln13-24, 72/ln18-23.

17 INQ001329/10, INQ003532/4, INQ010098/par1.24.

18 INQ007384/1.

19 INQ003323, INQ003322, INQ003379, INQ003341.

20 INQ007279.

days, with the same team (often with trainee Maritime Operations Officers) having to manage the response.

6.12 The review also recorded the following issues.

- a.** Despite repeated requests from HM Coastguard, there had been a delay in sharing the French tracker, the operational spreadsheet used by the French Coastguard to record small boat activity, which showed over 23 incidents when received.
- b.** Resourcing and capacity issues were apparent. It was said to be clear that available resources were becoming stretched with several assets conducting secondary (before returning to shore) or multiple taskings (after their initial deployment). Often there were no available assets to cover the number of apparent distress incidents that were being logged. In addition, a request for support from RNLI Ramsgate was declined by the SMC as it would have left no resource available for a response if required on the north side of the coastline. This resulted in one migrant vessel being left for over two hours with a single Border Force jet-ski, while all other RNLI and Border Force assets were committed to other tasks. This created a risk that if the small boat's condition deteriorated, there may have been people in the water with no asset available to rescue them.

6.13 As a result of these events, the Clandestine Operations Liaison Officer identified, in the following order, a number of critical risks:

- loss of organisational reputation
- staff retention, welfare and morale
- loss of life at sea from ineffective and inadequate preparation and/or response
- failure to recognise or declare a major incident when the criteria have been met
- inability to adequately defend the organisation at any subsequent investigation, inquest or inquiry which focuses on post-incident reviews and/or lessons learnt.

6.14 In response, the Clandestine Operations Liaison Officer made the following recommendations to counteract the risks evidenced by the events of 4 August 2021:

- the SMC was required to be physically present at MRCC Dover for all amber and red days ('amber' meant crossings were likely or probable, and 'red' meant that crossings were highly likely)
- staff at MRCC Dover should be sufficiently trained on all amber and red days to support the SMC

- there was a need for adequate preparation and resourcing to be conducted when there was credible intelligence and/or information to indicate that an amber and/or red day was likely
- standard operating procedures and protocols that were tested, trained, exercised and regularly reviewed should be implemented
- there should be migrant specific post-incident reviews both internally (and with partner agencies) to ensure that lessons are learnt and new strategies or tactics could be developed
- welfare support should be put in place for staff who were exhibiting any signs of stress, tiredness or a drop in performance due to repetitive exposure to amber and red days
- there should be proportionate and careful use of ‘broadcast action’ when dealing with multiple migrant incidents in distress, and ‘broadcast actions’ which could be focused on specific vessels by using C-Scope/Automatic Identification System
- early access to the French tracker was required to ensure that the operations room was not overwhelmed with information immediately and had sufficient time to assess the data
- the creation of a single UK migrant incident tracker was required, which all parties (HM Coastguard and Border Force) could access and input into.

6.15 Just over a week later, similar issues were identified in a report relating to 15 August 2021, conducted by the HM Coastguard Head of International Liaison. On this occasion, both unmanned aerial assets had to return to base, resulting in reliance on Border Force assets to search for vessels and provide a recognised maritime picture. Furthermore, the remote SMC struggled to maintain situational awareness. As a result, those in the operations room at MRCC Dover had to provide the remote SMC with more detailed information in ViSION and needed to speak with them regularly. The position was said to reflect a “lack of awareness at other stations” and “[highlighted] the limitations of remote SMC conduct” as “much of the information the SMC requires is not available in ViSION and the migrant incident tracker”. It was noted that the search and rescue team simply lacked capacity to deal with other significant incidents in zone 14 and that Maritime Operations Officers were at capacity throughout, with “no adequate time for any rest, comfort or meal breaks until mid-afternoon”. The consequence was that there was “no adequate or comprehensive recording/logging of information in the operations room or the [Joint Control Room] which impacts the ability to review or reconstruct incidents in the future”.

6.16 The report set out substantially the same risks from such events as the Clandestine Operations Liaison Officer on 4 August 2021. Recommendations were made which “mirrored or further supported” a number of the observations,

risks and recommendations made by the Clandestine Operations Liaison Officer's review of 4 August 2021.²¹

- 6.17** On 16 August 2021, the Chief Coastguard requested an urgent meeting to discuss the Dover migrant response.²² The following day, on 17 August 2021, the HM Coastguard Divisional Commander, Mr Mike Bill, sent an email to the Chief Coastguard in which he referred to the report of 15 August 2021 and summarised its findings, highlighting the similarities with the 4 August report. In addition, Mr Bill expressed the view that MRCC Dover had insufficient staff, noting among other things that "Maritime Operations Officer recruitment [had] been challenging", with two out of the seven Maritime Operations Officers recruited in March to April having decided it was not for them. High numbers of crossings were commonly experienced not just on red days, but also on amber and yellow days, and days that were considered green five days earlier. Mr Bill also described how the multitude of trackers used meant that there was "no single version of the truth". Finally, Mr Bill noted that high intensity days met the definition of a major incident although they were not declared as such, and that doing so would "advertise to the wider world...[and] partner agencies that we are stretched at Dover and may not be able to support any request coming from them". He set out a list of recommendations and proposed actions.²³
- 6.18** These challenges were recognised again on 21 August 2021, following a debrief between HM Coastguard's strategic cadre. The JRCC Co-ordination Centre Manager circulated a document entitled 'Migrant debrief – initial themes' for the purposes of a meeting with the Chief Coastguard and others.²⁴ This identified issues and proposed actions at a strategic, tactical and support level. This document, among other things, explained that those at the tactical level were "overwhelmed by [the] volume of work" and were not able to step back and have the "overall helicopter view in terms of tactical command. They were unable to remove themselves from operational. Operational level also overwhelmed". The debrief report specifically noted that it was not possible to keep up with the red, amber and green rating of small boat incidents categorised as 'distress'. In relation to the welfare of staff, the debrief report stated that "it was very clear that the [Border Force Joint Control Room] staff, Dover ops team...were all under significant stress and effectively 'firefighting'. All were unable to take any effective breaks, and/or refreshments which compounded human factor and welfare risks".²⁵ The proposed resolution was more support staff to take some strain. Finally, a concern about air support and "lack of fixed wing/observations" was also noted (although said to be resolved).

21 INQ003323.

22 INQ003320.

23 INQ003322.

24 INQ003378, INQ003379.

25 INQ003323.

6.19 The report identified the following risks:

- loss of life through ineffective and inadequate preparation and/or response
- loss of situational awareness and a common recognised picture
- loss of organisational reputation
- negative impact on staff wellbeing and morale
- inability to adequately defend the organisation at any subsequent investigation, inquest or inquiry which focuses on post-incident reviews and/or lessons learnt.

6.20 A recruitment campaign in August resulted in the appointment of nine officers.²⁶ In September 2021 a second recruitment campaign was launched, resulting in five officers being appointed.²⁷ Around this time Mr Bill, the HM Coastguard Divisional Commander, devised and circulated a staffing issues flowchart in an attempt to manage the occasions when MRCC Dover would be understaffed.²⁸ The flowchart is reproduced at Figure 7.

6.21 Nonetheless, problems relating to the adequacy of staffing continued throughout November 2021, up to and including the date of the incident.²⁹ For example, on 16 November 2021, it was noted at a red day meeting that no SMC was available for the coming Friday or Saturday. The Small Boats Tactical Commander agreed to cover the Saturday.³⁰

6.22 On 19 November 2021, search and rescue zones 11 and 13 (which had previously been the responsibility of MRCC Dover) were reallocated to Humber MRCC and JRCC respectively to provide MRCC Dover with “enduring, reliable, operational network support to coordinate the [search and rescue] response to small boats crossings”.³¹

26 INQ010098/93/par5.69.

27 INQ010098/93/par5.69.

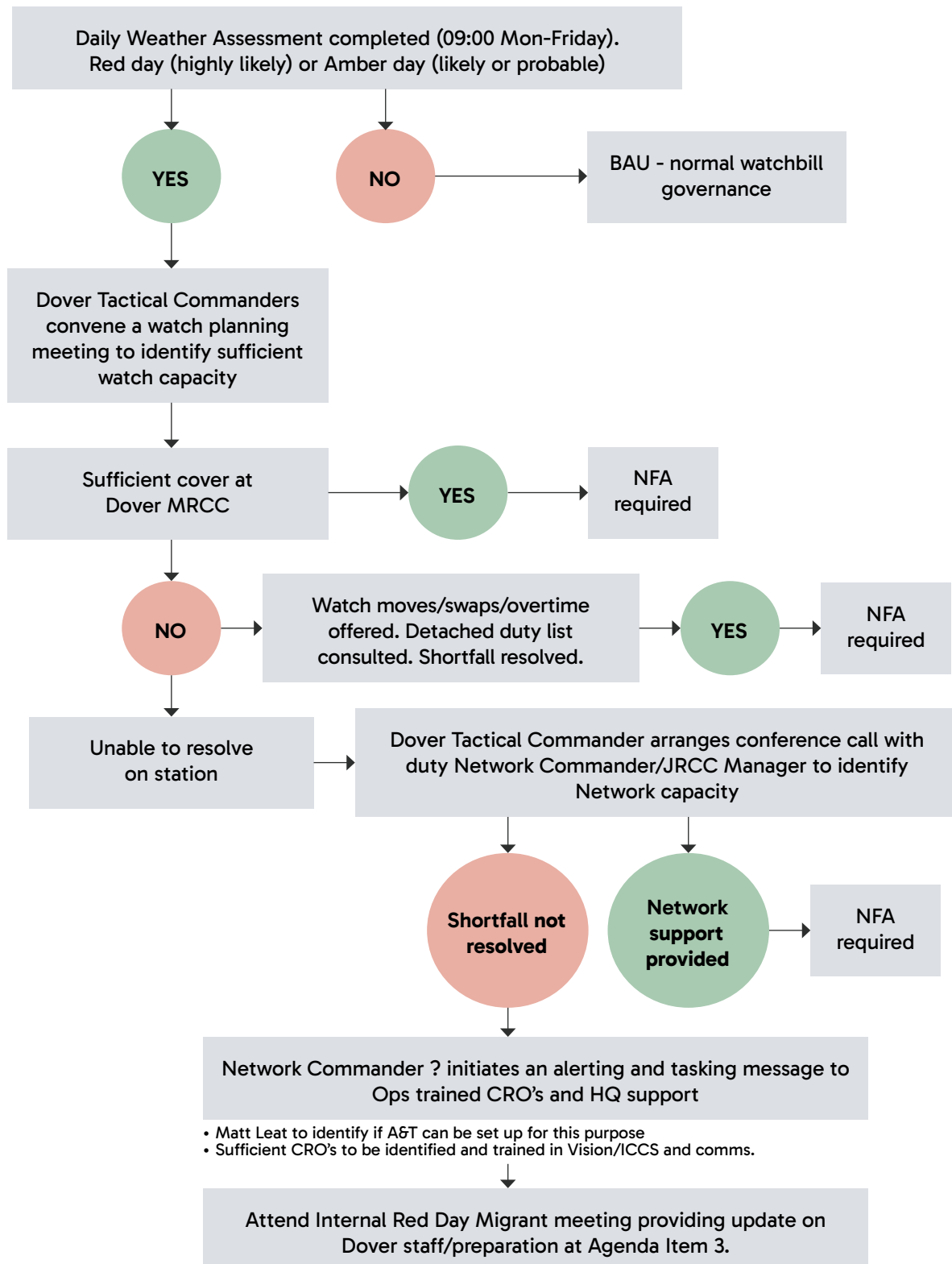
28 INQ003417, INQ003418.

29 INQ000215.

30 INQ000209/1.

31 INQ003731.

Figure 7: Flowchart for staff planning on migrant red or amber days (recreated using the original flowchart provided by Mr Bill, HM Coastguard Divisional Commander)



BAU = business as usual; NFA = no further action; CRO = Coastguard Rescue Officer; A&T = alerting and tasking; ICCS = Integrated Communication Control System

- 6.23** At a red day meeting on Monday 22 November 2021 to discuss the week ahead, it was noted that the network numbers were healthy, but that SMC availability at Dover was low and that having two SMCs at Dover on nights was insufficient.³² Further, that there had been no response locally for overtime, nor were any ‘externals’ available for those nights. However, Mr Richard Cockerill, ordinarily based at the JRCC, was due to be present at MRCC Dover for the day shift on both Wednesday and Thursday as Operation DEVERAN support.³³ Mr Cockerill was a qualified SMC and team leader.³⁴ Operation DEVERAN support was generally provided by SMCs from the JRCC or MRCC Humber who would be physically present at Dover to support the operations room.³⁵ Mr Cockerill’s role was to act as a Maritime Co-ordinator, which was equivalent to a Maritime Operations Officer.³⁶
- 6.24** Following the red day meeting on 22 November, the JRCC Manager sent an email to all coastguards requesting volunteers to travel to Dover to assist the MRCC with the operational response to anticipated small boats activity during the night shifts of 23 to 24 November 2021.³⁷ Following this email, Mr Cockerill suggested that he begin his shift slightly earlier, at 05:00 on 24 November 2021.³⁸ Accordingly, he began his shift at 05:00 on 24 November 2021 and therefore his working hours overlapped both the night and day shifts.³⁹

System for alleviating staff pressures

- 6.25** In theory, the network flexing or zone flexing system should have assisted with staffing pressures, including on MRCC Dover. However, the 4 August 2021 review identified problems with this system, including “a loss of effective communication with the remote SMC, which had consequences to shared situational awareness and joint understanding of risk”. In a meeting on 2 November 2021, it was observed that “sometimes locally colleagues can forget about the wider support available even if the numbers on duty at a particular location feel low”.⁴⁰ The Inquiry heard evidence from witnesses which echoed these points: in short, in the context of small boat search and rescue, effective situational awareness required relevant staff to be in the same room.⁴¹

32 INQ000206.

33 INQ000233/10, INQ000409/‘DOVR’ tab/row85.

34 INQ009634/8/par14.

35 INQ010720/181/ln19-25, 186/ln11-19.

36 INQ009634/13/par28, 15/par35-36, 15-16/par38.

37 INQ006765.

38 INQ010720/189/ln24.

39 INQ010138/8-9/par36, INQ009634/13-14/par31.

40 INQ008142/2.

41 INQ010720/112-116/ln25-23, INQ010128/2.

- 6.26** As can be seen from the foregoing, there was a long-standing problem of short staffing at MRCC Dover. The staffing problems had been repeatedly identified within HM Coastguard, and they had been expressly related to risks. These issues had not been adequately resolved by November 2021. Zone flexing or network flexing was not an adequate solution to HM Coastguard's staffing problems at MRCC Dover.

Resources: maritime resources

- 6.27** As explained in Chapter 4, HM Coastguard primarily relied on RNLI and Border Force maritime assets to respond to small boat incidents. This section considers problems relating to the suitability and capacity of maritime assets and the relevant stakeholders' awareness of them.

Border Force assets: suitability

- 6.28** Border Force became involved in responding to small boat search and rescue from 2018, due to the increase in small boat crossings. Border Force originally deployed cutters and coastal patrol vessels. Border Force subsequently introduced crew transfer vessels from 2021.⁴²
- 6.29** It was recognised from early on that Border Force vessels were not entirely suited to the task of search and rescue.⁴³ The evidence of Mr Stephen Whitton (Head of BFMC) to the Inquiry was that all of the vessels used by Border Force had limitations and were not dedicated search and rescue assets. He stated that the cutters had been very effective at conducting rescues which involved smaller boats carrying fewer people, but that the cutters could not embark people as quickly as crew transfer vessels.⁴⁴ In Mr Whitton's view, the cutters had provided a good rescue capability for the small boats which initially crossed with about 14 to 16 people. As the small boats got bigger and the number of people on board increased, they exceeded the ideal operational capabilities of the cutters.⁴⁵ The coastal patrol vessels were limited in numbers to 50. Large numbers presented a stability issue as well as a challenge for the crews to safely run the vessel in terms of any emergency procedures or managing a large group on board.⁴⁶

⁴² A crew transfer vessel is a twin-hulled platform, which has a larger deck space than a Border Force cutter or coastal patrol vessel. It has a higher wheelhouse and sheltered accommodation, which is not a feature of either the cutter or the coastal patrol vessel. The introduction of crew transfer vessels was intended to provide a more bespoke maritime rescue capability. In July 2021, the first crew transfer vessel (Hurricane) was brought into service. Hurricane was intended to be deployed during the busiest periods because it was better suited to search and rescue and could carry more people than the cutters.

⁴³ INQ010134/24-25/par66, INQ000190/2, INQ004467/73/par8.82, 75/par8.92.

⁴⁴ INQ010742/57-58/ln14-2.

⁴⁵ INQ010742/58-59/ln16-1.

⁴⁶ INQ010742/57-58/ln14-2.

- 6.30** Mr Daniel O'Mahoney (Director of CCTC) similarly gave evidence that neither coastal patrol vessels nor cutters were designed for small boat rescues. He explained that they had helpful characteristics (such as a fast speed) but their speed also made them unstable, and embarking people from small boats was quite challenging.⁴⁷
- 6.31** Mr Kevin Toy (Commander of HMC Valiant), who also gave evidence to the Inquiry, agreed that cutters were not designed or equipped as a dedicated rescue vessel or to carry out mass rescues. His evidence was that they were not designed or equipped to take large numbers of passengers, and he stated that people who were rescued often had to be held outside, not under cover, while travelling back to port.⁴⁸ He explained that it was extremely challenging to embark people rescued from small boats onto HMC Valiant. A system involving a boarding ladder next to the rigid hull inflatable boat was adopted, with those who were unable to climb the ladder embarked using the stern launch slipway mechanism. However, the workability of this system was limited by sea conditions and weight restrictions.⁴⁹
- 6.32** While crew transfer vessels were intended to provide a more suitable asset, they were not deployed to all incidents, and even their use did not resolve concerns about the suitability of Border Force assets. The evidence of Mr Simon Ling on behalf of the RNLI was that the crew transfer vessels could pitch quite considerably in wave heights over 1 metre.⁵⁰ Before 23 November 2021, it had been recognised that Border Force was “relying heavily on RNLI as they have the right vessels for the wave height”.⁵¹ Reliance on the RNLI to assist Border Force due to the unsuitability of Border Force assets necessarily increased pressure on RNLI resources.

Sufficiency of maritime assets: Border Force

- 6.33** In the early part of the small boats crisis, there was some reservation about increasing the number of assets allocated to deal with small boat crossings “to prevent encouraging migrant attempts” and so that Border Force was not seen as a “taxi service”.⁵² However, as early as 30 September 2020, there was a recognition at a migrant activity interoperability meeting between HM Coastguard and CROSS Gris-Nez that “both sides have insufficient assets to deal with heavy days”.⁵³ Further, as noted above, in August 2021 HM Coastguard reviews identified resourcing and capacity issues, noting that “[o]ften there were

47 INQ010742/168-169/ln22-6.

48 INQ010717/30-31/ln21-12.

49 INQ010717/31-32/ln17-8.

50 INQ010741/151/ln11-25.

51 INQ004159/2.

52 INQ009054/1, INQ003752/1.

53 INQ000217.

no available assets to cover the number of ‘apparent’ distress incidents that were being logged”.⁵⁴

- 6.34** The Home Office was also aware that its assets were at capacity and were close to being overwhelmed by the numbers of small boat crossings. A Home Office intelligence document noted that the number of people who crossed on 21 August 2021 reportedly ranged from 814 to 869 (with reconciliation of events yet to be completed over a week later) and that it “is highly likely that frontline resources were stretched to capacity due to the number of migrants encountered, creating challenges in data recording”.⁵⁵
- 6.35** In September 2021, a draft letter from the MCA to the Home Secretary recorded, in the context of discussing the potential impact if the French withdrew co-operation due to the implementation of turnaround tactics, that “this is likely to require substantial and immediate investment to bolster our capability in a number of areas, not least our maritime capability in the Channel, which is already stretched at current levels”.⁵⁶ It was reiterated that Border Force was stretched in an email of 28 September 2021.⁵⁷
- 6.36** At the end of October 2021, a CCTC meeting entitled ‘Resourcing SOLAS 2022’ was held to address the issue of resourcing search and rescue at sea. It was suggested at the meeting that civilian vessels, manned with Border Force personnel, could be commissioned for search and rescue operations.⁵⁸
- 6.37** On 11 November 2021, a critical incident was declared at Tug Haven, which was the processing site for those rescued from small boats, due to the number of arrivals overwhelming capacity there.⁵⁹ An internal email within the DfT discussing this event noted that:
- “[Border Force] maritime teams are also under significant pressure, made worse by some [Border Force] vessels being out of operation due to Covid cases. [Border Force] do not have suitable vessels to rescue people due to the types of crafts used for crossings and are relying heavily on RNLI as they have the right vessels for the wave height. [Border Force] shared concerns regarding the resilience of the RNLI due these pressures [sic] and are working with the MCA.”⁶⁰

54 See paragraph 6.12. INQ007279/3.

55 INQ003412.

56 INQ003472/2.

57 INQ003507/2.

58 INQ010337/38/par108.

59 INQ010134/43/par132-133, INQ010337/29-32/par79-88, INQ004159, INQ008112, INQ001110.

60 INQ004159/2.

This triggered a series of cross-Whitehall meetings in which the limits of search and rescue capacity were discussed.⁶¹ On 12 November 2021, Ms Claire Hughes (then Director of HM Coastguard) was reported as raising “no immediate concerns. But it was definitely a problem”.⁶²

- 6.38** Not only was the risk of assets being overwhelmed appreciated for a significant period before the incident, but it also appears that it was recognised as a potential problem immediately in advance of 24 November 2021 itself. In an email to Mr George Papadopoulos (the Small Boat Tactical Commander) dated 26 November 2021, Mr James Crane (SMC for the day watch of the 24 November 2021) reflected on the events of that day. He stated that:

“It became very apparent during the day shift of 23rd November 2021 that the 24th was going to be a heavy day, and the asset availability was going to be stretched for what had been initially prescribed as an AMBER forecast...this is simply not sustainable for us to have to work with high numbers of migrant calls with two waterborne Border Force assets...the RNLI are already stretched...[W]e are all aware of the issues regarding resourcing assets from both parties. Mike Bill [Divisional Commander] is aware of this...”⁶³

- 6.39** Very shortly after the events the Inquiry is investigating, on 2 December 2021, at a tabletop exercise attended by organisations involved in the response to the small boats issue in the English Channel, it was noted that “maritime assets [are] stretched to the limit”.⁶⁴

- 6.40** Border Force’s knowledge that they were unprepared for a mass casualty on or around the date of the incident is also apparent from emails dated 24 November 2021, when the Home Office was discussing internally the events which were taking place in French territorial waters that day. A comment was made about whether the government was “confident around a response, should today’s event unfolded [sic] in UK [territorial waters]?”. Candidly it was admitted by reply: “If it is the same as I have found elsewhere, I have low confidence that we are prepared or have an [standard operating procedure] or plan.” The response was that: “We ran a [tabletop] recently on this through [the JMSC], there is quite a bit that needs picking up as there will be numerous agencies involved and we need to determine at what point any immigration action would need to be taken.”⁶⁵

61 INQ001101, INQ010337/29-32/par79-88, INQ001966, INQ003715, INQ007893, INQ008168, INQ008169, INQ006725, INQ004191, INQ001336, INQ001179, INQ007886, INQ008099.

62 INQ008099/3.

63 INQ003735.

64 INQ009954, INQ010742/62-66/ln5-14.

65 INQ005265.

- 6.41** The insufficiency of Border Force assets to meet demand was not resolved by 23 November 2021. As Mr O'Mahoney stated in his evidence, "frankly, we just needed more boats".⁶⁶

Sufficiency of maritime assets: RNLI capacity

- 6.42** As noted in Chapter 4, part of the maritime search and rescue capacity in the English Channel was provided by the RNLI.
- 6.43** The RNLI's corporate witness, Mr Ling, gave evidence on the challenges faced by the RNLI and its volunteers in relation to small boat search and rescue.⁶⁷
- 6.44** Firstly, the unprecedented increase in the level of small boat crossings and rescue demand between 2017 and 2021 placed significant pressure on staff and volunteers at stations which served the Dover Strait.⁶⁸ For example, at Dover Lifeboat Station, crew went from an average of 25 service calls a year to 158 in 2021. At Dungeness Lifeboat Station, crew went from an average of 12 service calls a year to close to 100. November 2021 was the busiest month on record for the RNLI, with 64 small boat crossing taskings and 2,262 casualties rescued.⁶⁹
- 6.45** Secondly, the particular challenges presented by small boat crossings increased pressure on RNLI assets, staff and volunteers. These included the high number of people per boat, unseaworthy boats, limited accurate information, the condition of casualties and the extensive rescue area. The challenges were exacerbated by the limited capability of Border Force assets.⁷⁰ As explained already, RNLI vessels were relied on where conditions were unsuitable for Border Force to conduct small boat rescues. Border Force had shared concerns about the "resilience of the RNLI due these pressures [sic]" earlier in November 2021.⁷¹
- 6.46** Thirdly, and more generally, Mr Ling gave evidence about the traumatic impact of attending small boat crossing incidents on the mental health of RNLI crews.⁷² He also gave evidence about the abuse which was directed at the RNLI as an organisation, and to some of its volunteers, due to their role in responding to small boat crossings.⁷³ Sadly, it is evident that these factors also increased pressure on the RNLI and its volunteers.

66 INQ010742/196/ln15-24.

67 INQ010101.

68 INQ010101/13-14/par38.

69 INQ010101/12-14/par35-38.

70 INQ010101/13-24/par38-58.

71 INQ004159/2.

72 INQ010101/22/par52.

73 INQ010741/49-51/ln10-6. As I said at the public hearings, RNLI crews do not deserve such abuse, and we should all be grateful for what they do.

- 6.47** The RNLI took commendably proactive steps to improve its ability to respond to small boat incidents. These included recruiting more volunteers and facilitating the development of equipment specifically designed to address rescue challenges in such incidents. However, it is clear that there remained resource pressure on the RNLI as at November 2021.
- 6.48** Despite the pressures and challenges, RNLI assets and volunteers continued to be made available to HM Coastguard to attend small boat incidents throughout November 2021. In particular, RNLI assets were available for tasking by HM Coastguard on 23 to 24 November 2021. However, as seen in the following chapters, awareness within HM Coastguard of pressures on RNLI resources impacted on tasking decisions during the incident.

Resources: aerial assets

- 6.49** As explained in Chapter 4, private companies including 2Excel provided aerial search and rescue assets to HM Coastguard. One critical purpose of the aerial assets was to provide HM Coastguard with effective situational awareness (in particular, an understanding of the small boat activity in the English Channel). The 2Excel fixed-wing aircraft were the primary resource used in this regard.
- 6.50** The contract with 2Excel was amended a number of times after it was first executed in 2019 to increase the number of aircraft available to the MCA and to increase their flying hours.⁷⁴ But by September 2021, it was apparent that the increase in small boat activity had placed considerable pressure on the fixed-wing aircraft 2Excel provided.⁷⁵ On 7 October 2021, the MCA held an initial meeting to discuss how best to procure additional assets for the purpose of situational awareness in the Channel. This was the first step towards what became Operation CAESAR, which was intended to increase aerial resources.⁷⁶ There was a submission to the Secretary of State for Transport on 18 November 2021 in relation to this.⁷⁷ However, Operation CAESAR did not become operational until 1 March 2022.⁷⁸

HM Coastguard operational systems

Systems for recording and sharing information: ViSION

- 6.51** As explained in Chapter 4, ViSION was an incident management software used by HM Coastguard to record information relating to search and rescue incidents.

⁷⁴ INQ010335/3/par9-11, INQ006328, INQ006327, INQ006326, INQ006323.

⁷⁵ INQ008057/2, INQ009378.

⁷⁶ INQ001370, INQ010098/par2.20.

⁷⁷ INQ000103, INQ000106, INQ008131.

⁷⁸ INQ010098/par2.22, 2.44, 5.2, 5.61.

At the Inquiry's hearings, the ViSION system was referred to as the single source of the truth, emphasising its importance to HM Coastguard staff as the primary source of information in relation to an ongoing search and rescue incident.⁷⁹ However, there were several problems with the use of ViSION.

- 6.52** Firstly, at the time of the incident, the maritime and aeronautical arms of HM Coastguard used different systems: the MRCCs used 'ViSION 4', whereas the ARCC used 'ViSION 5', which had additional applications to assist with aerial operations.⁸⁰ The ARCC could not access ViSION 4 and, as far as the Inquiry is aware, the MRCCs did not have access to ViSION 5.⁸¹ The evidence of the Aviation Tactical Commander was that if the ARCC and MRCC both used the same system, he would have had access to MRCC search and rescue logs, and would have used these for further information and awareness where required.⁸² Therefore, the use of different versions of ViSION limited information sharing.
- 6.53** Secondly, even though HM Coastguard recognised the importance of ViSION, pertinent information regarding small boat incidents was routinely not recorded, or not recorded contemporaneously, within it. That was because HM Coastguard staff were overwhelmed by the volume of incidents and were required to undertake other duties such as call handling.⁸³ This issue had been highlighted in the 4 August 2021 review, which had noted that staff had been struggling with the amount of information, including logging it.⁸⁴

Systems for recording and sharing information: HM Coastguard tracker

- 6.54** As explained in Chapter 4, the HM Coastguard tracker was used to record information about small boat incidents, in order to develop situational awareness and obtain a recognised maritime picture, as well as to reconcile calls which were received from small boats. The issues relating to the use of this tracker to share information with Border Force are addressed in Chapter 7.

Systems for communicating with small boats

General challenges in communicating with small boats

- 6.55** HM Coastguard gave evidence to the Inquiry as to the challenges it faced in communicating with small boats. HM Coastguard was aware of these challenges by around 2018, which included the following.⁸⁵

79 INQ010715/154/ln14-22, INQ010746/179/ln11-14.

80 INQ009628/par42-46.

81 INQ009628/par44, INQ010098/par3.75.

82 INQ010718/108/ln6-11/ln24.

83 INQ007279/4/par7, INQ003323/3-4, INQ010142/29/par89, INQ010720/117-118/ln20-17, 123/ln5-15, INQ010719/155-156/ln20-12.

84 See paragraph 6.11. INQ007279/4.

85 INQ010098/6-7/para 1.15, 8/par1.21.

- Small boats were not equipped with recognised maritime means of communication, such as VHF radio, digital selective calling, or beacons enabling their location to be identified. This meant that communication with small boats was by mobile phone, which frequently cut out when used in the Channel.⁸⁶ Beacons could not be used to identify the location of the boats.
- Small boats were not equipped with standard navigational equipment or means of detection, and did not have a qualified person helming the boat. This meant that it was difficult for HM Coastguard to obtain accurate information about the location of the boats.
- Calls were derived from multiple people within one vessel, with no single point of contact. This meant that HM Coastguard would often receive multiple reports from one small boat. The callers did not always provide consistent details about each incident, which created difficulties in reconciling incidents.
- There were communication difficulties due to English not being the first language of those calling from small boats, which meant that callers could not respond to “requests for information regarding locations”, or “couldn’t tell you where they were going”.⁸⁷
- Inaccurate information was provided by callers (whether intentionally or otherwise), including about the numbers of people onboard and the level of distress of the small boat. In the report completed on 4 August 2021, the Clandestine Operations Liaison Officer recorded that “once migrant vessels know they are in UK waters”, they “use prepared ‘scripts’ to contact multiple emergency services (often from the same vessel), to request immediate assistance due to “vessel sinking”, “critically ill individuals” or “loss of engine in the Traffic Separation Scheme”.⁸⁸

6.56 A further known limitation on communications with small boats related to obtaining caller location. As explained in Chapter 4, where calls were made to HM Coastguard using emergency call numbers, the Enhanced Information Service for Emergency Calls could be used to obtain the caller’s location. However, this service was not available when HM Coastguard received a call through international emergency roaming (when the caller from a small boat was not connected to their home network at the time they called the English authorities). Even where the Enhanced Information Service for Emergency Calls was available, the error radius could be anything up to two or three miles so the accuracy of the locational information provided could vary.⁸⁹

86 INQ010098/53/par3.31.

87 INQ009634/32/par60, INQ010140/18/par51.

88 INQ007279/2. See also paragraph 6.68.

89 INQ010098/10/par1.26, 51/par3.23, 53/par3.31.

Use of WhatsApp and HM Coastguard mobile phone

- 6.57** In October 2020, HM Coastguard introduced the use of a mobile phone to enable communication with callers from small boats by WhatsApp, as a result of shared learning with French counterparts. It published guidance on Dover WhatsApp use on 19 October 2020 which explained how to access and use WhatsApp, including how to send location information.⁹⁰
- 6.58** Although it was evidently a positive step, there were a number of difficulties with its use.
- 6.59** Firstly, the Inquiry heard evidence that the intended use of the mobile phone was limited to the passing of positions via WhatsApp, and there was guidance not to answer a call from the phone.⁹¹ However, there was nothing to prevent calls from being made to the mobile phone, and callers had no reason to think that the number was not monitored. The SMC on the night of 23 to 24 November 2021 gave evidence that there was no training about monitoring the phone and no policy in place.⁹² This meant that calls could be made to the mobile phone which would not be answered or acknowledged by HM Coastguard staff.
- 6.60** Secondly, calls received on the mobile phone were not recorded or retained on HM Coastguard systems.⁹³ This was contrary to the guidance in the IAMSAR Manual, which required that all voice equipment used for communications should be attached to a multi-channel tape recorder, preferably with a time recording, to allow the review of verbal information.⁹⁴ This meant that information received through mobile phone messages was not reliably retained or shared through the ViSION system, potentially limiting situational awareness.

Language difficulties

- 6.61** HM Coastguard was aware of challenges with communicating with small boats, including language difficulties, from around 2018.⁹⁵
- 6.62** Language Line, an interpretation service, had been available for use by HM Coastguard by at least 2018.⁹⁶ However, the MCA's evidence to the Inquiry was that although "staff were trained in Language Line use and it was a tool available to staff", it was "not typically utilised in the Channel due to the challenges to

90 INQ006747.

91 INQ010715/19-20/ln5-14.

92 INQ010715/25/ln18-26/ln19.

93 INQ010715/26/ln2-19.

94 International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 1', paragraph 2.3.109(a).

95 INQ010746/14/ln4-15.

96 INQ010392/20/par48.

obtain reliable mobile phone signals and the inability on occasions to call back”.⁹⁷ In oral evidence to the Inquiry, the MCA’s corporate witness explained that “the challenges with using Language Line are that you need to sustain a call for a long period whilst a translator is sourced”, and that because not many calls came in via the 999 system, HM Coastguard did not always have a phone number to call back.⁹⁸

6.63 In his evidence to the Inquiry, the SMC on the night of 23 to 24 November 2021 explained that, while MRCC Dover had access to Language Line services to facilitate communication with people on small boats, in reality it was not used much. Often, calls would be very short or would cut off due to bad signal before there was time to connect to Language Line. He explained that: “[T]hrough experience and common sense, officers learned how to communicate with those who did not speak English well, but it was a major barrier to receiving the information that we needed to locate small boats that often could not be overcome.”⁹⁹

6.64 An HM Coastguard standard operating procedure entitled ‘Terminating a call originating from a migrant vessel’, which was issued in December 2021 after the incident, included the following guidance:¹⁰⁰

“Language barrier

If the language barrier prevents the operational call taker from obtaining information as outlined above, then every possible attempt is to be made to identify the nationality/first language of the casualty in order to initiate a connect call with an interpreter from Language Line.

...

If language barrier prevents operational call takers from gathering information, established [sic] connect call with a Language Line translator in order to follow L.I.N.P. [questioning] process and obtain a likely casualty position as a minimum.”

6.65 It does not appear that there was similar guidance in place by 23 November 2021, although operational witnesses were evidently aware of the option of using Language Line.¹⁰¹

97 INQ010746/146/ln16-17, INQ010098/52/par3.28.

98 INQ010746/146-147/ln19-7.

99 INQ010392/20/par48.

100 INQ010468.

101 INQ004725.

- 6.66** The IAMSAR Manual recommends verbal conversations with written messages where there are language barriers.¹⁰² A system reflecting this process was later put in place by HM Coastguard on 18 April 2023, known as the ‘ICU-Hub’.¹⁰³ Within the ICU-Hub is a text chat function which enables continuous messaging with the phone user. When the ‘auto-translate’ option is selected, the system supports two-way translation. Incoming messages in foreign languages are automatically translated into English. Operators can then type their response in English, and the system will automatically translate the reply into the recipient’s language, or the operator may choose a different target language if required. This translation function is available both within the ICU-Hub portal and via WhatsApp. The MCA’s evidence was that this enabled translation in near-real time. It is reflected in the updated HM Coastguard standard operating procedure ‘Terminating a call originating from a migrant vessel’, dated 23 February 2024, which states: “Consider the use of ICU-Hub’s chat translate function” in relation to language barriers.¹⁰⁴ However, the chat translate function was not available on 23 to 24 November 2021.
- 6.67** It is evident that language barriers complicated communication with small boat occupants. HM Coastguard was aware of this and also of the practical difficulties with using the Language Line service. Despite this, no alternative communication mechanisms had been put in place by November 2021.¹⁰⁵

Inaccurate information provided by callers

- 6.68** There was a known, or perceived, issue of inaccurate or exaggerated information being provided by small boat callers. This was reflected in the 4 August 2021 review, which referred to the use of scripts by occupants of small boats when contacting emergency services, specifically referring to a “vessel sinking”, “critically ill individuals” and a “loss of engine”.¹⁰⁶
- 6.69** The Inquiry received evidence of a widely held belief within HM Coastguard that those on small boats regularly exaggerated information about their condition and level of distress (although the Inquiry also heard evidence that this may have been based on the genuine subjective belief of callers).¹⁰⁷
- 6.70** It is not necessary to determine whether or not incorrect or exaggerated information was provided, intentionally or otherwise. However, it is clear that HM Coastguard was, or should have been, aware that this was the belief of its

102 International Maritime Organization and International Civil Aviation Organization (2019), ‘IAMSAR Manual Volume 1’, paragraph 4.2.2(e).

103 INQ004342/recommendation 13.

104 INQ005165.

105 INQ010746/147/ln8-13.

106 INQ007279/2.

107 INQ010719/57/12-20, INQ010740/50/ln20-23, 53/ln4-19, INQ010720/204-205/ln16-6, INQ010718/99/ln1-22, INQ010746/152-153/ln22-11.

staff, and should have ensured that the potential impact was considered and addressed. In particular, there was a clear risk, which should have been apparent to HM Coastguard before November 2021, that its staff might assume that information received from small boat callers was inaccurate, and therefore not act although it was true.

- 6.71** In June 2021, HM Coastguard delivered training on confirmation bias and human factors.¹⁰⁸ The assumption of Mr Papadopoulos, the Small Boat Tactical Commander in November 2021, was that the training would have been rolled out to all operational staff within the HM Coastguard network.¹⁰⁹ Mr Papadopoulos explained that the training slides were tailored for search and rescue, which included small boat search and rescue.¹¹⁰ He did not think that it would have been critical to tailor the training to small boat search and rescue specifically, because HM Coastguard's training was by default to take everything at face value and "not ... to make assumptions and potentially think about considering downgrading the response to a search and rescue incident unless we have that credible information".¹¹¹ The MCA's corporate witness agreed, stating that "all Coastguards are taught from day one that you take all information on face value", and that this training was instilled in all staff throughout their career.¹¹²
- 6.72** Mr Papadopoulos was unable to explain why HM Coastguard felt the need to deliver training on confirmation bias as he was not involved in that decision.¹¹³ Nevertheless, he was of the view that the training on confirmation bias would have been "highly beneficial", as there was a risk that frontline operators would reach certain conclusions or be biased in certain directions as a result of the belief that callers from small boats may exaggerate.¹¹⁴
- 6.73** The evidence of the SMC on 23 to 24 November 2021, Mr Neal Gibson, was that he had not received any training specific to assessing information being provided by callers on small boats, but his general search and rescue training provided him with the necessary skill set to be able to assess and verify information being provided.¹¹⁵
- 6.74** The evidence of Mr Dominic Golden, the Aviation Tactical Commander on 23 to 24 November 2021, was that he did not see any formal HM Coastguard

108 INQ000362.

109 INQ010740/59-60/ln82.

110 INQ010740/56/ln7-18.

111 INQ010740/58/ln11-25.

112 INQ010746/155/ln17-25.

113 INQ010740/57/ln5-11.

114 INQ010740/57-58/ln12-6.

115 INQ010715/86/ln4-19.

documentation providing information, advice or guidance, or any policy or procedure relating to the issue of potential exaggeration and how to respond.¹¹⁶

- 6.75** The evidence before the Inquiry was that operational HM Coastguard staff had received no specific training regarding the possibility of exaggeration by small boat callers.¹¹⁷
- 6.76** HM Coastguard's policy was that all small boat incidents should be treated as being in the distress phase when they entered the UK search and rescue region.¹¹⁸ In theory, this meant that information provided by small boat callers did not determine whether or not the boats would be categorised as in distress. This is consistent with the evidence of the MCA's corporate witness that the information provided by small boat callers was taken at face value.¹¹⁹
- 6.77** However, the evidence of HM Coastguard witnesses involved at an operational level in responding to small boat incidents indicated that their response was impacted by their awareness of potential exaggeration by small boat callers.¹²⁰ In particular, Mr Gibson's evidence was that the belief that callers from small boats did sometimes exaggerate their level of distress "was in people's minds, of can we...take what we're told at face value, you know, is...everyone on fire and sinking? No, probably not". He explained that he would be "mindful when you gather the information, analyse it, assess it, verify it, to get what you can".¹²¹
- 6.78** The widely held belief that callers from small boats routinely exaggerated their level of distress created the risk that callers from a small boat facing a real emergency may not be believed. In those circumstances, staff should have received 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.

Systems: small boat training and policies

- 6.79** HM Coastguard had a number of policies and guidance documents addressing the search and rescue response generally, which were also applicable to small boat search and rescue.
- 6.80** The overarching standard operating procedure was 'Incidents involving migrants', with the version in place in November 2021 being finalised on 6 October 2021.

¹¹⁶ INQ010718/102-103/ln24-6.

¹¹⁷ INQ010715/181/ln13-21.

¹¹⁸ INQ007381/4.

¹¹⁹ INQ010746/153-155/ln19-17.

¹²⁰ INQ010718/99-105/ln1-24, INQ010715/160/ln17-23, 181-182/ln24-12, INQ010719/57-59/ln9-17, INQ010720/102-105/ln17-10, 108/ln1-19.

¹²¹ INQ010715/85-86/ln6-3.

There was also an ARCC small boat response document dated 26 October 2021, which defined a search and rescue operational flight and provided relevant guidance.

- 6.81** With input from HM Coastguard, a subset of policies or guidance documents relating to small boats was developed specifically in connection with Operation SOMMEN. In particular, HM Coastguard policies were developed to enable the de-escalation of incidents from being ‘distress phase’ incidents, to enable termination of search and rescue and the deployment of Operation SOMMEN.¹²²
- 6.82** However, the 4 August 2021 review plainly identified a gap in relation to training and policies linked to small boat search and rescue, with the recommendation that standard operating procedures and protocols that were tested, trained, exercised and regularly reviewed should be implemented.
- 6.83** The evidence of HM Coastguard’s operational witnesses was that they had not received specific training linked to small boat incidents.¹²³
- 6.84** Moreover, there were specific issues relating to small boat crossings which increased risks within the search and rescue response, and which HM Coastguard was, or should have been aware of. But adequate policies, guidance and training were not developed, in particular:
- communicating with small boat callers and obtaining location, having regard to limitations of communications technology, lack of equipment to provide location information and language barriers
 - the treatment of information received from small boat callers, which was believed to be inaccurate or exaggerated
 - detailed guidance on the reconciliation of multiple reports relating to the same incident, in particular where there appeared to have been multiple calls from the same boats – also, the standard operating procedure entitled ‘Search suspension and termination’ did not contain sufficiently detailed guidance on the termination and suspension of search and rescue incidents¹²⁴
 - the prioritisation of small boat incidents, given HM Coastguard’s policy was that all small boats were to be treated as in distress¹²⁵
 - information sharing between HM Coastguard, the Home Office and other organisations with involvement in small boat incidents, including the use of the tracker, and responsibility for obtaining, recording and sharing information

122 See paragraphs 5.16–5.18 and 5.20–5.21.

123 INQ010715/18-19/ln20-3, INQ010720/95-96/ln17-3.

124 INQ000450.

125 INQ007381/4.

- the use of Mayday relays during small boat incidents, including when this would or would not be appropriate – the Mayday relay, a distress message transmitted over VHF radio to all mariners in the vicinity, was one of the methods which HM Coastguard could use to get the assistance of ordinary maritime vessels with search and rescue
- the circumstances in which it would be appropriate to declare a major incident in relation to small boat crossings
- searching for small boats
- preparing for the anticipated entry of small boats into the UK search and rescue region and deploying appropriate assets to small boat incidents.

Chapter 7:

Search and rescue: co-operation and assurance

Introduction

- 7.1** The focus in this chapter is on the co-operation between search and rescue stakeholders. It examines the level of co-ordination and co-operation between UK government departments and agencies, and between UK public authorities and commercial contractors. It also considers the arrangements for oversight of the MCA. The chapter then examines UK-France co-operation. Like Chapter 6, it primarily considers the position up to 23 November 2021.

Department for Transport and Home Office

- 7.2** As described in Chapter 4, the Secretary of State for Transport has responsibility for maritime security and search and rescue, including by “establishing, operating and maintaining an adequate and effective civil maritime and aeronautical search and rescue”.¹ Further, the DfT sponsors the MCA and HM Coastguard.² The Home Office is responsible for matters concerning irregular migration to the UK.³ Where irregular migration takes place via UK territorial waters, this engages the concept of maritime security.⁴
- 7.3** Small boat crossings were considered within government to be, first and foremost, a border security matter.⁵ Therefore, the Home Office led the policy response to small boats, with input and, where necessary, co-ordination from the DfT.⁶ However, both HM Coastguard and Border Force agreed that small boats were ‘distress’ level safety of life at sea incidents by virtue of their circumstances in the Channel.⁷

1 Maritime security is defined in the UK’s updated National Strategy for Maritime Security as “upholding laws, regulations, and norms to deliver a free, fair and open maritime domain” (INQ008171/14/par8). However, the DfT uses the term to refer to commercial maritime interests and port regulation (INQ010747/11-12/ln12-10).

2 INQ010747/4/ln13-18.

3 INQ010742/134-135/ln25-2.

4 INQ010137/3-7/par8.

5 INQ008117, INQ001049, INQ010337/20-21/par48, INQ010742/140/ln14-20.

6 INQ010337/20-21/par47-49, INQ010742/134/ln18-24.

7 INQ001016/1/par6, INQ000619/11, INQ001131.

- 7.4** Around July 2019, the engagement between the DfT and Home Office focused on establishing where responsibilities ought to lie as small boat crossings had become business as usual.⁸ However, from at least April 2020 onwards, the majority of interactions between the DfT and the Home Office regarding small boats concerned the development of Operation SOMMEN, which in broad terms was the policy of ‘turning around’ small boats at sea.⁹

Impact of Operation SOMMEN

- 7.5** The evidence to the Inquiry of one of the two Home Office corporate witnesses was that the development of Operation SOMMEN did not impact the Home Office’s relationship with the DfT or HM Coastguard.¹⁰ I know that the civil servants involved would have maintained a professional approach when dealing with one another.
- 7.6** However, the Inquiry received material in which the MCA repeatedly raised concerns about the development of the policy, which demonstrates that the Home Office corporate witness underplayed somewhat the impact of Operation SOMMEN. Communications between the MCA and the DfT and within the DfT in November 2020 indicated a lack of clarity on what was being proposed in respect of Operation SOMMEN.¹¹ For example, following a meeting between three Directors General (Home Office, DfT and the Foreign, Commonwealth and Development Office) on 17 November 2020, an internal DfT email stated that: “There were also several references [in the meeting] to close working between [Home Office] and DfT which felt odd given that the lack of this has been a specific issue”.¹² In a submission to the MCA Sponsorship Board, the MCA Chief Executive maintained that he was “deeply concerned about the situation and the continuing lack of clarity from Border Force”.¹³ A month later, in a meeting with a Transport Minister, he reported that the MCA was “challenging Border Force on how decisions on changes in tactics are being cleared and the quality and timeliness of information being passed to them”.¹⁴
- 7.7** The DfT also had doubts about the policy’s legality. This was most clearly expressed in an email from the DfT to the Home Office on 19 November 2020, where the DfT stated that it was “not clear what is being planned and for when, and whether it is legal, and most importantly for DfT, the risks around safety of life at sea and search and rescue activity”.¹⁵

8 For example, INQ001131, INQ008137.

9 See paragraphs 5.16–5.18 and 5.20–5.21.

10 INQ010742/222–223/ln13–7.

11 See INQ003996, INQ002636, INQ005009/4.

12 INQ001105.

13 INQ001016/1/par6.

14 INQ002671.

15 INQ002216.

- 7.8** A final concern with Operation SOMMEN was, as the Home Office corporate witness accepted in his evidence, that a very considerable amount of time and resource was occupied by planning for it.¹⁶ While the witness did not believe that this drew focus from planning to meet the increased demand for search and rescue in the Channel, it seems to me that there would have been challenges in being able to plan for both at the same time.¹⁷ This appears to be borne out by the documentation which the Inquiry received. Even taking into account duplication in the disclosed evidence, there was a large amount of material about the implementation of the Operation SOMMEN policy, and a much smaller amount which demonstrated planning for the demands placed on resources by the increase in small boat crossings during 2021.

The DfT's oversight of MCA

MCA Sponsorship Board

- 7.9** The Secretary of State for Transport is ultimately accountable for the MCA.¹⁸ In theory, the MCA's performance is to be overseen by the DfT through the MCA Sponsorship Board.¹⁹ The MCA Sponsorship Board meets quarterly and its purpose is to inform the agency owner (the relevant DfT Director General) of MCA performance and to provide the MCA Chief Executive with advice, support and assistance.²⁰ It is chaired by the agency owner.²¹ The DfT's internal review found that this was often not the case.²² Sponsorship Board meetings are attended by senior members of the DfT and MCA, including the agency sponsor (the DfT Director of Maritime), the MCA Chief Executive and the MCA non-executive Chair.²³
- 7.10** The Sponsorship Board reviews the MCA risk register and other documents during its meetings.²⁴ However, the evidence was that the minutes of the meetings "do not record all the discussion of each risk".²⁵ Instead, the greatest risks were attended to outside of these meetings and the Sponsorship Board meetings only had a high-level reviewing function.²⁶ There was no record of discussing 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

16 INQ010742/223/ln16-19.

17 INQ010742/224/ln6-7.

18 INQ000955/4/par11.

19 INQ000955/13/par46.

20 INQ010337/12/par29, INQ000955/par47-48, 91.

21 INQ000955/13/par46, INQ010337/12/par29.

22 INQ008152/30. See also paragraph 7.22.

23 INQ000955/13/par46, INQ010337/12/par29.

24 INQ010747/21/ln6-9, INQ010747/56/ln9-22.

25 INQ010747/58/ln14-19.

26 INQ010747/56/ln13-22.

Sponsorship Board, even though a document referencing the risk had been prepared for the meeting.²⁷ The evidence from the DfT's corporate witness was that it "would have been considered".²⁸

- 7.11** The omission from the meeting minutes is particularly striking, not only because of the Sponsorship Board's intended function, but also because the consequences of this risk were likely to be grave. However, in the circumstances, the omission is of less significance because the department accepts that it was aware of the risk of overwhelm long before its formal entry into the risk register through its informal methods of overseeing the MCA. Discussions had begun taking place by at least June 2021. By the time the risk was recorded on the MCA risk register, the department had "some understanding as to what the capability improvements could and should be".²⁹

Other assurance under the MCA Framework

- 7.12** In addition to the MCA Sponsorship Board, the MCA Framework required the MCA to report regularly its financial and non-financial performance to the agency sponsor and to inform them of any changes which may impact the achievement of the MCA's objectives.³⁰ In a similar way, the agency owner was required to ensure that there were arrangements in place to monitor the MCA's activities, address significant problems, periodically assess risks, and bring concerns about the MCA's activities to the MCA and DfT boards.³¹
- 7.13** There were also other 'liaison arrangements' involving different combinations of key senior individuals which took place at varying intervals.³² For example, the agency owner met monthly with the MCA Chief Executive to discuss objectives and tactics. The agency sponsor held regular one-to-one meetings with the MCA Chief Executive "to ensure a steady flow of information between MCA and DfT, and that there is alignment to support and enable a single maritime voice". The Inquiry heard that was as frequent as twice a week.³³ Also, the agency sponsor was to "chair regular 'Contact Group' meetings (every fortnight where possible) between the MCA Chief Executive, MCA Directors and Deputy Directors within the Maritime Directorate to discuss live, cross-cutting, and time critical issues".³⁴

27 INQ008055, INQ009214, INQ010747/59/ln2-15, INQ010726.

28 INQ010747/59/ln9-12, INQ010774/3/par9.

29 INQ010747/47/ln12-14.

30 INQ000955/20/par88.

31 INQ000955/6/par21.

32 INQ000955/20-21/par91.

33 INQ010747/57/ln1-3, INQ010747/57/ln12-13.

34 INQ000955/20-21/par91.

The MCA Board

- 7.14** The MCA Board also had a function in providing oversight of the MCA's activities to the DfT. The agency sponsor and relevant Deputy Director often attended MCA Board meetings or were sent the documents for them.³⁵ Small boat issues were discussed at these meetings.³⁶

Ad hoc oversight arrangements

- 7.15** There were a number of other, less formal, methods by which the DfT oversaw the MCA, mainly comprising meetings between varying individuals. The evidence was that on a day-to-day basis from 2018 onwards, the DfT and HM Coastguard worked closely with one another regarding small boats.³⁷ One example were weekly 'small boat huddles' between the DfT and MCA from early July 2021, preparing for the roll-out of Operation SOMMEN.³⁸
- 7.16** Many of these meetings do not appear to have been consistently or thoroughly minuted.³⁹ Taking the small boat huddles as an example, no formal minutes were kept, simply a list of actions. While the evidence the Inquiry received was that the meetings were intended to be held weekly, in many instances it is impossible to have an accurate idea of the frequency of such meetings, or the totality of what was said or discussed.⁴⁰ It is regrettable that more methodical and detailed records were not kept given the salience of the small boats issue and the risk to life presented.
- 7.17** The department also suggested that the line management of the MCA Chief Executive, who is a senior civil servant, provided a level of accountability.⁴¹ It is an open question whether routine line management could have added any material degree of assurance to the DfT.
- 7.18** I also note that, in general, the DfT relied on the MCA as subject matter experts in the field of operational search and rescue. On the one hand, I appreciate that this is often a necessary feature of the executive agency arrangement. On the other hand, this fact does raise questions over how well-equipped the DfT was to challenge or scrutinise the MCA and ultimately hold it to account.

35 INQ000955/11/par39, INQ009167.

36 For example, see INQ002641, INQ002669.

37 INQ010747/34-36/ln10-12, INQ010774/4/par12.

38 INQ010337/57/par160.

39 INQ010747/82/ln15-20.

40 INQ002848.

41 INQ010747/83/ln1-14.

DfT internal departmental review

- 7.19** DfT conducted an internal departmental review of the MCA over a three-year period from 2018.⁴² The interim findings of the report were made known to the MCA in October 2021. The report was never finalised or published, although the copy of the document provided to the Inquiry was dated November 2021.⁴³
- 7.20** The internal departmental review was intended to be a “light touch assessment to examine specific live issues and particular areas of MCA’s work” in relation to “accountability and governance, and the relationship with the department only”.⁴⁴ The review was at pains to emphasise that “it did not go as far as examining efficacy and efficiency” of the MCA.⁴⁵ One of the reasons for this was because the MCA was to undergo a full review in 2022 as part of a “Cabinet Office...2022 Arm’s Length Body (ALB) Review Programme...which will consider governance, accountability, effectiveness, and efficiency”. The Cabinet Office review scheduled for 2022 did not in fact take place. However, in 2022 the Transport Secretary did seek to commission a further review of the MCA.⁴⁶
- 7.21** The 2021 internal review made a number of recommendations relevant to the Inquiry’s work and supportive of its recommendations. These were:
- that the DfT/MCA framework document should be updated, specifically to avoid duplication of work between MCA and the DfT with regard to maritime policy, “including in technical areas” such as “[search and rescue] protocols”⁴⁷
 - that the DfT sponsor and MCA should undertake a “Relationship Health Check” as soon as possible and every subsequent two years, to improve accountability and assurance and forge the relationship between the department and MCA⁴⁸
 - that the MCA ensure that there is alignment between its key performance indicators and the objectives in the annual business plan⁴⁹
 - that the MCA should continue to build on its collaborative relationship with the RNLI.⁵⁰

42 INQ010337/61/par175, INQ008151/2.

43 INQ008152.

44 INQ008152/4.

45 INQ008152/4, 16, 57.

46 See paragraph 7.25.

47 INQ008152/9.

48 INQ008152/9.

49 INQ008152/9. I note that this was reportedly also an area which was of interest the IMO auditors during the III Code audit: see INQ010760.

50 INQ008152/11.

- 7.22** The internal review found that Sponsorship Board meetings were often not chaired by the agency owner, and that DfT officials were not given sight of submissions to ministers.⁵¹ It also found that the MCA Framework did not accurately reflect policy roles and responsibilities.⁵² Furthermore, it concluded that there was a disconnect between the MCA's key performance indicators for 2021 to 2022, as a considerable number of them related to business-as-usual activities or hygiene factors which limited "the ability to provide a robust view for MCA outcomes and progress against Ministerial priorities".⁵³ The review also considered there to be a need for greater sponsor (DfT) input in the agreement of objectives and greater collaboration with MCA in agreeing submissions to ministers.⁵⁴
- 7.23** In considering the recommendations of the review, the MCA Board expressed its "surprise" and "disappointment" at the lack of consultation as part of the review, which is perhaps in itself a further example of difficulties in the working relationship.⁵⁵ The MCA Board supported the recommendation for an updated framework document, noting that the update to the MCA Framework was underway, and that ministerial submissions were subject to DfT comment and clearance before reaching a 'Red Box'.⁵⁶ It also welcomed the recommendation for a Relationship Health Check, but emphasised that the MCA Chief Executive and the agency sponsor should have regular discussions about priorities and that "in practice, this is about personal relationships rather than anything too formal".⁵⁷ The MCA Board's response to the recommendation that key performance indicators should be better aligned with business plan objectives was that they could "simply differentiate in the annual business plan between [key performance indicators] that are externally-facing or are relevant to the internal running of the Agency".⁵⁸ Finally, with regard to the RNLI, it was asserted that the MCA "had built excellent and strengthened relationships with the RNLI...strategically, at the operational level in terms of emergency responses and with our combined and coordinated safety campaigns and communications".⁵⁹

51 INQ008152/30.

52 INQ008152/30.

53 INQ008152/9.

54 INQ008152/35.

55 INQ000961/4.

56 INQ008153/2.

57 INQ008153/2.

58 INQ008153/2.

59 INQ008153/2.

- 7.24** The department’s evidence at the Inquiry hearings was that the internal review had assured it that the MCA was performing “efficiently and effectively”.⁶⁰ To put it no higher, I found this evidence unconvincing given the clear and repeated disclaimers, throughout the document, that it did not examine these matters.⁶¹ However, the limitations of the internal review go further than this. In an email dated 24 November 2021, the MCA Chief Executive said that, given the period over which the review had been drafted, “it is almost impossible reading it to understand what is current and what is history” and that he was “concerned that the report might require significant change in order for it not to be potentially misleading to readers”. This was an assessment that the DfT agreed with, and so instead the DfT requested “that where the recommendations are still meaningful, we should progress those to feed into a full review as part of the [Cabinet Office Arm’s Length Bodies] review...”.⁶² These comments are unlikely to reflect a document from which significant assurance can be drawn.
- 7.25** As mentioned previously, the Cabinet Office review did not take place in 2022. However, on 1 April 2022 the Transport Secretary commissioned a review of MCA processes to “ensure they are fit for purpose”.⁶³ In response to the email formally commissioning that review, the MCA suggested that “the MCA has conducted the full review requested albeit for the slightly different driver of [International Maritime Organization] III Code and PSC [Port State Control] obligations”.⁶⁴ In support of that proposition, the MCA referred to “a four-year programme of root-and-branch review of all operating procedures culminating in the IMO mandatory audit of the maritime administration of the UK in October 2021”.⁶⁵ The MCA relied heavily on their preparation for the IMO III Code audit having identified and corrected any gaps.⁶⁶ Ultimately, it was suggested that the III Code audit was a strong indicator that the MCA’s processes were fit for purpose.⁶⁷
- 7.26** It is puzzling that the MCA apparently sought to resist a further review which had been commissioned directly by the Secretary of State for Transport, particularly when it was aware of the shortcomings of DfT’s 2021 internal review. It must have been aware of the very specific nature of the IMO III Code audit.⁶⁸

60 INQ010747/66-68/ln18-12.

61 INQ008152/4, 16, 57 cf, INQ010337/61/par174, INQ010747/68/ln4-12.

62 INQ008151/2.

63 INQ010766.

64 INQ010766.

65 INQ010766.

66 See paragraph 7.27.

67 INQ010766.

68 See paragraph 7.28.

International Maritime Organization III Code audit

7.27 The Department's evidence was that further assurance was derived from the IMO's III Code audit of the MCA.⁶⁹ A III Code audit is carried out pursuant to the IMO's mandatory audit scheme.⁷⁰ The last III Code audit took place over 11 days between 14 and 28 October 2021.⁷¹ The DfT itself had a limited role in the IMO audit process.⁷² The III Code audit was in fact a review of the UK as an IMO State, not of the MCA specifically.⁷³ The audit comprised various sessions, each approximately an hour in length, on a range of matters primarily related to the UK's coastal and flag State responsibilities.

7.28 The purpose of the audit was threefold:

- firstly, to determine the extent of the UK's compliance with its obligations under mandatory IMO instruments
- secondly, "to determine the effectiveness of the implementation of these objectives"
- finally, "to seek and verify the administrative and technical oversight methodology" applied by the UK in respect of mandatory IMO instruments to crown dependencies, including the extent of regulatory alignment between the UK and its crown dependencies.

It can be seen from this that the III Code audit assesses matters through a specific lens, namely compliance with IMO instruments. It is unlikely to be in a position to comment in detail on HM Coastguard systems, compliance and culture according to standards set by the MCA's sponsor department or the UK government more generally.

7.29 Ultimately, the report made no adverse search and rescue findings, except as to Gibraltar and the Cayman Islands.⁷⁴ The DfT may have been assured to a degree by the fact that this audit was in process, but it was only finalised and made available to the MCA in draft on 21 February 2022. This was after the events of 23 to 24 November 2021. Therefore, the DfT cannot have been assured by its contents before the incident.⁷⁵

69 INQ010337/62/par177-180.

70 INQ010774/5/par17.

71 INQ010337/62/par178.

72 INQ010774/5-6/par18-19.

73 INQ008173/3/par1.8.

74 INQ008152.

75 INQ010337/62/par178.

UK Government Internal Audit Agency

7.30 Finally, the MCA may be periodically audited by the UK Government Internal Audit Agency (GIAA).⁷⁶ The GIAA is an executive agency within government which provides objective insight to central government departments and their arm's length bodies, including both the DfT and MCA.⁷⁷ In their evidence at the hearings, the DfT was unable to state the last time the GIAA audited the MCA.⁷⁸ Subsequently, the DfT told the Inquiry that they had not commissioned the GIAA to conduct an audit of the MCA: all executive agencies must commission and fund their own audits.⁷⁹ The DfT stated that the MCA had commissioned a governance audit in December 2023, and intended to commission a further audit in 2025 regarding its UK Second Generation Search and Rescue Aviation Programme.⁸⁰ The obvious inference is that no GIAA audit of the MCA was commissioned before 2023.

Border Force and HM Coastguard/MCA

Absence of an overarching memorandum of understanding

- 7.31** Border Force was regarded as an additional facility to HM Coastguard.⁸¹ This characterisation hardly reflected the reality of what was taking place operationally, given that Border Force was conducting around 90% of small boat rescue operations.⁸² Moreover, by virtue of the Operation DEVERAN Operational Order, a minimum resource commitment had effectively been made in respect of Channel operations (one cutter and two coastal patrol vessels).⁸³ In fact, in response to an enquiry made by the Independent Chief Inspector of Borders and Immigration in 2019 as to whether there was an MoU between HM Coastguard and Border Force, the then Director of HM Coastguard referred to Border Force as a declared asset.⁸⁴ This was reflected in the Chief Inspector's report.⁸⁵
- 7.32** Despite Border Force and HM Coastguard having worked together in relation to small boats since 2018, there has been no MoU between the two setting out how they would work together.⁸⁶ By contrast, there had been an agreement in place with the RNLI since 2010 and a formal MoU since 2020.⁸⁷ One was also in place

76 INQ010774/4/par14.

77 INQ010774/4/par14.

78 INQ010747/79/ln21-24.

79 INQ010774/4/par14.

80 INQ010774/4/par14.

81 INQ010098/80/par5.16.

82 INQ010137/37/par94. See paragraph 4.17 on 'additional facility'.

83 INQ000619/14.

84 INQ003817, INQ002344/par1.

85 INQ004467/37/par6.50.

86 INQ010746/122-123/ln16-9, INQ010746/123-124/ln24-2.

87 INQ000655, INQ000096.

in respect of Operation ISOTROPE whereby the military assumed command and control in respect of small boat operations between April 2022 and January 2023.⁸⁸ In the frequency with which Border Force was tasked by HM Coastguard (although in Border Force's case, the taskings were specifically to small boat incidents), the MCA could offer no explanation for the absence of an MoU.⁸⁹

7.33 In evidence the MCA stated, through their corporate witness, that the absence of an MoU had “no impact in the working relationship or how Border Force made their assets available as additional facilities to HM Coastguard”.⁹⁰ It was further said that the introduction of an MoU “wouldn't add anything, in terms of [HM Coastguard's] response”, that an MoU “won't change the operational working relationship or the response that happens on a daily basis”, and that an MoU “wouldn't change the events that happened on 24 November”.⁹¹

7.34 I am not persuaded that an MoU in this area would be without benefit. In evidence before the Inquiry there are examples of where those involved in the small boats response were unclear of their responsibilities, or where an agreed protocol may have aided the search and rescue response.⁹² Although expressed in the context of turnaround tactics, a senior member of HM Coastguard articulated the “need for absolute clarity on the tasking military/govt vessels to a [search and rescue] incident coordinated by HMCG [HM Coastguard]...in writing, MoU etc”.⁹³ Even if Border Force vessels were a declared asset to HM Coastguard, that would only go so far in defining the roles and responsibilities of each organisation and articulating the objectives of such taskings. The potential for uncertainty about these matters, and the possible consequences which could flow from them, coupled with the frequency of small boat crossings, all support the case for an MoU.

Joint exercises

7.35 Despite working so closely together, no joint training exercises took place involving Border Force, HM Coastguard and RNLI before November 2021.⁹⁴ On 4 November 2021, the JMSC did conduct a table-top simulation exercise regarding multiple migrant capsized incidents.⁹⁵ However, by this date the small boat issue had been ongoing for some time. The nature and frequency of small boat incidents means that joint practical training exercises between these stakeholders would, in all likelihood, have been of benefit. Finally, there

88 INQ009649/15/par7.1.

89 INQ010746/123/ln11.

90 INQ010746/123/ln11-17.

91 INQ010746/124/ln6-17, 125/ln13-15, 124/ln14-16.

92 See paragraphs 7.51, 9.32, 11.23, 12.10, 12.31 and 12.32.

93 INQ002373.

94 INQ010746/130/ln10-24.

95 INQ005259.

were practical training exercises with regard to the tactics deployed as part of Operation SOMMEN.

Red day planning meetings

- 7.36** Days on which crossings were highly likely to take place were known as ‘red days’. The likelihood of small boat crossings was assessed in light of the weather forecast for the Dover Strait.⁹⁶ The Met Office had been commissioned to provide this information by the CCTC and forecasts were spread to stakeholders, including Border Force and HM Coastguard, at around midday on Monday to Friday.
- 7.37** There was a five-tier colour coded ranking of how likely crossings were. Dark green meant crossings were highly unlikely, light green meant crossings were unlikely, yellow meant crossings were a realistic possibility, amber meant crossings were likely or probable, and red meant that crossings were highly likely.
- 7.38** According to the Operation DEVERAN Operational Order, specific planning was to be undertaken in relation to red days, which became known as red day meetings.⁹⁷ The Operation DEVERAN Operational Order was a document which set out the particulars of Border Force’s small boat response.⁹⁸ The meetings would discuss forecast weather conditions according to the Operation DEVERAN weather assessment, staffing, risks to an effective response, and the operational response. Before 16 November 2020, the meetings were internal HM Coastguard meetings. Thereafter, they were attended by individuals from the MCA, HM Coastguard, Border Force and the RNLI.

Sharing of the HM Coastguard tracker

- 7.39** HM Coastguard and Border Force MCC would exchange copies of small boat trackers.⁹⁹ Until shortly before the incident, the HM Coastguard tracker would be emailed to Border Force, and Border Force used this document to update its own tracker.¹⁰⁰ However, by the time of the incident, the HM Coastguard tracker was accessible online to both HM Coastguard and Border Force.¹⁰¹ However, it was unclear whether, as at 24 November 2021, Border Force could edit the tracker or simply view it.¹⁰²

⁹⁶ INQ000619/7.

⁹⁷ INQ000619/14, an example of which INQ000204. These were formally called small boat response planning meetings (INQ010098/27-28/par2.10). At one point they were also described as operational response conference calls (for example, INQ000182).

⁹⁸ INQ000619/14.

⁹⁹ INQ010135/9/par21.

¹⁰⁰ INQ010135/8-9/par20.

¹⁰¹ INQ010142/10/par24.

¹⁰² See paragraphs 7.43-7.44.

- 7.40** Shared access was a development which occurred following recommendations made in two migrant incident activity reviews produced by HM Coastguard in August 2021. As noted in Chapter 6, one of the reviews observed that “the Border Force Liaison Officer was struggling to maintain situational awareness ... being unable to maintain his tracker on the white board in the Joint Control Room or adequate notes of the information received from the Border Force assets”. This led to Border Force references being misassigned to unresolved incidents, and insufficient information being passed to correlate duplicate incidents. It was said that these problems were “due to Border Force and HM Coastguard not having access to a combined/shared migrant incident tracker, requiring information to be passed by email or verbally, causing delays, duplication of effort and risking errors during information transfer”.
- 7.41** In mid-August, the Divisional Commander for MRCC Dover also identified defects in tracker use. He explained that the existence of multiple trackers meant that there was “no single version of the truth”.¹⁰³
- 7.42** Border Force ultimately obtained access to HM Coastguard’s tracker on 15 November 2021.¹⁰⁴ Border Force confirmed to HM Coastguard that it had access in an email on 22 November 2021.¹⁰⁵ It is around this date that most Inquiry witnesses recalled access being granted.¹⁰⁶
- 7.43** A specific issue was whether Border Force was able to edit HM Coastguard’s shared tracker as at 23 November 2021. The written evidence of Ms Karen Whitehouse (of Border Force MCC) to the Inquiry was that at the date of the incident, Border Force personnel had ‘read-only’ access to the tracker.¹⁰⁷ In her oral evidence, Ms Whitehouse accepted that a document showing changes made to the HM Coastguard tracker on the night in question indicated that Border Force had both ‘read’ and ‘write’ access to the tracker, so that amendments could be made by Border Force by 23 November 2021.¹⁰⁸ Her colleague, Mr Thomas Willows, suggested that in fact they did not.¹⁰⁹
- 7.44** In evidence at the hearings, Mr George Papadopoulos, the Small Boat Tactical Commander, accepted that he could not confirm whether, by 23 November 2021, Border Force could amend and update the tracker, or whether it only had read-only access. Finally, the ‘index of versions’ document reflects that at certain times on 24 November 2021, changes were made by Home Office personnel, which tends to suggest Border Force was able to make changes

103 INQ003322.

104 INQ010051.

105 INQ010650.

106 INQ010740/60-61/ln23-18, INQ010718/36/ln17.

107 INQ010698/2/par3.

108 INQ010718/37-38/ln12-18, INQ007058/2.

109 INQ010720/37-40/ln13-24.

to the document. To my mind, there is no need to make any finding on the matter. As Mr Papadopoulos explained, even read-only access would still have benefited Border Force, by providing them with access to information within the HM Coastguard tracker, which would be immediately available and would not need to be communicated by email.¹¹⁰ In other words, compared to previous arrangements, this would have been a benefit.

Border Force tracker

- 7.45** Border Force operated its own tracker document, known as the ‘Op DEVERAN Live Update’. This document is also referred to as a ‘spreadsheet log’.¹¹¹ However, the actual file name for the document is the ‘BF MCC Operation DEVERAN Live Update.xlsx’.¹¹² For convenience this is referred to as the ‘Border Force tracker’.¹¹³ The Border Force tracker was circulated by email, together with a summary of the number of incidents in the body of the email, to named recipients within the BFMC, the CCTC, Border Force Liaison Officers working in the Joint Control Room, HM Coastguard and the relevant Commanders.¹¹⁴ Before the existence of the Border Force tracker, incident information had been recorded on a whiteboard.¹¹⁵ This system changed due to the increase in the number of incidents and the need to report the activity to multiple parties.¹¹⁶
- 7.46** The Border Force tracker was mainly populated using relevant information from the HM Coastguard tracker.¹¹⁷ HM Coastguard would task Border Force MCC by telephone, and once HM Coastguard had updated the HM Coastguard tracker to record a Border Force asset next to a particular event, Border Force would then use that information to update its tracker.¹¹⁸ Border Force would also make a note in the Border Force tracker of any other relevant information which had been provided by HM Coastguard during the tasking phone call.
- 7.47** The Border Force tracker indicated whether incidents were closed or open, the HM Coastguard reference, the Border Force reference (see paragraph 7.48) if one had been given, when Border Force had been notified of the small boat, whether it was in UK territorial waters, positional information, a brief description of the small boat, its estimated time of arrival to the median line, and which Border Force asset had been allocated to rescue it. Comments under ‘brief description’ could include whether the boat was believed to be in French or UK waters, whether the event was believed to be a duplicate and of which other event,

110 INQ010740/60-61/ln23-18.

111 INQ010137/46/par116, INQ010135/6-7/par16.

112 INQ000471, INQ000472.

113 An example of this document can be seen at Figure 15.

114 INQ010137/42/par112-113, INQ010135/8-9/par20, INQ001202, INQ001206.

115 INQ010135/10/par24.

116 INQ010135/10/par24.

117 INQ010135/8-9/par20. See also paragraph 12.32.

118 INQ010135/10-11/par24.

whether the event had been closed, and details of any boat and passengers identified with the event.¹¹⁹ Red font was used to highlight new information which had been added to the Border Force tracker with each circulation.¹²⁰ The Border Force tracker had a red, amber and green rating, which was red when a Border Force asset was tasked to an event, amber when people on board small boats had been boarded onto the vessel, and green when those boarded onto the vessel had disembarked safely at shore.¹²¹

- 7.48** At the point when a Border Force vessel had embarked people on board small boats, Border Force MCC would issue an 'M' number (such as M934), and the vessel Commander would spray it onto the small boat.¹²² This would be noted on the Border Force tracker so that if there was a later call relating to an abandoned small boat, it could be ascertained whether the people on the boat had already been rescued.¹²³ The 'M' number was also used for other non-search and rescue-related purposes, such as attributing individuals to a particular small boat, and for COVID-19-related tracing.¹²⁴
- 7.49** It appears that there was limited awareness of the Border Force tracker within HM Coastguard. The Divisional Commander for MRCC Dover did not recall there being any policies or procedures in place within HM Coastguard regarding the Border Force tracker.¹²⁵ The Small Boat Tactical Commander was not aware of the Border Force or any other tracker, except for the HM Coastguard and French trackers.¹²⁶ The SMC at the JRCC on the night shift of the 23 to 24 November 2021 did not believe he ever received or had sight of the Operation DEVERAN live update.¹²⁷ Mr James Crane, the SMC at MRCC Dover during the day shift of 24 November 2021, also appears to have been unaware.¹²⁸ The MCA states that there is only one UK tracker, owned by HM Coastguard and updated by both HM Coastguard and Border Force (the HM Coastguard tracker), suggesting a lack of awareness of the separate Border Force tracker.¹²⁹

Withdrawing assets

- 7.50** On a number of occasions, HM Coastguard faced the prospect of Border Force withdrawing its resources from supporting search and rescue operations. This occurred in 2019, due to a perception that search and rescue was detracting

119 For example, see INQ000525 and INQ000526.

120 INQ010137/46-47/par116.

121 INQ010135/10-11/par24.

122 INQ010135/10-11/par24.

123 INQ010135/10-11/par24.

124 INQ010135/10-11/par24.

125 INQ010097/6/21par21.

126 INQ009632/26/par67.

127 INQ010140/16/par42.

128 INQ010142/10/par24.

129 INQ010098/61/par3.66.

from other law enforcement priorities.¹³⁰ It happened again in 2020, due to a perception that Border Force had become a “taxi service”.¹³¹ In response to this, it was also suggested internally within HM Coastguard that consideration be given to bringing Border Force “into wider [HM Coastguard] ownership thus developing a process similar to other [coastguards] globally”.¹³² It was noted that this was “not unrealistic with future planning”.¹³³

- 7.51** The possibility of Border Force withdrawing its assets also happened shortly after the incident, in December 2021, although the evidence suggests that discussions about this took place in the CCTC at least by the end of October.¹³⁴ On this occasion, it was also noted that both Border Force and the RNLI were being regularly overwhelmed.¹³⁵ One of the Home Office corporate witnesses explained that he understood this to be a reference to how search and rescue was interfering with Border Force’s law enforcement role.¹³⁶ The fact that HM Coastguard did not have a significant degree of control over the primary assets responsible for effecting this type of search and rescue left HM Coastguard in a vulnerable position, without any proper contingency plan in place. These discussions were ultimately overtaken by the introduction of Operation ISOTROPE, which gave the military primacy over the response to small boats in the Channel.¹³⁷

HM Coastguard and private aerial asset providers

- 7.52** The challenges presented by small boats meant that it was more difficult for HM Coastguard to obtain a recognised maritime picture on a given night.¹³⁸ The importance of a recognised maritime picture is clear from both the oral and documentary evidence the Inquiry received. It was crucial that MRCC Dover had this information, so that they could respond adequately to search and rescue incidents and deploy resources appropriately.¹³⁹ Despite its importance, the absence of a maritime picture was not something which would be reported to the Duty Strategic Commander, so that support could be provided to the Maritime Tactical Commander or SMC.¹⁴⁰

130 INQ008159, INQ008158.

131 INQ002387/1.

132 INQ002536/1.

133 INQ002536/1.

134 INQ005272, INQ010337/38/par108.

135 INQ005272/par1.

136 INQ010134/31/par87.

137 See paragraph 16.13.

138 INQ010098/52-54/par3.29-3.36.

139 INQ010715/180/ln9-17, INQ000148/3, INQ010740/52/ln14-23, INQ010740/92/ln15-16, INQ010742/154/ln17-25.

140 INQ010719/174/ln9-12.

- 7.53** HM Coastguard used a range of information to establish a recognised maritime picture.¹⁴¹ Usually, information was initially obtained “via Op EOS flights and access to the French Migrant Tracker”.¹⁴² Information and intelligence could also be obtained from the Home Office and the French authorities. However, the difficulties in reconciling the information received from small boats directly meant that air search and rescue assets took on a heightened significance.¹⁴³ Air assets, and specifically 2Excel assets, were described by the Aviation Tactical Commander on the nightshift of 23 to 24 November 2021 as the “de facto solution” where there were difficulties in obtaining a maritime picture.¹⁴⁴ This is because the sensors on 2Excel’s aircraft provided imagery to help build the maritime picture.¹⁴⁵ The importance of aerial assets was recognised as far back as June 2020, with the advent of Operation EOS and certainly by December 2020.¹⁴⁶ Deficiencies in the maritime picture were for HM Coastguard to resolve. Only if there was an impact on border security would the Home Office have given it attention.¹⁴⁷
- 7.54** On 30 September 2021, the Chief Coastguard issued a temporary operating instruction to the ARCC.¹⁴⁸ This instruction stated that on red days a fixed-wing aircraft would be provided on scene to support MRCC Dover, and that on amber days an aircraft would be held in readiness at Lydd or Southend.¹⁴⁹ The instruction noted that the primary function of the fixed-wing assets was to inform and support maritime operations to build a recognised maritime picture, which ideally should match the migrant tracker.¹⁵⁰ The instruction added that “[i]nevitably, by the end of a busy day, there will be a number of vessels that have been recorded on this Migrant Tracker but have been unaccounted for”. An end-of-day search would be requested following the conclusion of the red/amber day tasking, or earlier if activity had reduced sufficiently, or all vessels had been accounted for.¹⁵¹
- 7.55** Finally, due to the increase in crossings, 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

141 INQ010098/52-55/par3.29-3.40.

142 INQ007279/1.

143 INQ010740/52-53/ln24-3.

144 INQ007824/3.

145 INQ010716/17/ln2-10.

146 INQ002547, INQ008338/13, INQ010742/179-181/ln 21-1.

147 INQ010742/53/ln10-18.

148 INQ006195.

149 Notwithstanding this instruction, 2Excel’s larger King Air aircraft had issues operating out of Lydd. Therefore, when tasked pursuant to the instruction, Southend was their airport of choice (INQ009628/13/par32). INQ006195.

150 INQ006195.

151 INQ006195.

number of small boats located and rescued.¹⁵² The effect of this was that helicopter flying time was being used up in these reconciliation missions, which could have an impact later in the day if a subsequent, more traditional search and rescue request was received.¹⁵³

HM Coastguard, other Channel stakeholders and Mayday relays

- 7.56** As well as governmental search and rescue partners, HM Coastguard could, in principle, engage other mariners in the Dover Strait to assist with search and rescue operations. As noted in Chapter 6, one of the methods which HM Coastguard could use to get the assistance of ordinary maritime vessels with search and rescue was a Mayday relay. Mayday relays are a distress message which are transmitted over VHF radio to all mariners in the vicinity. VHF Channel 16 is the designated channel for such transmissions. The content of a Mayday relay is preceded by a tone, known as a digital selective calling alert. The tone differs depending on whether the message relates to a 'distress', 'urgency' or 'safety' situation. The 'distress' tone is to be used for a Mayday relay.
- 7.57** There are two significant issues with the operation of this system in the Dover Strait. The first is that much of the maritime traffic in the Dover Strait consists of very large container ships or tankers. Those on board are unlikely to be able to see small boats or people in the water because they are at considerable height above the sea, it is dark, or the sea conditions are likely to obscure small objects in the water. These large vessels are also unlikely to be able to easily stop or divert their course without causing significant hazards to the many other similar vessels in the Dover Strait. It may be difficult for these vessels to approach a small boat without overwhelming or swamping it due to their different profiles. Therefore, the assistance they are able to provide may be limited to standing off and awaiting the arrival of a search and rescue asset and/or providing lifesaving apparatus.¹⁵⁴
- 7.58** The second issue with the Mayday system is its system of enforcement. As set out in Chapter 2, masters of vessels have a legal obligation pursuant to Regulation 33(1) of Chapter V to the Annex to the 1974 SOLAS to proceed with all speed to render assistance to people in distress at sea, unless they are unable to do so or it would be unreasonable or unnecessary in the circumstances to proceed. Enforcement action, including criminal prosecution, for failing to comply with this obligation can be taken by the MCA's regulatory compliance investigations team. While HM Coastguard does not have the power to take enforcement action itself, it has an important role in referring potential breaches of the regulatory regime to the regulatory compliance investigations

152 INQ009628/21/par53.

153 INQ009628/21/par53.

154 INQ003050.

team for investigation and, if appropriate, action. Despite the existence of this enforcement mechanism, the Inquiry has received evidence from the head of the regulatory compliance investigations team that enforcement action for a breach of Regulation 33 is extremely rare due to the evidential and practical challenges associated with proving the elements of the breach.¹⁵⁵ In circumstances where it is unlikely that enforcement action is taken, there may be little incentive for vessels to comply with their obligations on receiving a distress signal in the Channel. The implications of this for future recommendations are addressed in Chapter 17.

HM Coastguard and RNLI

- 7.59** The RNLI is a declared facility to HM Coastguard. Their relationship to one another is set out in an agreement between the two organisations from 2010, and since 2020, in a formal MoU.¹⁵⁶ Neither document was specific to search and rescue in respect of small boats. The 2010 document aimed “to harmonise [search and rescue] theory, procedures and operational requirements”, and set out a number of technical and operational matters as to how missions would be conducted. The 2020 MoU was a higher-level document, which set out the broader roles, responsibilities and commitments between the two parties.
- 7.60** The resource pressures on RNLI and HM Coastguard’s awareness of this have been addressed in Chapter 6. By 23 November 2021, the awareness that RNLI was under considerable pressure meant that, on days when there was a busy period of crossings in the next shift, HM Coastguard was reluctant to task additional assets.

Border Force and RNLI

- 7.61** The pressures on RNLI resourcing discussed in Chapter 6 also affected its relationship with Border Force. Among other things, the delays associated with handing over people to Border Force (delaying redeployment of vessels and protracting the length of service) placed strain on working relationships.¹⁵⁷
- 7.62** Tensions came to a head in November 2021, when, in the early hours of 20 November 2021, Ramsgate RNLI Station refused a tasking from HM Coastguard to a small boat incident, stating that “UK Border Force [was] not doing their job”, and that they did not believe the tasking was to be made to a vessel in distress.¹⁵⁸ Evidently, Border Force capacity limitations and the HM Coastguard policy that all small boats should be treated as being in distress

¹⁵⁵ INQ010788.

¹⁵⁶ INQ000655, INQ000096.

¹⁵⁷ INQ010101/4-9/par13-24.

¹⁵⁸ INQ010098/43-45/par2.63-2.69, INQ004359, INQ000712, INQ000205.

resulted in a higher level of taskings for RNLI vessels. However, a further meeting was held that evening in which the RNLI clarified that it would respond to distress situations.¹⁵⁹

UK-France co-operation: the context to co-operation between HM Coastguard and French CROSS Gris-Nez

- 7.63** The relationship between HM Coastguard and the French Coastguard in respect of search and rescue in the Dover Strait was primarily governed by the Mancheplan.¹⁶⁰ The version in force at the time of the incident was dated 30 May 2018.
- 7.64** The purpose of the Mancheplan is to “establish the policy and procedures for incident response management and co-operation in the event of an accident in the geographical sea area covered by the Plan”.¹⁶¹ An event to which the Mancheplan applies is known as an “event at sea for which co-ordination is necessary”.¹⁶² This includes maritime search and rescue specifically and “where one of the States is not in a position to cope alone with a complex event at sea and requires the support of the other State”.¹⁶³ The Agreement makes provision for geographical jurisdiction (Articles 5 to 7 and Annexes 1 and 2), information sharing and joint exercises (Articles 12 to 16 and 21), responsibility for co-ordinating a search and rescue (Articles 17 to 20), and asset sharing (Article 22). The parties to the Mancheplan are required to have regular meetings and share feedback regarding significant incidents.¹⁶⁴ The agreement provides for a Mancheplan point of contact in each operational centre.¹⁶⁵
- 7.65** The search and rescue requirements of the Mancheplan can be summarised as follows. Responsibility for co-ordinating search and rescue depends on the location of the incident and specifically which side of the ‘Mancheline’ the incident takes place.¹⁶⁶ However, this can be transferred by agreement, depending on two factors: which state will probably be deploying the majority of assets to the incident, and the most appropriate point of disembarkation.¹⁶⁷ Such arrangements are made by telephone call between operational centres and are subsequently confirmed in writing.¹⁶⁸

159 INQ000220, INQ010098/43-45/par6.23-6.24.

160 INQ000002, INQ000095, INQ000095/Articles 5-7, 31 and Annexes 1 and 2.

161 INQ000095/19/Article 3.1.

162 INQ000095/17/Article 2.1.

163 INQ000095/29/Articles 11.1-11.2.

164 INQ000095/41/Article 29, 33/Article 15.

165 INQ000095/33/Article 14.2.

166 INQ000095/21/Article 6, 35/Article 19.

167 INQ000095/33/Article 20, 45/Article 32.

168 INQ000095/45/Article 33.

- 7.66** The co-ordinating State may call on the other to provide assets to assist an operation they are co-ordinating.¹⁶⁹ Such requests are through operational centres and may be made by email, fax or telephone and subsequently confirmed in writing.¹⁷⁰ If assets are provided, they will operate according to the co-ordinating operational centre.¹⁷¹
- 7.67** Pursuant to Article 2.2 of the Mancheplan, from 2016 meetings took place to discuss search and rescue in the Channel twice a year in what was known as the ‘Anglo-French Accident Technical Group’.¹⁷² These meetings were chaired jointly by France and the UK.¹⁷³ Generally, they were attended by the MCA and the French Maritime Prefecture.¹⁷⁴ Before the meeting, an official exchange of information took place regarding any significant changes with an impact on the Mancheplan.¹⁷⁵ Senior leadership of MRCC Dover also met with CROSS Gris-Nez monthly from around November 2020 to discuss operational matters.¹⁷⁶
- 7.68** In terms of broader diplomatic co-operation, on 18 January 2018 the UK and France signed the Sandhurst Treaty concerning the reinforcement of co-operation for the co-ordinated management of the shared border.¹⁷⁷ As noted earlier, as part of this agreement the UK committed £45 million to create the Centre Conjoint d’Information et Coordination at the port of Coquelles.¹⁷⁸ The use of the Centre Conjoint d’Information et Coordination in both French and UK operations is addressed in paragraph 5.3.
- 7.69** On 24 January 2019, the Home Secretary and the French Minister for the Interior signed a joint action plan. This involved the allocation of funds under the Sandhurst Treaty and pledging further funding for further technology and French patrols. They met again in relation to the joint action plan on 29 August 2019. This involved further resources and funding under the Sandhurst Treaty to prevent departures of small boats from France, and closer working between both sides. The objective of the action plan was to halve the number of successful crossings (recorded in summer months) by the end of October 2019 and to further reduce it by the end of December 2019 such that crossings would be an “infrequent phenomenon” by spring 2020.

169 INQ000095/49/Article 35.

170 INQ000095/49/Article 36.

171 INQ000095/49/Article 37.

172 INQ010098/70-71/par4.10-4.11, INQ000095/17/Art2.2, INQ000170, INQ000173, INQ000174, INQ000175, INQ000176, INQ000172, INQ000177, INQ000184, INQ000192, INQ001333.

173 INQ000095/17/Article 2.2.

174 INQ010098/70/par4.10.

175 INQ000095/31-32/Articles 13-14.

176 INQ000181, INQ000193, INQ000194, INQ000196, INQ000197, INQ000199, INQ000208, INQ000216, INQ000218, INQ000219.

177 INQ010134/10-11/par29.

178 INQ010134/10-11/par29.

- 7.70** Between October and December 2020, the UK and France developed and signed a joint statement for collaboration on tackling illegal migration. This resulted in the UK investing £28.1 million to support France's efforts against small boats in Boulogne and Dunkirk.
- 7.71** In practice, in relation to small boat issues, the Home Office was the primary department which liaised with the French at an inter-governmental level.¹⁷⁹ The DfT was also able to engage with France at a senior and ministerial level.¹⁸⁰

Operational co-operation between HM Coastguard and French CROSS Gris-Nez

The French tracker

- 7.72** CROSS Gris-Nez collated information it had received about small boat crossings in its search and rescue region into a document referred to by HM Coastguard as the 'French migrant tracker' (French tracker). The French tracker was emailed by CROSS Gris-Nez to MRCC Dover, but CROSS Gris-Nez would also call or radio updates to HM Coastguard about small boats. At a meeting between HM Coastguard and CROSS Gris-Nez on 30 September 2020, it was confirmed that the handover process between France and the UK for search and rescue operations was for CROSS Gris-Nez to telephone and email MRCC Dover. HM Coastguard would also share a truncated version of the HM Coastguard tracker with its French counterparts.¹⁸¹
- 7.73** Updated versions of the French tracker were periodically sent if there were developing incidents. The French tracker was intended to consolidate all records of small boats held by French authorities. It included details of each incident and associated positional data and telephone numbers. The French tracker was colour coded. Green meant that a case was closed from the search and rescue point of view in the French search and rescue region, orange meant a boat was in the process of being secured, and white meant an incident was neither closed nor being secured.¹⁸² In contrast to the HM Coastguard tracker which used a phonetic alphabet code-word (e.g. Alpha, Bravo, Charlie) reference system for incidents, the French tracker used a numeric reference. An example of the French tracker can be seen below at Figure 8.¹⁸³

179 INQ010337/71-72/par214-215, INQ005223, INQ005227, INQ005216, INQ001028, INQ002224, INQ002225, INQ000629, INQ000630, INQ003902, INQ003904, INQ003900, INQ003901, INQ009059.

180 INQ010337/71-72/par214 and, for example, INQ004260, INQ004244, INQ004312, INQ005341.

181 INQ001234, INQ001262.

182 INQ008341.

183 INQ008341.

Figure 8: Extract of the French small boats tracker sent from CROSS Gris-Nez to HM Coastguard at 04:44 on 24 November 2021

1		<u>3501</u>	2102	CANAL DES DUNES	VIGIE DK	SEMI RIGIDE	40
2		<u>3502</u>	2224	LEFFRINCKOUCKE	POLICE DK	SEMI RIGIDE	30
3		<u>3503</u>	2224	LEFFRINCKOUCKE	POLICE DK	SEMI RIGIDE	30
4		<u>3504</u>	2230	CANAL DES DUNES	VIGIE DK	SEMI RIGIDE	30
5		<u>3505</u>	2316	WISSANT	POLICE	SEMI RIGIDE	15
6			0013	LEFFRINCKOUCKE	POLICE	SEMI RIGIDE	30
7	A	<u>3507</u>	0048	Bouée MPC	SAMU 62	SEMI RIGIDE	33 13 femmes 8 enfants
8			0107	Berck	Police	SEMI RIGIDE GRIS	30 à 40
9			0111	Dunkerque ?	tél migrant		33 3 enfants 6 femmes
10		<u>3510</u>	0230	Bouée Sandétié	Flamant	NOIR	40
11		<u>3511</u>	0256	Bouée Sandétié	Flamant		
12			0343	Berck	Tel migrant		50
13			0349	Chenal Dunkerque	CMA CGM Mermoz	GRIS	30

FLAMANT		284° / 6 NDS		51°07.40N / 001°42.67E	possible MIG 7 et 9
FLAMANT		253° / 5 NDS	03 :19	51°07.16N / 001°55.54E	
FLAMANT		272 ° / 6 NDS	03:10	51°07.00N 001°43.50	SRR UK
		AT EARTH		AT EARTH – NO CROSSING	
		AT EARTH		AT EARTH – NO CROSSING	
		276/4NDS	00:00	51°04.58N / 002°25.06E	
		305 / 4	0130	51°07,4N 001°45,4E	SRR UK Possible MIG 1 et 9
					possible MIG 7 et 1
FLAMANT		300 / 6	03 :00	51°10 N 001°47 E	SRR UK
FLAMANT		330 / 5	03 :00	51°09 N 001°46 E	SRR UK
SNS Berck	SNS Berck	Stop		50°27 N 001°32 E	
Escaut		310 / 4,5	04:40	51°05 / 002°00	

- 7.74** The French tracker was a key source of information for MRCC Dover in the initial information gathering and small boat tracking phase of its response to small boat crossings. The information shared by CROSS Gris-Nez would be captured by HM Coastguard in ViSION and saved to a new or existing incident.¹⁸⁴ The positions of small boats provided within the French tracker would be used, along with other information sources, such as C-Scope, unmanned aerial vehicles, and reports from private or commercial maritime traffic, to attempt to track them. The French tracker would also be relied on for information during the final review and completion phase of small boat operations.¹⁸⁵ At around the time of the incident on 23 to 24 November 2021, Border Force was being provided with the French tracker.¹⁸⁶

Delay in receiving the French tracker

- 7.75** In order for HM Coastguard to obtain an early and accurate recognised maritime picture, track small boats, and provide an effective search and rescue response, it was important that the French tracker was sent promptly by CROSS Gris-Nez to MRCC Dover, and that updates were regularly provided reflecting new or revised information.¹⁸⁷ However, there were issues of delay in provision of the French tracker.
- 7.76** In a meeting between HM Coastguard and CROSS Gris-Nez on 2 December 2020, HM Coastguard raised concerns about delay by French colleagues in informing HM Coastguard of migrant operations and providing the French tracker, despite chasing.¹⁸⁸
- 7.77** The migrant incident activity review dated 4 August 2021 also expressed concerns about delays in receiving the French tracker.¹⁸⁹ This report recognised a loss of life as a consequence of the matters they identified.¹⁹⁰ It explained that “[e]arly access to the French Migrant Tracker can ensure that the Ops Room aren’t overwhelmed with information immediately and have sufficient time to assess the data. This was apparent when Thursday’s (5th August) day started with 7 incidents on the French tracker as opposed to 23 incidents on Wednesday”.¹⁹¹

184 INQ009632/22-23/par57-59.

185 INQ007279/2.

186 INQ010718/85-86/ln15-14.

187 As to the meaning of a ‘recognised maritime picture’, see paragraph 4.32.

188 INQ000218.

189 INQ007279/2.

190 INQ007279/4.

191 INQ007279/5.

- 7.78** The fact that the French tracker was routinely not sent in a timely manner, and the consequent impact of this, was known about at the highest level within HM Coastguard. In an email on 17 August 2021, the Divisional Commander for MRCC Dover, Mr Mike Bill, emailed the Chief Coastguard to confirm that the delays in sending the French tracker would be raised (again) with the French.¹⁹² The following day, at a meeting on 18 August 2021 between MRCC Dover and CROSS Gris-Nez, there was a request for the “French migrant tracker [to be] emailed to Dover MRCC as often as possible and as early as possible”. The French representatives said that they would “feed this back to ops room”. A target date for this was set for 31 August 2021.¹⁹³ However, on the night of 23 to 24 November 2021 there was a significant delay in receiving the French tracker.

¹⁹² INQ003322/3.

¹⁹³ INQ000199.

PART 3:

Events of 23 to 24 November 2021

This part of the report contains a detailed narrative account of the events of 23 to 24 November 2021. It is broken down into time periods for ease of reading. Chapter 8 describes what happened to the small boat that was swamped (incident ‘Charlie’) and the actions of those involved in responding to it. This factual, narrative account is followed by analysis of what occurred that night. Chapter 9 focuses on the resources that were available on 23 to 24 November 2021. Chapter 10 considers the initial response to incident ‘Charlie’ and, in particular, on information gathering about the nature of its distress. Chapter 11 analyses the search response to incident ‘Charlie’, and Chapter 12 considers the events that led to the erroneous conclusion that incident ‘Charlie’ had been rescued.

Chapter 8:

Narrative account of the events of 23 to 24 November 2021

22 to 23 November 2021

- 8.1** In the week preceding the events of 23 to 24 November 2021, the Operation DEVERAN weather assessment, which predicted the likelihood of small boat crossings by reference to the weather forecast, said with moderate confidence that crossings were considered unlikely on the night of 23 to 24 November 2021.¹ From Monday 22 November 2021, the forecast for the night of 23 to 24 November changed from ‘unlikely’ to ‘likely’. Crossings were said to be ‘highly likely’ on 24-25 November.² The predicted period within which small boat crossings were said to be ‘highly likely’ was from 03:00 on 24 November 2021 until 09:00 on 25 November 2021.³
- 8.2** On Monday 22 November 2021, a ‘migrant red days’ meeting was held in the afternoon which covered the forthcoming week, including Tuesday 23 and Wednesday 24 November 2021.⁴ It was attended mostly by staff of HM Coastguard, including the Chief Coastguard, Mr Peter Mizen, as well as a representative from the Royal National Lifeboat Institution (RNLI) and a representative from 2Excel.⁵ Border Force was not represented. Mr Stephen Whitton had sent apologies on its behalf and the minutes record that he had sent a briefing note in advance.⁶ During the meeting, resourcing was discussed. It was noted that small boat activity over the preceding weekend (20 to 21 November 2021) had started significantly earlier than expected and that while there was no current need to adjust the planned timings of the scheduled surveillance flights, 2Excel should be aware of possible changes to timings.⁷ It was recognised that small boat activity could take place earlier on Tuesday 23 November, given the pattern over the preceding days in which “the amber days are starting to look more red than amber”.⁸ During the previous week,

1 INQ000131/1, INQ000134/1, INQ000137/1, INQ000140/1, INQ000143/1. See also paragraph 7.38.

2 INQ000146/1, INQ000150/1.

3 INQ000206/1/par2.

4 See also paragraphs 6.23 and 7.36 to 7.38.

5 INQ000206/1.

6 INQ000206/2/par3, INQ010137/41/par109.

7 INQ000206/3/par3.

8 INQ000206/5/par5.

1,096 people had crossed the Dover Strait on an amber day. This was only two people fewer than the record number of 1,098 people who crossed on a red day the week before.⁹

- 8.3** As regards surface assets, the RNLI representative attending the red days meeting confirmed that there were no planned off-service periods.¹⁰ The Border Force briefing document said that it was “planning to ensure [it had] good Op Deveran coverage from Border Force Maritime”.¹¹ Those attending the meeting observed that there were restrictions on the availability of Border Force assets in the period due to staff shift patterns, which had an impact on the RNLI whose volunteers were regularly being requested to launch and work through the night at sea while also having day jobs.¹² In relation to air assets provided by 2Excel, HM Coastguard recorded that there were sufficient assets available.¹³ As for staffing, the Chief Coastguard recognised that having two operational staff at MRCC Dover was insufficient.¹⁴ It was acknowledged that there had been no local response to a request for staff to work overtime.¹⁵ Accordingly, after the meeting, a request was sent to the entire HM Coastguard network requesting staff to travel to Dover to cover the night shifts of 23 to 24 and 24 to 25 November 2021.¹⁶
- 8.4** Following the meeting on 22 November 2021, the 2Excel representative who had been in attendance warned his team that there was significant risk in the period including the night of 23 to 24 November 2021 and advised 2Excel to “try and cover as much as [they] can”.¹⁷ By contrast, Border Force did not appear to be aware of the risks of the period, as discussed at the meeting. Mr Whitton has been unable to trace the minutes of that meeting, whereas he has been able to locate others.¹⁸ The operational Border Force witnesses who gave evidence to the Inquiry said that they received no particular warnings about the night and that there was nothing to indicate that it would be particularly eventful.¹⁹

9 INQ000206/5/par5.

10 INQ000206/2/par3.

11 INQ000206/2/par3.

12 INQ000206/3/par3.

13 INQ000206/3/par4.

14 INQ000206/4/par5.

15 INQ000206/4/par5.

16 INQ006765/1.

17 INQ001190/1.

18 INQ010137/40/par110.

19 INQ010135/19/par43, INQ010136/21/par57.

- 8.5** Throughout 22 November 2021, HM Coastguard made a number of tasking requests of 2Excel in respect of the planned Operation EOS fixed-wing flight on the night of 23 to 24 November 2021.²⁰ The overnight tasking request was for a fixed-wing flight between the hours of 03:00 and 08:00 on 24 November 2021 for the purposes of “accident prevention and surveillance”.²¹ The tasking form identified the following potential consequences of non-delivery of the patrol.
1. “Reduce the chance of suspect migrant vessels being identified earlier within their transit than was previously possible.
 2. This could impact on SAR [search and rescue] response times, decreasing the chance of early interdictions and potentially increasing risk to the migrants.
 3. Be detrimental to the building and analysis of the Maritime Domain Awareness Picture.”
- 8.6** HM Coastguard made a further tasking request for an aircraft to be on standby at Lydd or Southend and respond to taskings from MRCC Dover between the hours of 08:30 to 16:00 on 24 November 2021.²² In addition to HM Coastguard, the Home Office also made a tasking request under Operation ALTAIR for a flight between 00:01 and 05:00 on 24 November.²³ The covering email clarified that the earlier Operation EOS tasking took priority.²⁴
- 8.7** 2Excel initially indicated that it was unable to cover the whole tasking period for Operation EOS (03:00 to 08:00) due to unavailability of aircraft.²⁵ However, this changed by the evening of 23 November 2021. In a call between 2Excel and the Aviation Tactical Commander, Mr Dominic Golden, at 20:01 on 23 November 2021, 2Excel confirmed that there would be no gaps in the planned coverage throughout the night of 23 to 24 November 2021.²⁶ 2Excel also accepted the additional Operation ALTAIR tasking, and confirmed that it would be on task for 00:30 (a minor modification to the 00:01 requested timing for the flight’s commencement).²⁷ The acceptance of these tasking requests meant that there was a period of overlap: between 03:00 and 05:00 on 24 November, 2Excel would simultaneously cover both the Operation EOS and Operation ALTAIR taskings.

20 INQ001186. See paragraph 4.98 for an explanation of Operation EOS.

21 INQ000148/1.

22 INQ001188/2.

23 INQ006337/1. See paragraph 5.19 for an explanation of Operation ALTAIR.

24 INQ003895/4.

25 INQ001186/1.

26 INQ008827/4.

27 INQ003895/3.

- 8.8** In addition to the fixed-wing flights planned for 2Excel, on behalf of the Home Office, the company RVL was scheduled to fly a surveillance flight at a high level over the Dover Strait on the night of 23 to 24 November 2021. In the early evening of 23 November 2021, it became clear to the Aviation Tactical Commander that neither operator was aware of each other's planned activity, which he corrected for deconfliction purposes.²⁸
- 8.9** In relation to the available surface assets for 23 to 24 November 2021, Border Force identified two assets that were on standby: the cutter, the Valiant, and the coastal patrol vessel, Hunter, with the Valiant identified as the primary responder.²⁹ The crew transfer vessel, Hurricane, was identified as available from 06:00 on 24 November 2021. The rigid hull inflatable boat, Safeguard, was available from 06:30. Two jet skis, Juno5 and Juno6, were available from 07:00 with restricted hours, and the rigid hull inflatable boat, Artemis, from 07:30 (see Figure 9, which shows the asset availability on 23 to 24 November 2021).³⁰
- 8.10** All Border Force assets were identified as having a 'reactive' deployment strategy.³¹ A reactive tasking responds to a likely scenario involving a risk to lives, whereas a proactive tasking responds to the presence of conditions in which there could be a risk to lives.³²
- 8.11** As had been reported in the red days meeting of 22 November 2021, all lifeboat stations were on duty on the night watch of 23 to 24 November 2021.³³
- 8.12** On 23 November 2021, the Joint Maritime Security Centre issued a Situational Awareness Brief. It recorded levels of asset availability as acceptable and noted that the weather would be operational in the Dover Strait for small boats.³⁴
- 8.13** At 18:22 on 23 November 2021, the Home Office's Clandestine Channel Threat Command received intelligence estimating there could be hundreds of people arriving by small boat in the UK search and rescue region by 24 November 2021.³⁵

28 INQ000223/5.

29 INQ000566.

30 INQ000566.

31 INQ000566.

32 INQ010716/7/In11-23.

33 INQ010741/85/In1-5.

34 INQ002240/2-3. See also paragraphs 4.69 to 4.71.

35 INQ002267. See also paragraphs 4.72 to 4.73.

Figure 9: Operation DEVERAN planning 23 November 2021 to 24 November 2021

AMBER DAY PLANNING				
Maritime	Location [Tide Times]	Deployment Time		Deployment Strategy
VALIANT	Dover [Primary Responder]	Standby [DRORA in place/weather limitations]		REACTIVE (Offshore patrols)
HUNTER	Dover	Standby		REACTIVE (Offshore patrols)
HURRICANE	Ramsgate	0600hrs		REACTIVE (Offshore Patrols)
SAFEGUARD	Dover	0630hrs		REACTIVE (Inshore patrols)
JUN05	Dover	Available from 0700hrs [restricted hours]		REACTIVE (Inshore patrols)
JUN06	Dover	Available from 0700hrs [restricted hours]		REACTIVE (Inshore patrols)
ATHENA	Dover	Unavailable		REACTIVE (Inshore patrols)
ARTEMIS	Dover	0730hrs		REACTIVE (Inshore patrols)
Aerial	Location	Deployment Time		Deployment Strategy
MCGA Fixed Wing	Doncaster	Multiple Aircraft [Coverage 2200hrs – 0745hrs] On call thereafter		PROACTIVE (Surveillance)
TEKEVER AR3	Lydd	0530hrs – 1330hrs		PROACTIVE (Surveillance)
TEKEVER AR5	Lydd	Unavailable		PROACTIVE (Surveillance)
Shoreside	Location	Deployment Time		Deployment Strategy
MCC	Portsmouth	24/7		Command & Control
MCGA LO	Dover	Unavailable [Contact MCC]		Command & Control (Liaison)

The night watch of 23 to 24 November 2021

19:00 to 22:29 on 23 November 2021

- 8.14** At Maritime Rescue Coordination Centre (MRCC) Dover, the night watch began at 19:30 on 23 November 2021 and ran for 12 hours until 07:30 the next morning. There were two operational members of staff working on search and rescue that night: Mr Neal Gibson, a Search and Rescue Mission Co-ordinator (SMC) and team leader, and Mr Stuart Downs, a trainee Maritime Operations Officer. Mr Downs was partially qualified at that time. He had passed his ‘communications’ qualification, which permitted him to answer emergency telephone calls, but he had not yet completed the ‘incident response’ qualification, which was required before he could qualify as a Maritime Operations Officer.³⁶ There was also a non-operational trainee present. This person had not passed any HM Coastguard qualifications and had only been employed by HM Coastguard for some 30 days as at 23 November 2021.³⁷ In addition to the search and rescue team, the Vessel Traffic Service (VTS) team, which was responsible for the safe navigation of traffic in the Dover Strait, was also located in the same operations room in Dover. On the night of 23 to 24 November 2021, one member of the VTS team had taken unexpected sick leave, with the effect that the VTS team was also short staffed.
- 8.15** At the Joint Rescue Coordination Centre (JRCC), located in Fareham, the night watch on 23 to 24 November 2021 started at 19:00 and ran for 12 hours until 07:00 the next morning.³⁸ That night, Mr Christopher (Tom) Barnett, the SMC and team leader at the JRCC, led a team of one other Senior Maritime Operations Officer, seven Maritime Operations Officers and one non-operational trainee.³⁹ The JRCC staff operated MRCC Solent, which was based within the JRCC. Additionally, on the night watch of 23 to 24 November 2021, Mr Barnett had remote oversight of other MRCCs, including MRCC Falmouth and, for part of the night, MRCC Dover.⁴⁰ The Maritime Tactical Commander on duty that night, Mr David Jones, was also based at the JRCC. Due to staff illness, Mr Jones was the sole Maritime Tactical Commander working across the HM Coastguard network that night.⁴¹ There was a Strategic Commander, Mr Duncan Ley, who was on call throughout the night watch, but he was not contacted and remained at home. He was not considered to be working unless and until contacted.⁴²

36 INQ010392/24/par55.

37 INQ010715/33/ln5 .

38 For an explanation of the role of the JRCC, see paragraph 4.21.

39 INQ010140/4-5/par13.

40 See paragraph 8.32.

41 INQ010138/8/par35.

42 INQ010094/10/par37.

- 8.16** The Aeronautical Rescue Coordination Centre (ARCC) was also located in Fareham, in the same building as the JRCC. The ARCC was headed by Aviation Tactical Commanders. On the night watch of 23 to 24 November 2021, the Aviation Tactical Commander on duty, Mr Dominic Golden, led a team of four staff members, one of whom was a trainee. Two team members were on annual leave and one was off sick.⁴³ The two Tactical Commanders, Mr Golden and Mr Jones, were working at adjacent desks that night.
- 8.17** As regards HM Coastguard's search and rescue partners, at the Border Force Maritime Command Centre (Border Force MCC) Higher Officer, Ms Karen Whitehouse, was on duty during the night shift, accompanied by Immigration Officer, Mr Thomas Willows. They were based in Portsmouth and their shift ran from 20:30 to 07:30.⁴⁴ Ms Whitehouse explained to the Inquiry that she was required to work through the shift without taking an official break and would take equipment into the bathroom to ensure communications systems were not left unattended.⁴⁵ Mr Willows may have been working remotely that night but the Home Office has been unable to confirm this.⁴⁶
- 8.18** The crews of the Border Force maritime assets identified as on standby, as well as RNLI assets, were at rest until called. The crews of air assets contracted by HM Coastguard which did not have scheduled flights during the night watch, including Bristow helicopters and Tekever drones, were also at rest. By contrast, in the early evening of 23 November 2021, 2Excel and RVL's crews were readying themselves to fly the overnight flights as set out in the taskings they had accepted.⁴⁷
- 8.19** HM Coastguard's other key search and rescue partner in the Dover Strait, the French Coastguard, was operational on 23 to 24 November 2021 from the Centre Régional Opérationnel de Surveillance et Sauvetage (CROSS) Gris-Nez. This was located on the northern French coast, southwest of Calais.
- 8.20** At MRCC Dover, Mr Gibson was concerned about staffing levels at the outset of his shift. This was due to the combination of the expected low number of operational team members on search and rescue duty coupled with the unexpected loss of a VTS team member due to illness. At 19:39, Mr Barnett at the JRCC called Mr Gibson to discuss the staffing situation. Mr Gibson observed, by reference to the shortage of staff, that he was "running around like a headless chicken" and noted, in jest, that the ideal solution would be for staff members from the JRCC to be sent to Dover that night.⁴⁸ In the absence of this, Mr Gibson asked Mr Barnett to provide whatever

⁴³ INQ009628/24-25/par62.

⁴⁴ INQ010135/19/par43, 28/par69.

⁴⁵ INQ010135/19/par44.

⁴⁶ The evidence of Ms Whitehouse and Mr Willows was that they had no independent recollection: INQ010718/49/ln11-23, INQ010214/2/par5.

⁴⁷ See paragraphs 8.7 to 8.8.

⁴⁸ INQ010128/2.

assistance was available remotely from the JRCC.⁴⁹ Mr Gibson and Mr Barnett also discussed the likely level of small boat activity that night. Mr Gibson noted that Border Force's assets were all reactively deployed rather than going out proactively to search for small boats.⁵⁰ He also observed that there had been a regular failure on the part of the French Coastguard at CROSS Gris-Nez to notify MRCC Dover of small boat activity at an early stage. This meant that MRCC Dover would have no advance knowledge of small boat activity in the French search and rescue region until they had crossed into UK waters.⁵¹

- 8.21** Mr Gibson also called Mr Jones during the early evening of 23 November 2021 in an attempt to understand whether the Small Boat Tactical Commander, Mr George Papadopoulos, would be at MRCC Dover during the night watch.⁵² Mr Jones could not assist with the query and told Mr Gibson to call Mr Papadopoulos to check with him. The Inquiry has not identified any evidence to suggest that this call took place. Mr Papadopoulos was on call that night but, as with the Strategic Commander, Mr Ley, he was not contacted and remained at home.⁵³ Mr Papadopoulos was to be on duty from 07:30 on 24 November 2021, which was anticipated to be a very busy day.
- 8.22** At 21:00, HM Coastguard held a network management call which was led by Mr Jones, the Maritime Tactical Commander.⁵⁴ During the call, Mr Jones outlined the plans for resourcing across the network throughout the night. It was envisaged that two members from the JRCC would provide what Mr Jones called 'dynamic assistance' to MRCC Dover: one to monitor very high frequency (VHF), which is the primary channel for emergencies and the initial calling of other vessels, and the other to assist with search and rescue.⁵⁵ The Aviation Tactical Commander, Mr Golden, gave an aviation briefing for the night. He observed that "every man and his dog appear[ed] to be flying" that night and that there would be at least one, sometimes two, aircraft in the Dover Strait between 21:45 on 23 November 2021 and 09:00 on 24 November 2021.⁵⁶ Although he added the caveat that the planned flights were all weather dependant, at this point of the night, HM Coastguard still expected that 2Excel would provide full aerial coverage from 00:30.
- 8.23** Despite Mr Gibson's recognition on the call with Mr Barnett at 19:39 that the French Coastguard were likely to delay sending intelligence on small boats, HM Coastguard did not call the French Coastguard during the evening of

49 INQ010128/6-7.

50 IN01010128/2.

51 IN1010128/3.

52 INQ010129/2-3.

53 INQ010740/69/ln1-9.

54 INQ008822.

55 INQ010138/10/par40(d).

56 INQ008822/7.

23 November 2021 to check whether there was any small boat activity. In his oral evidence to the Inquiry, Mr Gibson said that he was likely to have been distracted by the administrative burden caused by having a staff member off sick.⁵⁷ Mr Barnett acknowledged that HM Coastguard did regularly call the French Coastguard to check if there was any small boat activity but added that there was a risk that frequent calls could be perceived as questioning the professionalism of the French Coastguard.⁵⁸ He said that his belief was that the French Coastguard was busy and that “the tracker would come when [the French Coastguard] could get the tracker to [HM Coastguard]”.⁵⁹ Mr Downs said that he would not have called the French Coastguard in the absence of a direction from the SMC.⁶⁰

- 8.24** Therefore, unknown to HM Coastguard at the time, at around 16:00 on 23 November 2021 as it was getting dark, a group of people left the makeshift encampment at Dunkirk where they had been staying and walked towards the French coast.⁶¹ After around two hours, they arrived at a sandy beach near Dunkirk, which was the launch site for the small boat associated with incident ‘Charlie’. They then waited while the people smugglers facilitating their crossing prepared the small boat and made arrangements for their departure.⁶² All the details of the crossing were arranged by the smugglers. This included the time and date of departure, the location of departure, the identities and numbers of people on board, and the small boat used. Each person in the group waiting to board had paid a significant sum of money to the people smugglers facilitating the crossing. Some or all of the people smugglers who arranged and facilitated the crossing are the subject of criminal proceedings in France.
- 8.25** The identities and nationalities of the people who the Inquiry has established boarded the small boat are set out in Part 4.⁶³ They comprised adults and children. There were at least 33 people. Some knew each other already. This included a group of Iraqi Kurds, who had met and travelled together on their journey to northern France.⁶⁴ Others, such as Mr Issa Mohamed Omar, one of the two known survivors of the incident, were travelling alone and knew no one on board.⁶⁵
- 8.26** Of the adults whose identity has been confirmed, there were seven women and 24 men. There were two confirmed children, Mubin Rizghar Hussein, aged

57 INQ010715/64/ln7-15.

58 INQ010719/82/ln2-13.

59 INQ010719/82/ln13-16.

60 INQ010720/131/ln11-15.

61 INQ010388/12/par65.

62 INQ010388/12/par66.

63 See paragraphs 13.5 to 13.8 and 13.14.

64 INQ010210/4/par19.

65 INQ010388/8/par41.

16, and Hasti Rizghar Hussein, aged seven. Mr Omar has told the Inquiry that there were others on board, including an Ethiopian man and at least two young children in addition to Hasti, who have neither been found nor accounted for.⁶⁶ His evidence was that before the group boarded the small boat, the smugglers told them that there were 33 in total. However, he believes that the smugglers misled them and boarded more people as the small boat was leaving.⁶⁷ In the absence of information to establish the identities of any additional people, the Inquiry has been unable to determine conclusively the number of those on board.

8.27 The small boat itself was recovered by the French authorities. It forms part of the evidence involved in the French criminal proceedings and has not been made available to the Inquiry. As Mr Omar explained, it was inflated by the people smugglers on the beach shortly before departure.⁶⁸ Mr Omar told the Inquiry that the small boat was light brown or beige in colour and around eight metres long. It had a petrol-powered engine at the back.⁶⁹

8.28 Mr Omar said that one person was instructed by the smugglers to steer the small boat and given a GPS device for that purpose. He believes that this person was also given emergency numbers to call.⁷⁰ Mr Omar further told the Inquiry that all of the people on board the small boat were provided with orange lifejackets with strips of reflective material, but these appeared to be stuffed with cotton and provided ineffective buoyancy. There was no other lifesaving equipment on board.⁷¹

8.29 In boarding the small boat, the group had to wade into the water. Mr Omar described the process of boarding the boat and setting off in the following terms:

“The inflated boat was carried into the water and people started to get on. People were getting on one by one and we were not in a rush. I was one of the last people to get on the boat. I had to wade into the water up to my navel. My legs were soaked when I boarded the boat. [...] The adults were placed on the inflated sides of the boat, and the families with small children in the middle. [...] It was very crowded on the boat and we were squeezed together. [...] The weather was fine when we set off, although it was cold and it had been raining on the beach. The water was quite calm at first, there were some waves but they were small.”⁷²

66 INQ010388/10/par51, 11/par62.

67 INQ010388/9/par44-46.

68 INQ010388/12/par66.

69 INQ010388/13-14/par74.

70 INQ010388/12/par67-68.

71 INQ010388/13/par71.

72 INQ010388/13-14/par72, 74, 75, 77.

- 8.30** At around 21:00, the small boat set off, under power of the engine on board. Mr Omar told the Inquiry that at around 22:00, after they had been travelling for around an hour, a French flagged vessel approached the small boat, shone a spotlight on it and followed it for some time.⁷³ HM Coastguard considers it unlikely that a French asset tasked by the French Coastguard followed the small boat. This is because the Flamant, the asset known to have been tasked by the French Coastguard on the night of 23 to 24 November 2021, was travelling at a speed faster than that of a small boat at all relevant times.⁷⁴ In the absence of confirmation from the French Coastguard, I am unable to determine this point conclusively. It is not necessary for me to do so.
- 8.31** However, the tracker document used by CROSS Gris-Nez to record information about small boats (the French tracker) suggests that the French Coastguard may have been aware of the small boat associated with incident ‘Charlie’ from around 21:00. The French tracker at 00:56 recorded that incident ‘1’ was detected at 21:02. It also recorded that the Flamant was the vessel associated with this incident.⁷⁵ Incident 1 was later identified as a possible duplicate of incident ‘Charlie’ (French reference ‘7’).⁷⁶

22:30 on 23 November 2021 to 01:29 on 24 November 2021

- 8.32** At 22:30 on 23 November 2021, Mr Gibson left the search and rescue team at MRCC Dover to provide break cover for the VTS team members. At the same time, Mr Downs, the other operational member of staff working on search and rescue at MRCC Dover that night, started his 90-minute break. From this point, there were no operational staff members working on search and rescue at MRCC Dover and all operations moved to the JRCC, with Mr Barnett as the SMC.⁷⁷ Then, at around midnight, Mr Downs returned from his break, at which point operations partially returned to Dover but with Mr Barnett providing remote cover as the SMC.
- 8.33** At 00:26 on 24 November 2021, MRCC Dover received the first call of the night from a small boat. This was identified by HM Coastguard as incident ‘Alpha’ and a ViSION log was opened.⁷⁸ This was in fact a call from someone on board the small boat associated with incident ‘Charlie’, but the connection was not made conclusively by HM Coastguard on the night itself. The call was transferred to MRCC Dover by the Port of Dover switchboard. It cut off before MRCC Dover could receive it but a number from the small boat caller was obtained by the

73 INQ010388/14-15/79-82.

74 INQ010510/3/par8.

75 INQ007691/1.

76 For example, see INQ007692/2.

77 INQ010140/7-12/par21-26, INQ010392/24-26/par56-57.

78 INQ000234.

Port of Dover switchboard operator (a UK mobile number ending in 523).⁷⁹ This phone number has subsequently been identified by the French authorities as belonging to one of the deceased, an Afghan national, Mr Husain Tanha.⁸⁰ At 00:31, the Maritime Operations Officer at MRCC Dover, Mr Downs, attempted to call that telephone number and heard an international dial tone. This led him to believe that the small boat was still in French waters.⁸¹ At 00:35, Mr Downs called CROSS Gris-Nez to alert the French Coastguard that there was a small boat believed to be within the French search and rescue region.⁸² On this call it became clear that in fact CROSS Gris-Nez was aware of four boats in French waters. However, MRCC Dover had not received the French tracker by the time of this call. Mr Downs requested it.

- 8.34** At around the same time as MRCC Dover received its first small boat call of the night, the Aviation and Maritime Tactical Commanders became aware of a deterioration in the weather and visibility conditions on both sides of the Dover Strait, which were described in an entry in the Aviation ViSION log at 00:38 as “significantly poor”.⁸³ The deterioration was rapid. An entry just 30 minutes earlier, at 00:18, had recorded very good visibility “on the whole with some exceptions”.⁸⁴ As a result of the poor visibility, 2Excel informed the ARCC that it had postponed its planned flight due to “concerns for suitable wx [weather] diversions for aircraft”.⁸⁵ In accordance with 2Excel’s Operation Manual, it required two diversion airports to be available given the poor weather conditions over the south coast at the time.⁸⁶ Of the two airports within range of the tasking area that were both open and above the required weather limits, one refused 2Excel’s request due to reduced staffing that night.⁸⁷
- 8.35** At around 00:40, the Aviation and Maritime Tactical Commanders issued a joint warning to the HM Coastguard network through the separate aviation and maritime ViSION systems. This recorded their concern that in the absence of a surveillance flight, HM Coastguard was “effectively blind”. The message cautioned against relaxing and expecting a normal night of small boat crossings, observing instead that “this has the potential to be very dangerous”.⁸⁸

79 INQ007644/3.

80 INQ008905/35/par4.1.6. This identifies him as “TAHNA Hussein, deceased”. Allowing for differences in transliteration, this is highly likely to be the same person identified by the Inquiry as Mr Husain Tanha: paragraph 13.5.

81 See also paragraphs 10.23 to 10.24. The expert evidence commissioned by the Inquiry shows that this is not a reliable indicator of international location.

82 INQ007645/2.

83 INQ000225/3.

84 INQ000225/2.

85 INQ000225/3.

86 INQ000646/136.

87 INQ000642/1.

88 INQ000225/3, INQ000235/3.

- 8.36** The Maritime Tactical Commander, Mr Jones, told the Inquiry that the intent of this message was to “warn...the teams of SMCs at the MRCCs, especially Dover, to stay alert and ready”.⁸⁹ However, the SMC at MRCC Dover, Mr Gibson, was still covering VTS at the time the message was sent and does not recall seeing it either at the time or later.⁹⁰ He told the Inquiry that despite not seeing the warning message, he had an awareness in any event that in the absence of a surveillance flight it would be harder to co-ordinate an effective overall search and rescue.⁹¹
- 8.37** At the same time as the joint warning was issued (00:40), the Aviation Tactical Commander, Mr Golden, called RVL to request any feedback from its flight that was operating at a high altitude over the Dover Strait at the time. He was told that the RVL flight had completed its initial flight over the Dover Strait and was currently over Southend to refuel before returning for a second flight.⁹² Mr Golden requested that if any information was obtained from the RVL flight about the conditions, it be passed on. He expressed similar concerns to those he recorded in the ViSION system shortly before: “[M]y thought process is...that we’re all beginning to relax our guard here thinking this is going to be a normal night and a normal night of migrants crossing. Now, of course, we suddenly have the potential of being completely blinded by fog and mist and suddenly getting ourselves caught short.”⁹³
- 8.38** At 00:56, HM Coastguard received the French tracker for the first time that night.⁹⁴ It showed that six small boats had been detected by the French Coastguard, of which two had been resolved because they had been prevented from launching.⁹⁵ It also showed that the French Coastguard had been aware of the first small boat at 21:02 on 23 November 2021 with 40 people on board (French reference ‘1’). Of the other three small boats that had launched, the tracker showed that the French had detected boats ‘2’ and ‘3’ at 22:24 on 23 November and boat ‘6’ at 00:13 on 24 November, each of which were said to have 30 people on board. There were location co-ordinates for the last known positions of all four boats that had launched, but the column for the times of the last known positions was empty. See Figure 10.

89 INQ010138/12/par44(d).

90 INQ010715/71-72/ln8-9.

91 INQ010715/73/ln10-25.

92 INQ008830/3.

93 INQ008830/3.

94 INQ007691.

95 Resolved incidents are filled in green on the French tracker.

Figure 10: French small boats tracker sent from CROSS Gris-Nez to HM Coastguard at 00:56 on 24 November 2021 (translated from the original French version)

FR Ref	UK Ref	SITREP n°	Detection time (UTC)	Sector	Origin of alert & Detection means	Support embarking migrants (type, colour, L, propulsion)	POB (M/F/child, with/without life jackets)
1			2102	CANAL DES DUNES	VIGIE DK	SEMI RIGID	40
2			2224	LEFFRINCKOUCKE	POLICE DK	SEMI RIGID	30
3			2224	LEFFRINCKOUCKE	POLICE DK	SEMI RIGID	30
4			2230	CANAL DES DUNES	VIGIE DK	SEMI RIGID	30
5			2316	WISSANT	POLICE	SEMI RIGID	15
6			0013	LEFFRINCKOUCKE	POLICE	SEMI RIGID	30

SRU rallying or searching	SRU in contact or rescue	Estimated route/speed	Last position time (UTC)	Last known position
FLAMANT		284° / 6 NDS		51°07.40N / 001°42.67E
FLAMANT		266° / 6 NDS		51°05.16N / 002°12.54E
FLAMANT		272° / 6 NDS		51°04.70N / 002°24.50
		AT EARTH		AT EARTH – NO CROSSING
		AT EARTH		AT EARTH – NO CROSSING
		276/4NDS		51°04.58N / 002°25.06E

- 8.39** The French tracker sent at 00:56 did not contain information about incident ‘Charlie’ (French reference ‘7’), although later versions of it suggested that the small boat associated with French reference ‘1’ could be a repeat of reference ‘7’ (incident ‘Charlie’). After receiving confirmation of small boat crossings that night, HM Coastguard made an information service broadcast to vessels in the Dover Strait requesting them to keep a look out and report any sightings of small boats to Dover Coastguard.⁹⁶ The broadcasts were repeated periodically throughout the night.
- 8.40** Mr Omar’s evidence was that the small boat associated with incident ‘Charlie’ started to encounter problems at around 01:00, at which point it was still in the French search and rescue region.⁹⁷ He recalled that water initially entered the back of the boat, near where he was sitting. People started using plastic bottles to bail it out. He believes that the small boat’s engine was still working and it was still moving at this point.⁹⁸ Mr Omar described the deterioration of the situation, as the water entry became uncontrollable and those on board were sitting in rising seawater:
- “It was not long before the water started coming in faster from the bottom of the boat. The water was coming in faster than we could scoop it out, and it was coming up to our knees. We could not do anything to stop it or to fix the boat. The water that was coming into the boat was extremely cold, to the point where my body started to feel numb.”⁹⁹
- 8.41** Mr Omar has described how the situation onboard the small boat was chaotic from the point that it started to take on water. Some people were trying to bail out water, some were trying to keep others calm, some were trying to pump in more air, some were using torches on their phones to try to attract attention, and many were making calls, both to seek help and to speak to family members. Calls were being made at the same time and in multiple languages.¹⁰⁰ People were panicked and some were screaming.¹⁰¹

⁹⁶ INQ007649, INQ007650.

⁹⁷ The Inquiry has not been provided with the calls between incident ‘Charlie’ and the French Coastguard. French media has reported the existence of an emergency situation when the small boat was still in French territorial waters: INQ010469.

⁹⁸ INQ010388/15/par85-86.

⁹⁹ INQ010388/15/par87.

¹⁰⁰ INQ010388/16/par88-90.

¹⁰¹ INQ010388/17/par98.

- 8.42** As water was entering the small boat, at or around 01:06, which was around 10 minutes after the French tracker was first sent, the French Coastguard first mentioned incident 'Charlie' (French reference '7') to HM Coastguard. This was during a call made by HM Coastguard to CROSS Gris-Nez to query the correctness of one set of co-ordinates recorded on the French tracker.¹⁰² The call was made by the non-operational trainee who wrote down the information received on a piece of paper.¹⁰³ On that call, the French Coastguard said that incident 'Charlie' was the small boat that was closest to the median line and the UK search and rescue region, at co-ordinates 51°06.51N, 001°46.21E.¹⁰⁴ The co-ordinates put incident 'Charlie' 0.6 nautical miles (nm) from the median line. The French Coastguard also provided two telephone numbers for incident 'Charlie' (a UK mobile telephone number ending in 095 and a German mobile telephone number ending in 666).¹⁰⁵ They reported that there were 33 people on board, including 13 women and eight children, with 14 people wearing lifejackets.
- 8.43** At 01:15, incident 'Charlie' was created on ViSION by Mr Downs on the basis of the information that he received from the non-operational trainee as recorded on the piece of paper.¹⁰⁶ Mr Downs entered this information into the incident 'Charlie' ViSION log. He recorded that incident 'Charlie' "appear[ed] in good condition".¹⁰⁷ However, the record of the small boat's condition was made in error. On the call at 01:06 between the French Coastguard and the non-operational trainee, the French Coastguard had reported that small boat '1' was said to be in "good condition".¹⁰⁸ No information had been given by the French Coastguard about the condition of incident 'Charlie' (French reference '7'). A few minutes after the creation of incident 'Charlie' in the ViSION system, the

102 INQ007647.

103 INQ004737, INQ010720/133/ln7-17.

104 INQ007647/2.

105 This UK number was saved onto the Coastguard's mobile phone under the name 'Charlie 24 Nov'. At 01:43, an SMS message was sent from the Coastguard's mobile phone to this number and there were two missed calls from this number to the Coastguard's mobile phone at 02:04 and 02:10: INQ009434/11-12/par3.9-3.10, 13/3.13. It appears that this German number was incorrect by one digit. A near identical German mobile telephone number (ending in 166) was saved onto the Coastguard's mobile phone under the name 'Charlie 24 Nov' at 01:44: INQ009434/11/par3.9. A text message was sent from the Coastguard's mobile phone to this number at 01:44, to which there was no reply, and there was no further communication with this number: INQ009434/13/par3.13.

106 INQ000237/1.

107 INQ000237/3-4.

108 INQ007647/3. The relevant extract is as follows:

"...COASTGUARD: Okay, the Flamant is not with migrant one?

FRENCH COASTGUARD: For the moment, no. But the dinghy is in good condition.

COASTGUARD: Okay, is the position of the boat you've just given --?

FRENCH COASTGUARD: The last position, I see. The last position is 5 1 degree, 0 4 5 4 minutes north. And longitude 1 degree 5 8 decimal 2 4 minutes east. This is the last position I have.

COASTGUARD: Of migrant one..."

co-ordinates and telephone numbers received on the call at 01:06 were added into the HM Coastguard tracker by Mr Barnett at the JRCC.¹⁰⁹

- 8.44** At around 01:20, Mr Downs at MRCC Dover called Border Force MCC about incident 'Charlie' (French reference '7') which, on the basis of the location co-ordinates provided by the French Coastguard at 01:06, he considered would have reached UK territorial waters by that point.¹¹⁰ The error about the small boat's condition was repeated by Mr Downs in this call. He also relayed an incorrect number of people on board (the French Coastguard had said there were 33, whereas Mr Downs told Border Force MCC that there were 30).
- 8.45** The Border Force cutter, the Valiant, was tasked directly after this call, at or around 01:25, when Ms Whitehouse's daybook records a call to the Valiant regarding incident 'C' ('Charlie').¹¹¹ At 01:29, Border Force MCC called MRCC Dover back to confirm the tasking.¹¹² The reason that the Valiant was tasked to incident 'Charlie' was because it was the first small boat to reach the UK's search and rescue region. At that stage, HM Coastguard had no knowledge that the small boat associated with incident 'Charlie' was in difficulty.
- 8.46** At around 01:28, the French Coastguard called MRCC Dover again to say that incident 'Charlie' was by then in the UK search and rescue region.¹¹³ The French Coastguard also provided an updated geolocation position obtained from those on board the small boat via WhatsApp (51°07.25N 001°45.22E) and a new number for those on board (a Turkish mobile telephone number ending in 879).¹¹⁴ Responsibility for the search and rescue of incident 'Charlie' was formally passed from the French Coastguard to HM Coastguard at this point.

01:30 to 02:26 on 24 November 2021

- 8.47** At around 01:30, Mr Gibson returned to the search and rescue team at MRCC Dover and Mr Barnett's period of providing remote SMC cover came to an end. Due to the increasing number of calls from small boats at the point when Mr Gibson returned, he and Mr Barnett did not have any significant handover discussion.¹¹⁵ A few minutes after his return, Mr Gibson started updating

109 INQ006778.

110 INQ007648/3.

111 INQ000565/1. Commander Kevin Toy's log records a call with Border Force MCC at 01:30: INQ002053. Border Force shortened the phonetic alphabet references used by HM Coastguard to the first letter of that word.

112 INQ007589/2.

113 INQ007651/2.

114 This Turkish mobile telephone number was saved onto the Coastguard's mobile phone under the name 'Charlie 24 Nov' / 'Charlie 24 November' at 01:45 and 01:49, respectively, on 24 November 2021: INQ009434/11/par3.9. A geolocation location position was sent from this phone to the Coastguard's mobile phone at 02:20: INQ009434/43-44/par3.20.

115 INQ010719/80/ln1-8.

ViSION logs. His first entry in the incident 'Charlie' ViSION log following his return was to change the incident grade from 'M' (the 'monitoring' phase) to 'D' (the 'distress' phase). He recorded that the change in incident grade was because HM Coastguard had received information that the small boat was now in UK territorial waters. The earlier error about the condition of the small boat associated with incident 'Charlie' was not relied on by Mr Gibson. He recorded that the condition of the small boat was unknown and there were no French assets on scene with it.¹¹⁶

- 8.48** Five minutes after Mr Gibson had returned to the search and rescue team in MRCC Dover, further calls from the small boat associated with incident 'Charlie' were received by MRCC Dover. Mr Omar's evidence was that calls for help were made both to the French Coastguard and HM Coastguard as soon as water started entering the small boat uncontrollably.¹¹⁷ At around 01:35, another call was received that was attributed to incident 'Alpha.' As with the call at 00:26, this was in fact a call from someone on board incident 'Charlie'. However, HM Coastguard did not link the two incidents definitively that night.¹¹⁸ The call was transferred from the Port of Dover operator who said that there was "a man screaming down the phone" but the call dropped before it could be transferred.¹¹⁹
- 8.49** Approximately two minutes later, at 01:37, MRCC Dover received the first call from incident 'Charlie' that connected.¹²⁰ This was from the same mobile telephone number as the calls at 00:26 and 01:35, which has been identified as belonging to Mr Husain Tanha, an Afghan national who is among the deceased.¹²¹ However, at the time this call was attributed by MRCC Dover to incident 'Foxtrot' (which was later in the night found to be a duplicate of incident 'Alpha'). The caller was in considerable distress and said those on board were "in the water" and "everything [was] finish[ed]". There was considerable background noise and shouting which made communication difficult. MRCC Dover passed HM Coastguard's mobile phone number to the caller. When the caller said that he had no internet in order to send a geolocation position, the HM Coastguard call handler said to call 999 to try to get a position that way.¹²² The call then ended. A few minutes later, at 01:45, there was a further call from someone on board incident 'Charlie' (that MRCC Dover again attributed to incident 'Foxtrot') but it again cut out before it could be transferred to MRCC Dover.¹²³

116 INQ000237/5.

117 INQ010388/16/par88.

118 HM Coastguard has since recognised that incident 'Alpha' is a repeat of incident 'Charlie.'

119 INQ007639/2.

120 INQ007591.

121 See paragraph 8.33.

122 INQ007591/5.

123 INQ007592.

- 8.50** At around the same time as Dover MRCC was in contact with callers on board the small boat associated with incident ‘Charlie’, at 01:43, Border Force MCC contacted 2Excel to follow up on the planned flight. Border Force MCC had not been informed by HM Coastguard that 2Excel would be unable to fly its scheduled fixed-wing surveillance flight due to the weather. 2Excel indicated that it had cancelled its first planned flight, its second planned flight was postponed until 03:00 and it was assessing the weather.¹²⁴
- 8.51** Mr Golden did not make enquiries with Bristow helicopters at this stage. He told the Inquiry that this was his “back pocket thought process” and that as “the ever-optimist”, he was holding out for the possibility that 2Excel would be able to get airborne later that night.¹²⁵ Mr Golden also told the Inquiry that he briefly considered and dismissed tasking an aircraft operated by RVL or Tekever to replace the fixed-wing surveillance flight, because he considered that “they would not be willing to fly low enough to the sea to see any vessels”.¹²⁶ He did not record his thought process or reasons on the night.
- 8.52** As a result of 2Excel’s cancelled surveillance flight, there was an awareness within Border Force and HM Coastguard that there were likely to be difficulties for the Valiant in locating the small boat associated with incident ‘Charlie’. Before the Valiant had left her berth at Dover, in a call at or around 01:38, Border Force MCC queried with Mr Downs at MRCC Dover how the Valiant would be able to locate and get locked on to incident ‘Charlie’ in the absence of aerial coverage and information as to the small boat’s course and speed.¹²⁷ Mr Downs apologised and said they would attempt to get a position by WhatsApp, but that currently the best advice was to “head from the UK towards [the French position] and hopefully you’ll come across them.”¹²⁸
- 8.53** At 01:48, MRCC Dover received the second iteration of the French tracker sent that night.¹²⁹ This now contained 10 incidents, including incident ‘Charlie’ (identified as French reference ‘7’). This contained different co-ordinates for incident ‘Charlie’ from those provided by the French Coastguard at 01:06 and 01:28, which the tracker identified as having been obtained at 01:30 (51°07.4N, 001°45.4E).
- 8.54** At the same time that it sent the French tracker, the French Coastguard called MRCC Dover to transfer a call from the small boat identified with incident ‘Charlie’.¹³⁰ The call was answered by Mr Gibson. The caller identified his name

124 INQ003895/2.

125 INQ010718/145/ln6-13.

126 INQ009628/31/par80, INQ010718/146/ln6-15.

127 INQ007652/3.

128 INQ007652/3.

129 INQ007692.

130 INQ007630.

as ‘Mubin’, although Mr Gibson mis-recorded this as ‘Moomin’.¹³¹ The caller was Mubin Rizghar Hussein, an Iraqi Kurdish boy who was aged 16 at the time and is among the deceased.¹³² There was significant background noise and shouting, consistent with Mr Omar’s evidence of the level of panic and distress on board.¹³³ Mubin said that they were “in the water” and were “finished”. He asked for HM Coastguard’s mobile phone number which was relayed to him by Mr Gibson. Geolocation information was sent via WhatsApp during the call, at 02:01, which provided the co-ordinates 51.146556, 1.748656.¹³⁴ Mubin said there were 40 people on board. An additional, new telephone number was obtained by MRCC Dover and linked to incident ‘Charlie’ (a UK mobile telephone number ending in 057), which was saved by MRCC Dover on its mobile phone at 01:59.¹³⁵ By this point, HM Coastguard had saved four telephone numbers in its mobile phone for incident ‘Charlie’.

- 8.55** During the latter part of the call between Mr Gibson and Mubin, it became apparent that those on board the small boat associated with incident ‘Charlie’ could see another vessel. Mr Gibson told the Inquiry that he used the co-ordinates received by WhatsApp at 02:01 to identify the GasChem Shinano, a liquefied petroleum gas tanker, as the vessel most likely to have been seen by those on board the small boat associated with incident ‘Charlie’.¹³⁶ HM Coastguard then made contact with the GasChem Shinano via VHF radio. Its crew reported that no small boats could be seen in its vicinity.¹³⁷ It was permitted to continue on its way and had no further contact with HM Coastguard that night.¹³⁸
- 8.56** The call between Mr Gibson and Mubin lasted 21 minutes. During the call and shortly after it ended, those on board the small boat associated with incident ‘Charlie’ called and messaged HM Coastguard’s mobile phone. At 02:04 and 02:10, calls were made from a mobile telephone number linked to incident

131 INQ000237/6 .

132 See paragraph 13.5.

133 INQ010388/17/par98.

134 INQ009434/13/par3.12, 42/par3.20. The co-ordinates provided via WhatsApp are Ellipsoidal co-ordinates (longitude and latitude). These were converted into Cartesian co-ordinates (eastings and northings) for the Mayday relay broadcast. See paragraph 8.63.

135 INQ009434/11/par3.9. The digital forensics report received by the Inquiry shows that this was the mobile telephone number associated with incident ‘Charlie’ that HM Coastguard had most communication with, namely: messages sent by HM Coastguard at 02:00, 02:07 and 02:09 requesting location information (INQ009434/13-18/par3.13-14.), two geolocation positions sent in response at 02:01 and 02:21 (INQ009434/15/par3.14), two voice calls missed by HM Coastguard at 02:57 and 03:12 (INQ009434/16/par3.14), and a message and failed call made by HM Coastguard on WhatsApp at 03:33 and 04:16, respectively (INQ009434/16/par3.14). French investigators believe this phone was linked to the deceased, Shakar Ali Pirot: INQ008905/35/par4.1.6.

136 INQ010392/47/par89.

137 INQ007393/2.

138 INQ007394/2.

‘Charlie’ which were not answered.¹³⁹ In addition to the geolocation position sent at 02:01, two further geolocation positions were sent at 02:20 and 02:21 by people on board the small boat.¹⁴⁰ The updated geolocation positions were not picked up until approximately an hour later, when Mr Gibson recorded those co-ordinates in the ViSION log for incident ‘Charlie’ at 03:28.

- 8.57** While Mr Gibson was speaking to Mubin, the Valiant was preparing to leave her berth at Dover. At 01:50, a Criminal and Financial Investigations Officer was embarked.¹⁴¹ This was a Home Office staff member embedded on each Border Force vessel whose focus was on enforcement and obtaining evidence relevant to potential future prosecutions for a range of immigration offences.¹⁴² Very shortly after their arrival on board, at 01:53, the Valiant left its berth at Dover.¹⁴³ It then took around 30 minutes from this point for the Valiant to clear the port of Dover.¹⁴⁴
- 8.58** At 02:04, there was a call between 2Excel and Mr Golden where the possibility of 2Excel getting airborne at all that night was discussed and discounted.¹⁴⁵ Mr Golden referred to the assumption that HM Coastguard would always get an aircraft and asked, rhetorically, what was the “plan B” for when the fixed-wing aircraft could not fly.
- 8.59** Directly after his call with 2Excel, at 02:14 Mr Golden called the captain of the search and rescue helicopter, R163, operated by Bristow, to alert him to a potential tasking. He requested that R163 launch to conduct a patrol tasking in the absence of 2Excel’s planned surveillance flights.¹⁴⁶ On this call, Mr Golden again said that the absence of situational awareness caused by the failed surveillance flight had the potential to “turn out to be a bit of a disaster”. The call ended with the captain of R163 saying that he would call back after he had gathered his thoughts.
- 8.60** Shortly afterwards, they spoke again and Mr Golden provided more detail.¹⁴⁷ He said that “as usual, that catalogue of phone calls is beginning to trickle in of the, you know, the classic, I’m lost, I’m sinking, my mother’s wheelchair is falling over the side, et cetera”. He also noted that Border Force had only launched one vessel and that they were not prepared to send any others out “unless we can convince them that there are people in real danger”. The captain of R163

139 INQ009434/12/par3.10.

140 INQ009434/15/par3.14.

141 INQ002053.

142 INQ010136/21/par59, INQ010717/19/ln6-19.

143 INQ002053.

144 INQ010136/23/par64-65.

145 INQ007824.

146 INQ007825/2-3.

147 INQ010697.

observed that the weather conditions, including fog and cloud, may make a search for small boats ineffective and that he would speak with his co-pilot, who was asleep at that point, before deciding whether to accept the tasking.

- 8.61** At 02:17, there was a further call from a mobile telephone number linked to incident 'Charlie' lasting for three minutes.¹⁴⁸ The call was made to HM Coastguard's mobile phone and was answered by the non-operational trainee at MRCC Dover. The call was not recorded as HM Coastguard's mobile phone was not integrated into its information management systems. No record of it was made in the ViSION logs. It is unknown what was said during this call.
- 8.62** At 02:25, Mr Downs answered a call from someone identifying as 'Jonas' or 'Jomash' who was on board a small boat.¹⁴⁹ The caller said: "[W]e need a rescue boat, please. We are sinking, We almost sink." He told Mr Downs that they had left from Dunkirk at 21:00, they had lost the engine and could see a big ship some way off. There was significant background noise and distressed shouting. The phone call lasted approximately five minutes before cutting out. Mr Downs had not obtained a phone number from the caller and the operator was unable to provide any Enhanced Information Service for Emergency Calls information, which was the system enabling information about the caller including telephone number and location data to pass to the emergency services. Mr Downs opened a ViSION log for this call but it was not given a phonetic alphabet reference. Around 20 minutes later (at 02:48), Mr Gibson identified this call as originating from incident 'Charlie' and closed the separate ViSION log.¹⁵⁰

02:27 to 02:42 on 24 November 2021

- 8.63** At 02:27, a Mayday relay was broadcast for incident 'Charlie'.¹⁵¹ Mr Gibson told the Inquiry that he decided to do so as a result of his call starting at 01:48 with Mubin, which he said left him with a gut feeling that there was a real emergency.¹⁵² The broadcast itself was undertaken by the Channel 16 operator at the JRCC. It said:

"Mayday relay, Mayday relay. Mayday relay. All stations, all stations, all stations. This is Dover Coastguard. Dover Coastguard, Dover Coastguard.

Mayday information number one. Small craft with 40 persons onboard in position 5108 decimal 5 north, 00144 decimal 5 east. This bears 244 degrees 1 decimal 8 nautical miles from the Sandettie lightvessel. Taking water and requiring immediate assistance.

Any vessel that can assist to contact Dover Coastguard..."

¹⁴⁸ INQ010392/50/par97, INQ001418.

¹⁴⁹ INQ007654/2.

¹⁵⁰ INQ000245/3.

¹⁵¹ INQ007660.

¹⁵² INQ010392/48/par90.

- 8.64** The text of the broadcast indicated clearly that it was a Mayday relay and a 'distress' incident. However, the JRCC operator used the 'panpan' digital selective calling alert, which was to be used for an incident in the 'urgency' phase and was therefore incorrect. As a result of the remote involvement of the JRCC in the broadcast of the Mayday relay and its operation of Channel 16, Mr Gibson was unaware that the incorrect digital selective calling classification had been used.¹⁵³
- 8.65** The co-ordinates given in the Mayday relay were those obtained via WhatsApp at 02:01.¹⁵⁴ At the time of the Mayday relay broadcast, MRCC Dover had not seen the updated positions sent by those on board the small boat associated with incident 'Charlie' to the Coastguard mobile phone at 02:20 and 02:21.¹⁵⁵ These updated positions were therefore not used.
- 8.66** The ViSION log for incident 'Charlie' recorded an entry by Mr Gibson at 02:28 that the French vessel, the Flamant, was the closest government vessel to the small boat in distress.¹⁵⁶ However, the Flamant did not contact MRCC Dover in response to the Mayday relay broadcast.
- 8.67** At around the time of the first Mayday relay broadcast, for approximately 10 minutes between 02:29 and 02:42, the HM Coastguard tracker showed erroneously that incident 'Charlie' had been resolved. Mr Barnett at the JRCC added an explanatory note that the French Coastguard had reported that search and rescue was complete.¹⁵⁷ The French tracker sent at 02:24 had recorded incident 'Charlie' (French reference '7') as resolved from a French search and rescue perspective as it was no longer in the French search and rescue region.¹⁵⁸ The erroneous entry in the HM Coastguard tracker confused Border Force MCC, who had live access to the HM Coastguard tracker and called MRCC Dover to raise a query about the status of incident 'Charlie'.¹⁵⁹ During this call, MRCC Dover confirmed that the incident remained ongoing and, at 02:42, the error in HM Coastguard's tracker was corrected by the JRCC.¹⁶⁰
- 8.68** By around 02:30, the Aviation and Maritime Tactical Commanders were aware that the weather was forecast to deteriorate further at around dawn and would improve again from around 10:00 onwards, meaning that there was a small weather window before dawn to get an aircraft airborne. At 02:31, the Maritime Tactical Commander, Mr Jones, made an entry to that effect in the migrant

153 INQ010392/55/par105.

154 See footnote 134 of Chapter 8.

155 INQ009434/12-13/par3.12, 44/par3.20.

156 INQ000237/7.

157 INQ006788.

158 INQ007693.

159 INQ007593/2.

160 INQ006791.

administration log, which was the ViSION log used to record generic information about small boats that could not be attributed to any specific incident. Mr Jones again referenced the absence of any recognised maritime picture due to the failed 2Excel surveillance flights and noted that the suggested course of action in order to obtain some situational awareness was for the Aviation Tactical Commander to speak to the captain of the helicopter R163, with a view to getting the helicopter airborne between 03:00 to 05:30.¹⁶¹

- 8.69** At 02:31, the Valiant responded to the Mayday relay. It had just cleared the Port of Dover and a member of its crew called MRCC Dover to query whether the Mayday relay related to the incident to which it had been tasked (incident ‘Charlie’).¹⁶² Mr Downs confirmed that it was the same incident and noted that the Flamant should be closer and that he would let the Valiant know if there was any change to the tasking as a result.¹⁶³ Following the call, at 02:34, Commander Toy recorded in his daybook that he was “proceeding to Mayday”.¹⁶⁴ In his witness statement to the Inquiry, Commander Toy said that while the language used by the Mayday relay of “taking water” is serious, it does not necessarily mean that a small boat is sinking as “[i]t was common for migrant vessels to take on water, given that they were wholly unsuitable for Channel crossings and, in particular, had a very shallow freeboard”.¹⁶⁵ Commander Toy and his crew were not told by HM Coastguard or Border Force MCC that incident ‘Charlie’ was sinking, or that there were potentially people in the water.
- 8.70** Also at 02:31, at the same time that Mr Downs was speaking to the Valiant, there was a further call from those on board incident ‘Charlie’, answered by Mr Gibson. The caller identified himself as ‘Hussain’. He did not identify his surname, but this could have been Mr Husain Tanha, one of the Afghan nationals on board, who had previously been in contact with HM Coastguard by WhatsApp.¹⁶⁶ Mubin also identified himself on the call and spoke again to Mr Gibson.¹⁶⁷ As before, there was significant background noise, shouting, panic and communication difficulties. The callers asked for help, said that they were “finished”, that the “boat [was] finished” and “broken”, and that they were “in the water” and were all dying.¹⁶⁸ They asked where the rescue boat was.¹⁶⁹ Mr Gibson said that he appreciated that everyone was very scared on the boat, but that he had already told them (during his previous call with Mubin that started at 01:48) that a rescue

161 INQ000235/5.

162 INQ007613/2.

163 INQ007613/2.

164 INQ002051/3.

165 INQ010136/23-24/par66.

166 See paragraph 8.33. Mr Omar also recalls that calls were made to HM Coastguard by one of the Afghans who was on board: INQ010388/17/par97.

167 INQ007655/6-8.

168 INQ007655/2, 4, 7, 8.

169 INQ007655/7.

boat was coming and he could not make it go any faster. He told them to stop making calls “because every time [they make] a call [HM Coastguard] think[s] there’s another boat out there”. Mr Gibson said that the rescue boat would arrive in less than half an hour. In the event, the time given was incorrect and the Valiant did not arrive at the Mayday relay position until almost an hour later, at or around 03:24.

- 8.71** The call lasted almost seven minutes before cutting out. No updated geolocation position for incident ‘Charlie’ was requested or obtained by HM Coastguard. In his oral evidence to the Inquiry, Mr Gibson said that he did not request an updated geolocation position because he assumed that those on board would send it.¹⁷⁰ He accepted that “it would have been good” to have requested it.¹⁷¹ An incident log was opened on the ViSION system for the call but was not given a phonetic alphabet reference and was closed at 02:40 by Mr Gibson as a repeat of incident ‘Charlie’.¹⁷²
- 8.72** In his witness statement, Mr Downs told the Inquiry that he recalled telling Mr Barnett that Mr Gibson was “having a row with someone called Moomin [sic]”.¹⁷³ In his oral evidence, Mr Downs clarified that what he meant by “having a row” was that Mr Gibson was trying to calm things down in a raised voice.¹⁷⁴ Mr Gibson, in his oral evidence to the Inquiry, said that the instruction not to call again was a request to those on board to be patient.¹⁷⁵ He also said that at this point he started to question his initial gut instinct that there was an emergency and questioned whether those on board incident ‘Charlie’ were in fact exaggerating their level of distress because the rescue boat had not arrived quickly enough.¹⁷⁶ The Inquiry heard evidence from HM Coastguard operational staff that there was a widely held belief in 2021 that callers from small boats regularly exaggerated their level of peril with the aim of being rescued more quickly.¹⁷⁷
- 8.73** At 02:41, Mr Christopher Trubshaw, the captain of the search and rescue helicopter R163, called the Aviation Tactical Commander, Mr Golden, to accept the patrol tasking that had been requested in the initial call at 02:14.¹⁷⁸ He indicated that the earliest that R163 would be airborne was by around 03:30.

170 INQ010715/114/ln5-13.

171 INQ010715/114/ln22-25.

172 INQ000247.

173 INQ010208/22-23/par97.

174 INQ010720/145/ln9-11.

175 INQ010715/117-118/ln8-7.

176 INQ010715/119/ln2-8: “...‘We’re all going to die, we’re all going to die’, is it exaggeration now, because we keep getting these phone calls without any more information? And I think this is where it starts to generate to me – is the level of distress being exaggerated because it is, you know, the boat’s not come quick [sic] enough?...”.

177 See paragraphs 6.69 to 6.70 and 12.18 to 12.22.

178 INQ007389/2. For the 02:14 call, see paragraph 8.59.

Mr Golden gave an initial outline of the tasking, which was to patrol the median line by flying up and down for 90 minutes. He said he would ask MRCC Dover to refine these instructions. Mr Golden also added that they were “now dealing with a distress [situation]” because “the first couple of calls, as you can imagine, are coming in now, of sharks with lasers surrounding the boats and we’re all dying type thing coming in”.¹⁷⁹ Mr Golden said that if “what [he] call[ed] a true SAR [search and rescue] incident” arose while R163 was undertaking this tasking, he would have to obtain another search and rescue helicopter from another location.¹⁸⁰

- 8.74** At 02:42, HM Coastguard received, for the first time, information about the condition of incident ‘Charlie’ from a source other than in a call from those on board the small boat itself, namely from the French Coastguard. Mr Gibson answered the call. The French Coastguard said that those on board incident ‘Charlie’ had said to them: “[H]elp me, help me, help me. We are in the water.”¹⁸¹ The French Coastguard speaker observed that her colleague was on the phone with the small boat associated with incident ‘Charlie’ at the same time. She said: “They call us and it’s not good for our other cases.”¹⁸² She then asked whether MRCC Dover had sent a rescue boat. Mr Gibson said that the Valiant was making best speed and the Flamant was “probably the closer vessel to respond if they are sinking”.¹⁸³ When, in response, the French Coastguard speaker said that she was not sure because the Flamant was then with another small boat, Mr Gibson said: “We did a Mayday relay for any vessel to respond as it was sinking”, and that the Flamant “obviously ...would be the quickest vessel to respond”.¹⁸⁴ The French Coastguard speaker audibly gasped on being told that the Valiant would take around 40 minutes to arrive on the scene but then abruptly ended the call.¹⁸⁵
- 8.75** There was no follow-up call between MRCC Dover and the French Coastguard relating to incident ‘Charlie’. Mr Gibson told the Inquiry that he heavily implied that the Flamant should attend the Mayday relay, but accepted that he did not specifically or directly make a request of the French Coastguard that the Flamant be tasked to incident ‘Charlie’.¹⁸⁶

179 INQ007389/3.

180 INQ007389/4.

181 INQ007656/2. The French Coastguard indicated on this call that incident ‘Alpha’ is a duplicate of incident ‘Charlie’ because the telephone numbers matched.

182 INQ007656/4.

183 INQ007656/3.

184 INQ007656/4.

185 INQ007656/5.

186 INQ010392/62/par118.

02:43 to 03:16 on 24 November 2021

- 8.76** The search and rescue helicopter, R163, was tasked following the call between Mr Trubshaw and Mr Golden at 02:41.¹⁸⁷ The tasking time was recorded by Mr Golden in the aerial search and rescue ViSION log as 02:51.¹⁸⁸ The mission was recorded as: “identify/localise positions of migrant vessels”.¹⁸⁹ Shortly afterwards, Mr Golden recorded an ‘AIR RAG’, which refers to a ‘review, assess, guidance’ (RAG) review conducted by an Aviation Tactical Commander.¹⁹⁰ This identified two areas of concern in relation to the tasking of R163. The first was visibility at Lydd given the risk of fog, and the second was identified as ‘mission creep’ and the over-use of R163.¹⁹¹ In his witness statement to the Inquiry, Mr Golden explained that his concern over mission creep related to the risk that the tasking would be extended by the maritime branch of HM Coastguard beyond a 90-minute surveillance flight with the effect of further reducing the availability of R163 on 24 November 2021.¹⁹²
- 8.77** At 02:45, the Mayday relay broadcast was repeated using the same text as the 02:27 broadcast.¹⁹³ As before, the incorrect digital selective calling alert of ‘urgency’ (rather than ‘distress’) was used.¹⁹⁴
- 8.78** At or around 02:50, the captain of R163, Mr Trubshaw, called MRCC Dover to request initial instructions.¹⁹⁵ Mr Gibson changed the instructions given by Mr Golden (a patrol along the median line) to a patrol of a rectangular box between the MPC Buoy up to the Sandettie Light Vessel.¹⁹⁶ Mr Gibson explained that the small boats were somewhere between the two search markers he had given and referred to the Valiant attending one small boat.¹⁹⁷ Mr Gibson did not mention incident ‘Charlie’ by name or tell Mr Trubshaw that a Mayday relay had been broadcast for a small boat in an emergency situation, or that there was a small boat sinking with potentially people in the water.
- 8.79** At 02:54, HM Coastguard received the first response to the Mayday relay broadcast. The Sixtine (a cargo ship) told HM Coastguard that it was within 4nm of the Mayday relay position and that it had had no sightings of a small boat.¹⁹⁸ It was permitted to continue on its way by HM Coastguard.

187 See paragraph 8.73.

188 INQ000226/3. There are minor variations of the tasking time across the ViSION logs. It is recorded as 02:47 in the migrant administration ViSION log: INQ000235/6.

189 INQ000226/4.

190 See paragraph 4.46 for an explanation of ‘RAG review’.

191 INQ000226/4-5.

192 INQ009628/34/par87.

193 INQ007823.

194 See paragraph 8.64.

195 INQ007601/2.

196 INQ008823/2-3.

197 INQ008823/5.

198 INQ007772 .

- 8.80** At 02:57, there was a further attempt made by those on board incident ‘Charlie’ (using the UK mobile telephone number ending in 057) to contact MRCC Dover by calling HM Coastguard’s mobile telephone. However, the call was not answered.¹⁹⁹
- 8.81** At 03:00, the third Mayday relay broadcast was made.²⁰⁰ Again, the text was identical to the initial broadcast and the incorrect digital selective calling alert was used.
- 8.82** At around the same time, Mr Gibson began reconciling outstanding incidents. At 03:01, incident ‘Bravo’, whose ViSION log had only been populated with information received from the French tracker at 00:56, and corresponded to French reference ‘1’, was closed by Mr Gibson as a repeat of incident ‘Charlie’.²⁰¹ No reasons were provided, although it is likely that Mr Gibson was guided by the French tracker sent at 02:24, which had recorded small boat ‘1’ as resolved on the basis that it was possibly a duplicate of incident ‘Charlie’.²⁰² At 03:02, Mr Gibson closed incident ‘Alpha’ as a duplicate of incident ‘Foxtrot’. Despite the French Coastguard having identified ‘Alpha’ as a further duplicate of incident ‘Charlie’ on the call with HM Coastguard at 02:42, HM Coastguard did not reconcile incidents ‘Alpha’ and ‘Foxtrot’ as duplicates of incident ‘Charlie’ on 23 to 24 November 2021. At 03:06, Mr Gibson entered on the ViSION log for incident ‘Foxtrot’ that the calls from incidents ‘Alpha’ and ‘Foxtrot’ had a “very similar story and background noise to calls for Charlie”.²⁰³ It has since been confirmed by HM Coastguard that incidents ‘Alpha’ and ‘Foxtrot’ were duplicates of incident ‘Charlie’.²⁰⁴
- 8.83** Between around 03:02 and 03:04, the merchant vessel Concerto repeatedly attempted to contact MRCC Dover. At around 03:03, HM Coastguard responded to tell Concerto to transfer to another VHF channel to await its call.²⁰⁵ However, for unknown reasons, HM Coastguard has no record of any further calls with Concerto. At around the same time (03:02), the Concerto contacted the French Coastguard to respond to MRCC Dover’s Mayday relay, reporting that it had not had any sightings at that time.²⁰⁶
- 8.84** At 03:06 and 03:12 there were two calls to MRCC Dover, both taken by Mr Downs, which contained a narrative and background noise consistent

199 INQ009434/44/par3.20, INQ001424.

200 INQ007553.

201 INQ000236/5.

202 INQ007693. The French tracker also recorded small boat ‘9’ (corresponding to HM Coastguard’s reference ‘India’) as a possible duplicate of incident ‘Charlie’ and this was closed as a duplicate by Mr Gibson at 03:58: INQ000242/3.

203 INQ000239/4.

204 INQ008905/34-35/par 4.1.4.

205 INQ010696/2.

206 INQ006210/2.

with incident ‘Charlie’.²⁰⁷ It cannot be proven definitively that these calls originated from incident ‘Charlie’ as Mr Downs did not obtain a telephone number or caller name from either call. However, it is known that the people on board the small boat associated with incident ‘Charlie’ were attempting to contact HM Coastguard at around this time. In addition to the missed call to HM Coastguard’s mobile phone at 02:57, a further attempt to call the mobile phone was made by those on board the small boat at 03:11. Again, the call went unanswered. The recollection of the survivor, Mr Omar, was that “desperate calls were being made right up until the moment [they] capsized”.²⁰⁸ Mr Gibson also recognised on the night that MRCC Dover “had the same boat calling regularly” which had generated many incidents.²⁰⁹

8.85 The person on the call to MRCC Dover at 03:06, which lasted for a minute and a half, said that there were 34 to 35 people on board, the boat was sinking, and that “part of [their] body [was] in the sea” before the call cut out.²¹⁰ Enhanced Information Service for Emergency Calls information could not be obtained.²¹¹ The information that sea water had filled the small boat to the extent that those on board were sitting in it was consistent with Mr Omar’s evidence to the Inquiry.²¹²

8.86 During the call at 03:12, which lasted around four and a half minutes, the caller repeatedly asked for help and said that they were “finished” and “in the water”.²¹³ HM Coastguard repeatedly asked the caller where he was, and when the caller was unable to provide a location beyond being in UK waters, he was told to call 999 and that if it did not work then he was “probably still in French waters”.²¹⁴ The caller said “no” in response and the call then cut out.²¹⁵ Neither a mobile number nor a geolocation position was requested from the caller. The following extract is taken from a transcript of the call:

“[...]

HM COASTGUARD: Okay, where are you?

MALE SPEAKER 1: On the water, on the water.

HM COASTGUARD: Okay, whereabouts in the water?

207 INQ007657, INQ007658.

208 INQ010388/17/par98.

209 INQ007602/2.

210 INQ007657/3-4.

211 INQ007657/4.

212 See paragraph 8.40.

213 INQ007658/2-6.

214 INQ007658/6-7.

215 INQ007658/7.

MALE SPEAKER 1: In the water.

HM COASTGUARD: Okay, I get you're in the water, but whereabouts? It's a big, big sea.

MALE SPEAKER 1: Please can you help me? I'm finished (Inaudible) finished, can you please? Hello?

HM COASTGUARD: Yeah I –, yeah whereabouts are you? The English Channel is a big place. Hello?

MALE SPEAKER 1: Finish, finish, (Inaudible) finish.

HM COASTGUARD: But where are you?

MALE SPEAKER 1: On the water, on the water.

HM COASTGUARD: I know you're on the water. You don't need to keep shouting at me that you're on the water. I know that. But whereabouts on the water?

MALE SPEAKER 1: England water, England water.

HM COASTGUARD: English water, okay. Whereabouts in the English water?

MALE SPEAKER 1: Yeah, yeah.

HM COASTGUARD: Whereabouts?

MALE SPEAKER 1: Yeah, yeah. (Inaudible)

HM COASTGUARD: Whereabouts are you in the English waters?

MALE SPEAKER 1: Yeah, yeah, English water.

HM COASTGUARD: Okay, if you hang up and dial 999 then the phone might give me your position.

MALE SPEAKER 1: Now I (Inaudible) my call, brother, there's no again calls.

HM COASTGUARD: There's no what?

MALE SPEAKER 1: There's no again call.

HM COASTGUARD: No, if you hang up and dial 999 and ask for the Coastguard it will give your position --

MALE SPEAKER 1: Yeah, yeah 999 there's no again call.

HM COASTGUARD: If it's not working then you're probably still in French waters.

MALE SPEAKER 1: Yeah, yeah. It's no again call, please can you help me?

HM COASTGUARD: If it won't connect on 999 then you're probably still in French waters.

MALE SPEAKER 1: No." [Call cut out]

8.87 In his oral evidence to the Inquiry, Mr Downs said that as a result of these two calls at 03:06 and 03:12, he understood that there was a small boat sinking with those on board imminently in danger of entering the water fully but that the seriousness of the situation did not register with him because "most boats most evenings would say exactly the same or very similar".²¹⁶ He opened two new incidents on ViSION for each call but failed to attribute a phonetic alphabet reference to either.²¹⁷ Both calls were closed by Mr Downs shortly afterwards as repeats of the ViSION log intended to record generic information about small boat activity (entitled the migrant administration log).²¹⁸ They were not attributed to any incident. In his oral evidence to the Inquiry, Mr Downs said that he believed that Mr Gibson would have been informed about these calls because he had no authority to close an incident without the authority of the SMC.²¹⁹ He was unable to say why the two incidents were closed as repeats of the generic migrant administration log.²²⁰

8.88 While Mr Downs was taking these calls, Mr Willows of Border Force MCC called Mr Gibson at 03:11 to discuss ongoing incidents.²²¹ Mr Willows queried whether incident 'Charlie' remained a Mayday situation. Mr Gibson replied:

"Well, they've told me it's full of water. 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. However, they've basically completely ignored a SOLAS Mayday distress call and – so yeah, it didn't kind of work how I wanted it to, but there was a reason for it. Now it looks like they [the Flamant] are also hot-footing it away at 30 knots which means there is potentially two to three craft just in the vicinity of the border and to the south of Sandettie. So, once the Valiant has dealt with Charlie, there could well be some other vessels within -- in that area."²²²

216 INQ010720/159/ln2-8.

217 INQ000249, INQ000248.

218 INQ000235/6-7.

219 INQ010720/150/ln2-7, 158/ln17-22.

220 INQ010720/149-150/ln23-1.

221 INQ007602.

222 INQ007602/3.

- 8.89** Having recognised the possibility of “other vessels” in the same area, Mr Willows said that they would “wait and see what the sort of numbers are and whether Valiant can deal with that”. Mr Gibson agreed and Mr Willows confirmed that they did not want to deploy any other assets at that point but would wait and see what developed. They both agreed that it was “the dream” not to get more than one asset out.²²³
- 8.90** While they were on the call, at 03:15, a new iteration of the French tracker was received by HM Coastguard and Border Force MCC by email (see Figure 11).²²⁴ This showed 11 small boats in total and provided new information on the location of those small boats that had been identified as being in a similar location to incident ‘Charlie’.

223 INQ007602/3.

224 INQ007695.

Figure 11: French small boats tracker sent from CROSS Gris-Nez to HM Coastguard at around 03:15 on 24 November 2021 (translated from the original French version)

FR Ref	UK Ref	SITREP n°	Detection time (UTC)	Sector	Origin of alert & Detection means	Support embarking migrants (type, colour, L, propulsion)	POB (M/F/child, with/without life jackets)	SRU rallying or searching
1			2102	CANAL DES DUNES	VIGIE DK	SEMI RIGID	40	FLAMANT
2			2224	LEFFRINCKOUCKE	POLICE DK	SEMI RIGID	30	FLAMANT
3			2224	LEFFRINCKOUCKE	POLICE DK	SEMI RIGID	30	FLAMANT
4			2230	CANAL DES DUNES	VIGIE DK	SEMI RIGID	30	
5			2316	WISSANT	POLICE	SEMI RIGID	15	
6			0013	LEFFRINCKOUCKE	POLICE	SEMI RIGID	30	
7	A		0048	MPC Buoy	SAMU 62	SEMI RIGID	33 13 women 8 children	
8			0107	Berck	Police	SEMI RIGID GREY	30 to 40	
9			0111	Dunkirk?	Migrant phone		33 3 women 6 children	
10			0230	Sandétié buoy	Flamant	BLACK	40	FLAMANT
11			0256	Sandétié buoy	Flamant			FLAMANT

SRU in contact or rescue	Estimated route/speed	Last position time (UTC)	Last known position	SRU GB for relay OR FR destination port	Time or HPA of relay or disembarkation (UTC)
	284° / 6 NDS		51°07.40N / 001°42.67E	possible MIG 7 and 9	
	266° / 6 NDS	0230	51°07.16N / 001°55.54E		
	272 ° / 6 NDS	03:10	51°07.00N / 001°43.50	SRR UK	
	AT EARTH		AT EARTH – NO CROSSING		
	AT EARTH		AT EARTH – NO CROSSING		
	276/4NDS	00:00	51°04.58N / 002°25.06E		
	305/ 4	0130	51°07,4N / 001°45,4E	SRR UK Possible MIG 1 and 9	00 44 78 97 83 75 23 + 44 73 09 93 42 96
					07 77 34 39 87
				possible MIG 7 and 1	905418785388 06 46 11 06 05
	300/ 6	03 :00	51°10 N / 001°47 E	SRR UK	
	330/ 5	03 :00	51°09 N / 001°46 E	SRR UK	

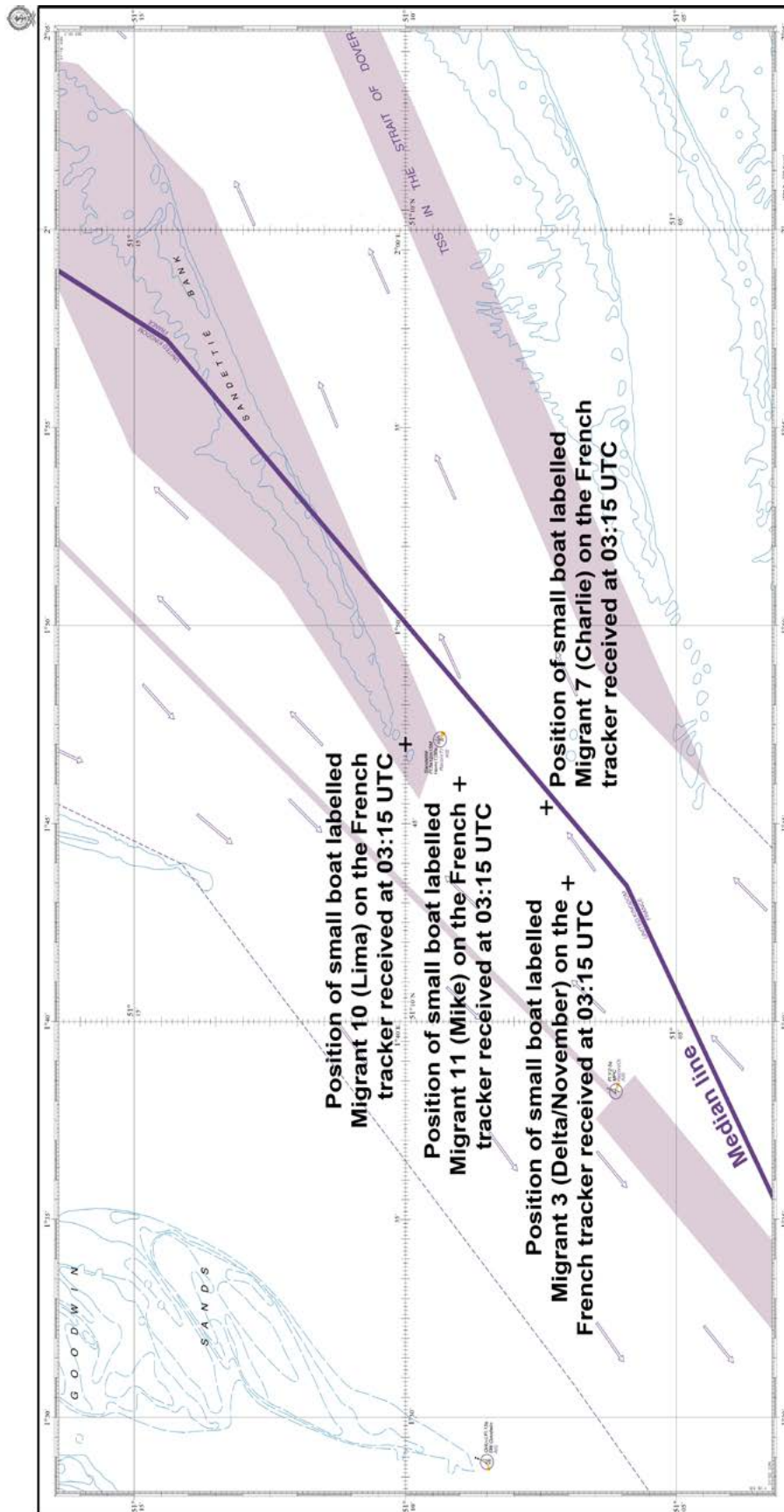
- 8.91** Mr Gibson and Mr Willows both received the updated French tracker during the call and discussed the new information on it. It showed that there were an additional three boats in a similar location to incident 'Charlie', near the Sandettie Light Vessel in the UK search and rescue region. The first was incident 'Delta', which was subsequently reconciled by MRCC Dover to be a repeat of incident 'November' (French reference '3'), and which Mr Gibson calculated was in the "same sort of place as 'Charlie'".²²⁵ The second and third were incidents 'Lima' and 'Mike' (French references '10' and '11' respectively), which Mr Gibson said were "pretty much slap bang on the Sandettie".²²⁶ "Figure 12 shows the positions of the four small boats identified by the French tracker as being in the vicinity of the Sandettie Light Vessel at 03:15.
- 8.92** Mr Gibson recognised that with four small boats in a similar area, the total number of people on board would be "pushing [their] luck for Valiant".²²⁷ However, despite this acknowledgment, HM Coastguard did not reconsider its original decision to wait and see. No other Border Force asset or RNLI lifeboat was tasked that night and there was no further discussion between Mr Gibson and Border Force MCC about whether to revisit the decision to task only the Valiant.

225 Presumably this referred to the 02:01 WhatsApp position as the updated positions sent by the small boat had not been seen by HM Coastguard at this time.

226 INQ007602/5.

227 INQ007602/4.

Figure 12: Positions of the four small boats identified by the French tracker in the vicinity of the Sandettie Light Vessel at 03:15 on 24 November 2021



Reproduced from Admiralty Chart 0323 by permission of the UK Hydrographic Office.

03:17 to 03:47 on 24 November 2021

8.93 It is likely that the small boat associated with incident ‘Charlie’ was swamped and the people on board fully entered the water at a point between 03:17, after the four-and-a-half minute long call which began at 03:12 had finished, and 03:33, the time that a WhatsApp message was sent by HM Coastguard to one of the mobile telephone numbers associated with incident ‘Charlie’. This message was sent after MRCC Dover became aware, at around 03:28, of the updated geolocation positions that had been sent by those on board the small boat to HM Coastguard’s mobile phone at 02:20 and 02:21.²²⁸

8.94 The message sent by MRCC Dover at 03:33 requested that a geolocation position be re-sent but went unanswered and was undelivered. The message shows one grey tick, whereas the previous message sent at 02:07 had two blue ticks.²²⁹ HM Coastguard also tried to call the same telephone number at 04:16 but the call failed.²³⁰ Expert evidence commissioned by the Inquiry concludes that the undelivered status on WhatsApp and the call failure is consistent with the phones of those on board the small boat associated with incident ‘Charlie’ having become submerged in the water and, therefore, no longer functioning.²³¹

8.95 One of the survivors of the incident, Mr Omar, has described the moment when the small boat associated with incident ‘Charlie’ became swamped and all of those on board entered the water fully:

“There was too much movement on the boat at this time and my side of the boat was deflating quickly. People were hysterical and crying and there were more people on my side of the boat than the other, which eventually caused it to tip over. The waves seemed huge at this moment and we all fell into the water. The boat capsized from the side that I was on so I fell into the water on my back. I remember having to swim out from beneath the boat as it flipped on top of me.

The screaming when the boat tipped and people fell in the water was deafening. I have never heard anything as desperate as this. I was not thinking about whether we were going to be rescued anymore; it was all about how to stay alive. It was dark and I could not really see. It was extremely cold and the sea was rough. Even if you were a good swimmer, it was very difficult to carry on in those conditions.”²³²

228 INQ000237/11, INQ009434/15/par3.14.

229 INQ001424.

230 INQ001426.

231 INQ010133/par5.2

232 INQ010388/18/par100-101.

- 8.96** While those on board the small boat associated with incident ‘Charlie’ had either entered or were at imminent risk of entering the water, at 03:19 the fourth (and final) Mayday relay broadcast was made.²³³ The text was the same as the other three broadcasts. However, the correct digital selective calling alert of ‘distress’ was used for the final broadcast.
- 8.97** At 03:23, the Concerto made further contact with the French Coastguard.²³⁴ Whereas 20 minutes earlier it had reported no sightings, at 03:23 the Concerto said that it could see a small craft with people on board.²³⁵ The French Coastguard instructed it to resume passage on the basis that it would take over search and rescue.²³⁶ The French Coastguard did not pass this information on to HM Coastguard.
- 8.98** At or around 03:24, the Valiant arrived at the Mayday relay position. It had taken the Valiant almost two hours from her initial tasking to arrive on scene. At this time, it was likely that those on board the small boat associated with incident ‘Charlie’ had either entered the water fully or were imminently at risk of doing so. The Valiant found nothing at the Mayday relay position which had been sent almost an hour-and-a-half earlier, at 02:01. In a call from the Valiant at 03:24, Commander Toy said he intended to proceed up towards the Sandettie Light Vessel because if the small boat associated with incident ‘Charlie’ had stopped, it may have drifted north.²³⁷ The Valiant was not told by HM Coastguard or Border Force MCC to look for a sinking or swamped small boat or warned that there were potentially people in the water.
- 8.99** At around the same time, the search and rescue helicopter, R163, was preparing to launch. Between 03:26 and 03:43, there was a short delay in getting airborne during which time a technical issue was resolved.²³⁸
- 8.100** At or around 03:30, HM Coastguard received the final response to the Mayday relay. The KWK Excelsus (a crude oil tanker) reported that it had made no sightings of a small boat in distress and was permitted to continue on its way.²³⁹
- 8.101** At 03:34, 10 minutes after the Valiant’s arrival at the Mayday relay position and having proceeded in a northerly direction towards the Sandettie Light Vessel, it identified two small boats using its night vision equipment.²⁴⁰ One small boat was stationary in the water and the other was underway. It proceeded towards the stationary small boat. Figure 13 shows the position of the Valiant at 03:24 and at 03:34.

233 INQ007561.

234 See also paragraph 8.83.

235 INQ006210/2. However, the log does not record the attempted contact with MRCC Dover.

236 INQ006210/2.

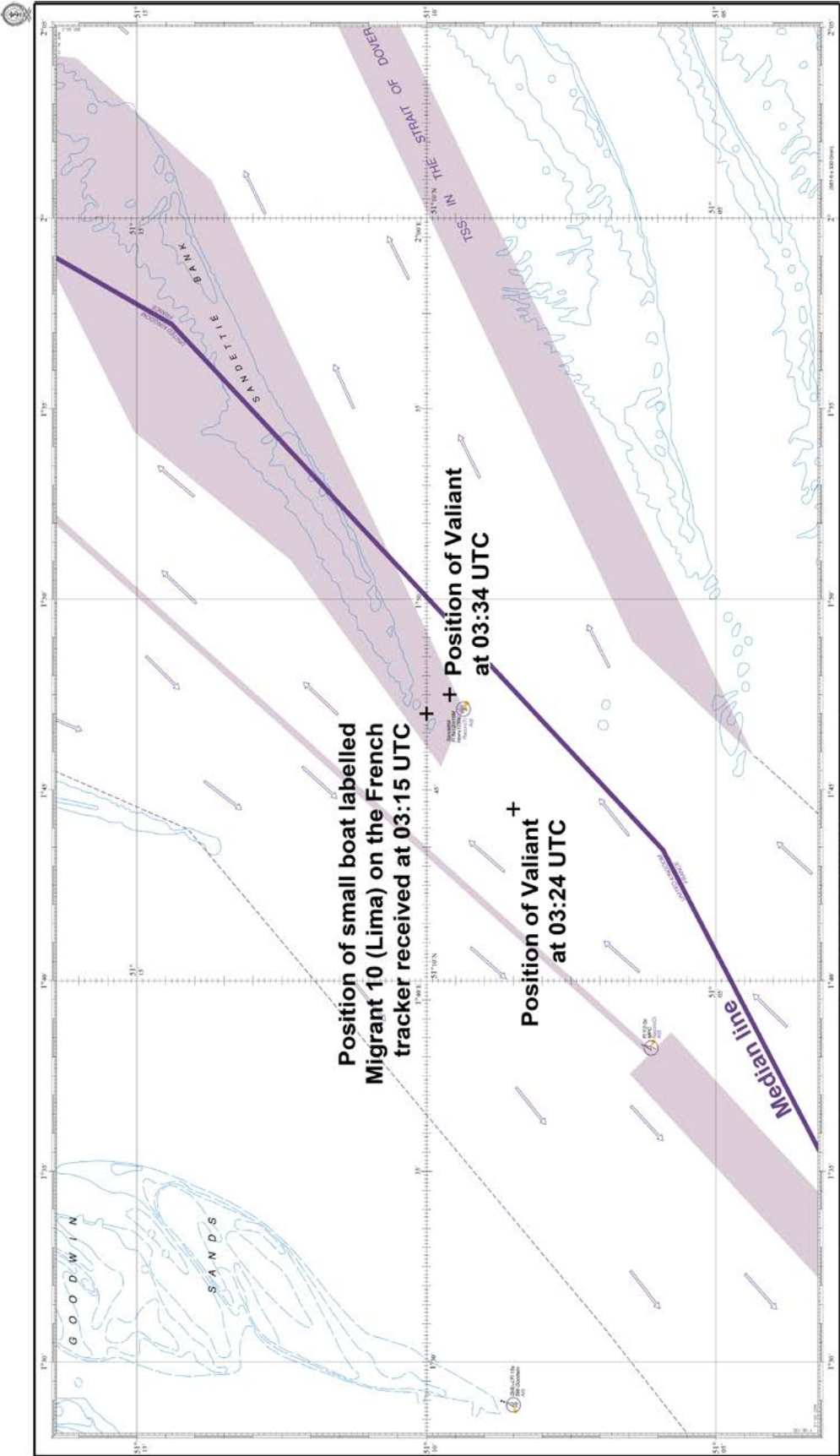
237 INQ007604/2.

238 INQ000226/5.

239 INQ006224.

240 INQ007605.

Figure 13: Position of the Valiant at 03:24 and 03:34 on 24 November 2021



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- 8.102** At 03:39, the Mayday relay was terminated. Mr Barnett recorded in the incident ‘Charlie’ ViSION log that after a discussion with Mr Gibson, there was “no requirement for Mayday relay as Valiant [was] in the area investigating targets”.²⁴¹

03:48 to 05:19 on 24 November 2021

- 8.103** At around 03:48, R163 lifted from Lydd.²⁴² At the same time that R163 was getting airborne, the Valiant arrived alongside the stationary small boat that it had identified with the night vision equipment. The Valiant provided its position to MRCC Dover and relayed that there were approximately 40 people on board the small boat.²⁴³ Mr Gibson’s initial response was that this could be incident ‘Charlie’.²⁴⁴ In order to verify this, Mr Gibson told the Valiant to ask whether there was a ‘Mumin’ on board (an incorrect rendering of one of the victims, Mubin Rizghar Hussein) and to check whether anyone on board had a telephone number ending 057.²⁴⁵ The other telephone numbers held by MRCC Dover for incident ‘Charlie’ were not provided to the Valiant and there was no interrogation by Mr Gibson as to the condition of the small boat, including whether it was sinking. Also at 03:48, Border Force Higher Officer, Ms Whitehouse’s daybook contained an entry recording the location of the small boat alongside the Valiant, which said: “[b]elieved incident C”.²⁴⁶
- 8.104** At 03:50, Mr Downs entered the following information in the ViSION log for incident ‘Charlie’: “Valiant on scene with unlit migrant vessel. 40 POB [people on board]. Stopped in the water”.²⁴⁷
- 8.105** At or around 03:52, Mr Gibson spoke again to the captain of R163, Mr Trubshaw, and gave updated instructions. Mr Gibson requested that R163 search around Sandettie Light Vessel with either an expanding square or a parallel track search, as the crew saw fit, for vessels in the area.²⁴⁸ A corresponding entry was made in the migrant administration ViSION log at 03:54 by Mr Gibson, which recorded that an expanding square search around Sandettie was recommended (it is unclear by whom) “as craft positions reported in the vicinity”.²⁴⁹ As with other calls, R163 was not told about incident ‘Charlie’ or that there was a small boat that had been reported to be sinking and there were possibly people in the water.

²⁴¹ INQ000237/11.

²⁴² INQ000226/5.

²⁴³ INQ007390/2.

²⁴⁴ INQ007390/2.

²⁴⁵ INQ007623/2. See also paragraph 8.54.

²⁴⁶ INQ000565.

²⁴⁷ INQ000237/11.

²⁴⁸ INQ008825/2.

²⁴⁹ INQ000235/8.

8.106 At 03:55, Border Force MCC called the Valiant to provide the ‘M’ or ‘Mike’ reference number for the small boat that had been located.²⁵⁰ This was M957 and was the first ‘M’ number to be provided during the night watch. It was sprayed on the side of the small boat that had been located by members of the Valiant’s crew. A minute later, at 03:56, Mr Downs entered the reference M957 into the ViSION log for incident ‘Charlie’.²⁵¹ A further minute later, at 03:57, Mr Barnett at the JRCC entered M957 into the HM Coastguard tracker in the column entitled ‘UKBF ref’ for incident ‘Charlie’.²⁵² This was an error since Mr Gibson had not conclusively identified M957 as incident ‘Charlie’ at this point. The image at Figure 14 is HM Coastguard’s tracker at 03:57 showing Mr Barnett’s entry.

Figure 14: Extract of the HM Coastguard tracker at 03:57 on 24 November 2021

Migrant Vessel (Alphabetical)	Duplicate of Migrant Vessel (Alphabetical)	Resolved / Ongoing	Initial Report Source (Free text)	FRENCH Ref (Free text)	HMCg GIN (Number)	UKBF Ref (Free text)
<i>Example:</i>	<i>Charlie</i>	<i>R / O</i>	<i>CG21 / Drone / Vessel</i>		<i>25653</i>	<i>M148</i>
ALPHA	FOXTROT	R	DOVER PORT		41381	
BRAVO	CHARLIE	R	FLAMANT	1	41383	
CHARLIE	BRAVO	O	GRIS NEZ	7	41384	M957
DELTA		O	FLAMANT	3	41385	
ECHO		O	GRIS NEZ	6	41387	
FOXTROT	ALPHA	O	DOVER PORT		41386	
GOLF			NO INCIDENT			
HOTEL		O		8	41388	
INDIA	CHARLIE	R		9	41389	
JULIET	LIMA	R		10		
KILO		O	POLICE		41392	
LIMA		O	FLAMANT	10	41394	
MIKE		O	FLAMANT	11	41398	

250 INQ007816. For an explanation of the numbering system used by Border Force MCC to identify each small boat located, see paragraph 7.48.

251 INQ000237/11.

252 INQ006802. Figure 14 is an extract of the spreadsheet.

- 8.107** Shortly after the Valiant had engaged with the first small boat, at 04:02, R163 arrived on scene.²⁵³ By this point, the people who had been on board the small boat associated with incident ‘Charlie’ had fully entered the water.
- 8.108** At around the same time that R163 arrived on scene, the Maritime Tactical Commander, Mr Jones went on a break (at around 04:04), returning to the operations room at the JRCC approximately 90 minutes later, at 05:40.²⁵⁴ He provided a contact number while he was on his break “if needed for any incident that require[d] [his] attention”. However, he was not contacted during this time for tactical support.²⁵⁵
- 8.109** At 04:14, having been alongside M957 for approximately 25 minutes, the Valiant responded to Mr Gibson’s request for confirmation of whether there was someone on board called ‘Mumin’ (Mubin Rizghar Hussein) and/or a person with the phone number known to be linked to incident ‘Charlie’. The Valiant reported that those on board had said that no one had called the Coastguard.²⁵⁶ This was obviously inconsistent with what HM Coastguard knew of incident ‘Charlie’ since Mr Gibson had acknowledged that multiple calls had been received from the small boat associated with that incident. In response to the Valiant’s reply, Mr Gibson said that he would call the number he had to see if anyone picked up.²⁵⁷ The call made at 04:16 failed.²⁵⁸
- 8.110** Soon afterwards, Mr Gibson abandoned his initial assumption that M957 could be incident ‘Charlie’. At 04:21, he asked the Valiant to confirm the colour of M957 noting that incident ‘Lima’ (French reference ‘10’) was a “black RHIB [small boat]”.²⁵⁹ The Valiant confirmed that it was a black inflatable.²⁶⁰ In response, Mr Gibson said that he “believe[d] this [M957] probably [was] incident Lima”, citing the matching description of boat colour and type and number of people on board. Mr Gibson then told the Valiant that they would “work with this potentially being ‘Lima’ and obviously carry our search on for ‘Charlie’ and vessels that have been reported in the area”.²⁶¹ Therefore, from 04:21, HM Coastguard’s working assumption was that M957 was incident ‘Lima’. There are no contemporaneous records showing that MRCC Dover informed Border Force MCC of this decision.

253 INQ000700/1.

254 INQ010138/19-20/par59.

255 INQ010138/20/par61.

256 INQ007573/2.

257 INQ007573/2.

258 See paragraph 8.94.

259 INQ007577/2.

260 INQ007578/2.

261 INQ007578/2.

- 8.111** All people from M957 had been embarked onto the Valiant by 04:34.²⁶² At 04:42, the Valiant called in to HM Coastguard a final head count of 35 people (20 men, two women and 13 suspected minors).²⁶³ The Valiant then told MRCC Dover that it was available for further taskings if required.
- 8.112** After embarking M957, the Valiant was no longer searching for small boats without co-ordinates but instead was tasked by MRCC Dover to go to vessels that had been located by R163. R163 had located its first small boat at around 04:18. It was described as a light grey vessel, eight metres long, under power, heading westerly.²⁶⁴ At 04:43, MRCC Dover called the Valiant to provide the co-ordinates obtained from R163 for that small boat and said that R163 had reported that it was not in distress or in immediate need of any assistance.²⁶⁵ Mr Downs recorded a corresponding entry in the generic small boat ViSION log (the migrant administration log) that there was no imminent threat to the people on board and no danger to life.²⁶⁶ R163 provided updated position information which was passed to the Valiant at around 04:50.²⁶⁷ The Valiant then proceeded to the position provided by R163.
- 8.113** At 04:44, the next iteration of the French tracker was sent to HM Coastguard and Border Force MCC.²⁶⁸ This showed again that there were four small boats in the vicinity of the Sandettie Light Vessel. There were no further small boats identified as having passed into UK waters.
- 8.114** At 04:56, Border Force sent its tracker, updated at 04:50, by email.²⁶⁹ The recipients were mainly employed within the Home Office but it was also sent to some recipients within the police, the National Crime Agency and to one HM Coastguard email address (the JRCC). The 04:50 Border Force tracker repeated the error made in HM Coastguard's tracker of attributing the M957 reference to incident 'Charlie'. It recorded the following additional remarks under the 'brief description' column for incident 'Charlie': "Vessel found and Valiant embarked a number of migrants". This was also an error. According to Mr Gibson's decision-making, the Valiant had embarked people on board incident 'Lima'.²⁷⁰ The 'summary' tab of the Border Force tracker at 04:50 recorded seven "unconfirmed incidents" concerning 140 people and recorded one "confirmed incident" relating to 30 people who had been embarked by Border Force. The image at Figure 15 is Border Force's tracker at 04:50, with updates from the last iteration marked in red.

262 INQ007467/2.

263 INQ007468/2.

264 INQ007469/2, INQ000235/8.

265 INQ007469/2.

266 INQ000235/8.

267 INQ007579/2.

268 INQ007696.

269 INQ001215, with cover email: INQ001216.

270 See paragraph 8.110.

Figure 15: Border Force tracker at 04:50 on 24 November 2021

Border Force Maritime Command Centre: Operation DEVERAN Live Update									
Live Update [4]: [TIME] 04:50									
Status	MCGA Ref	BF Ref	UK TTW	MCC Notified	Initial Lat/Long	POB	Brief Description		
Duplicate	A		NO [FR]				Dover Port. Intl ringtone- believed in Fr waters. Re opened by CG. Duplicate of F		
Duplicate	B		NO [FR]		21 04.54N 001 58.24E	40	Report from Flamant. SAR complete by FR. Now updated to not be SAR by FR. Duplicate of C		
Embarked/BF	C	M957	NO [FR]	1:25	51 06.15N 001 46.21E	30	No asset with event. Believed to already be in UK waters. Valiant called. Valiant attending. ETA 1 hr to location. Now a Mayday. vessel found and Valiant embarked a number of migrants.		
Open	D		NO [FR]	1:25	51 04.70N 002 24.5E	30	With Flamant. Inflatable		
Open	E		NO [FR]	1:25	51 04.58N 002 25.06E	30	NFD. Inflatable		
Open	F			1:25			Duplicate of A		
Closed [MCGA]	G			1:36			No incident		
Open	H		NO [FR]	1:36		40	Semi rigid, grey.		
Duplicate	I		NO [FR]	1:36		33	3 infants, 6 females- left Dunkerque. Initial report was SAR by FR. Duplicate of C		
Duplicate	J		NO [FR]	1:36		40	Duplicate of L		
Open	K			2:36			Call to police.		
Open	L		NO [FR]	2:36	51 08N 001 51E	40	Black vessel. Flamant with vessel.		
Open	M		YES	3:21	51 09N 001 46E		With Flamant		

- 8.115** The erroneous belief held by Border Force MCC that M957 was incident ‘Charlie’ was not corrected by MRCC Dover or the Valiant. At 05:04, Border Force MCC called the Valiant referring to M957 as incident ‘Charlie’. The speaker from Border Force MCC asked how many people the Valiant had embarked for incident ‘Charlie’. In response, the speaker on board the Valiant provided the total head count but did not point out that the small boat had in fact been identified by the SMC, Mr Gibson, as incident ‘Lima’.²⁷¹
- 8.116** At around 05:00, Mr Richard Cockerill joined the watch at MRCC Dover. He recalled that the operations room was calm and relaxed when he started work.²⁷² He could not recall receiving any significant briefing from Mr Gibson but noted that he was not expecting a full handover due to his staggered shift start time which meant that he was not taking over from any outgoing staff member.²⁷³ He told the Inquiry that Mr Gibson asked him to familiarise himself with what was happening operationally by reviewing the ViSION logs.²⁷⁴ He did not recall that there were any ongoing high priority incidents in the distress phase or being made aware of any Mayday relays. But he was aware, when he joined the watch, that a Border Force vessel was dealing with an ongoing incident in its final stages.²⁷⁵

05:20 to 07:30 on 24 November 2021

- 8.117** At around 05:20, the Valiant made contact with a second small boat. This was the light grey vessel which was not in distress and had been located previously by R163.²⁷⁶ At 05:22, Border Force MCC assigned the ‘M’ number M958 to this small boat.²⁷⁷ Figure 16 shows the position of M958 at 05:21 when the Valiant was alongside.
- 8.118** Shortly after the Valiant had engaged with M958, Mr Gibson recorded in writing his earlier decision that M957 corresponded to incident ‘Lima’. At 05:27, he made an entry in the ViSION log for incident ‘Lima’ recording his belief that the vessel was picked up by Valiant at 04:23 and all migrants were recovered at 04:36.²⁷⁸
- 8.119** A few minutes later, at 05:30, Mr Gibson also updated HM Coastguard’s tracker. Under the column entitled ‘outcome’, for incident ‘Lima’ he wrote: “recovered by Valiant 0436UT [sic] boat abandoned and marked with strobe”.²⁷⁹ Figure 17 is HM Coastguard’s tracker at 05:30.

²⁷¹ INQ007627/2, INQ007817/2.

²⁷² INQ009634/14/par32.

²⁷³ INQ009634/14/par33, INQ010720/196/ln6-7, 199/ln2-4.

²⁷⁴ INQ010720/200/ln5-10.

²⁷⁵ INQ009634/14/par34.

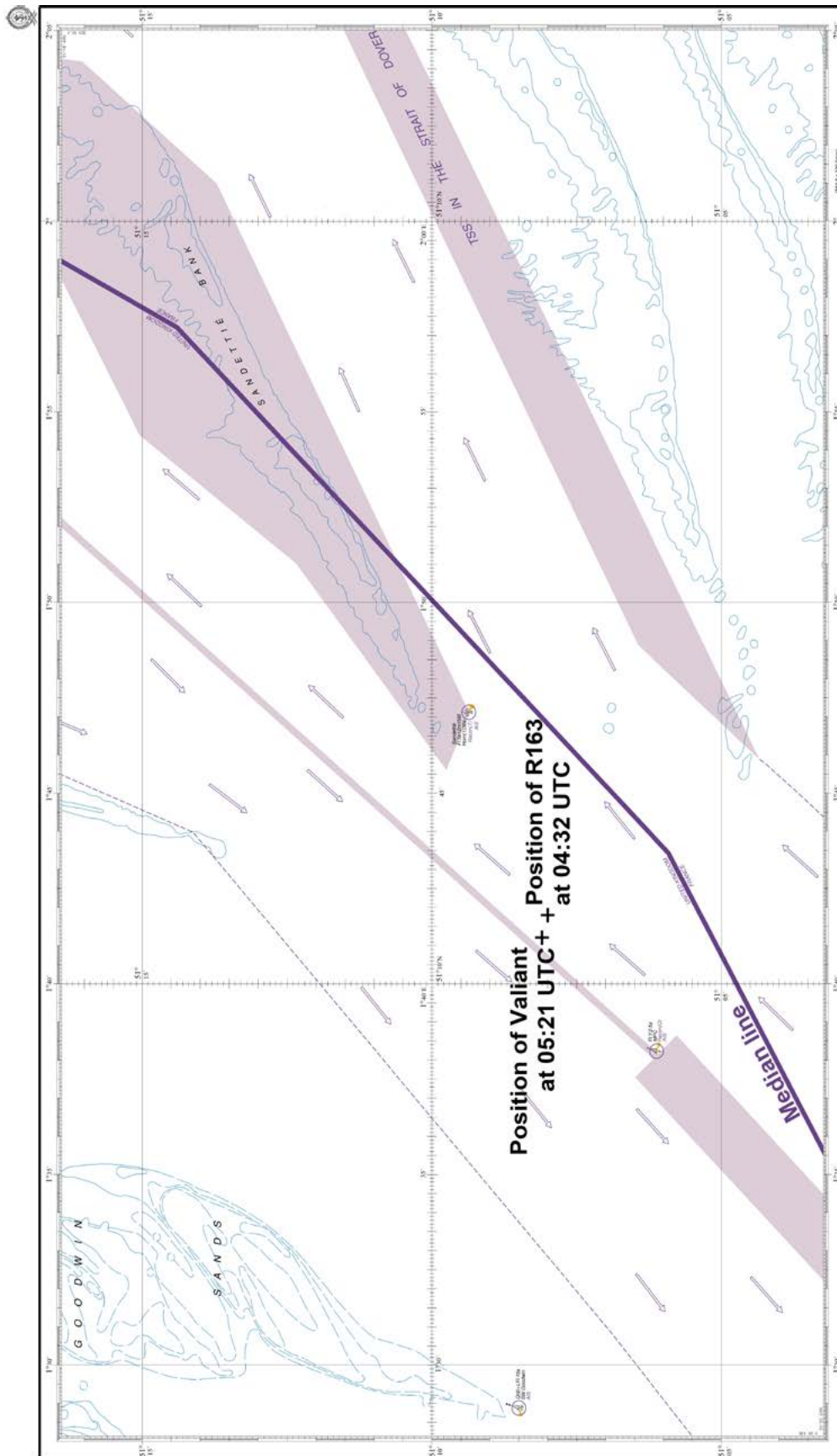
²⁷⁶ See paragraph 8.112.

²⁷⁷ INQ007820/2.

²⁷⁸ INQ000246/4.

²⁷⁹ INQ006808. Figure 17 is an extract of the full spreadsheet. Non-material columns and rows have been omitted.

Figure 16: Position of M958 at 05:21 on 24 November 2021



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Figure 17: Extract of the HM Coastguard tracker at 05:30 on 24 November 2021

Migrant Vessel (Alphabetical)	Duplicate of Migrant Vessel (Alphabetical)	Resolved / Ongoing	Initial Report Source (Free text)	FRENCH Ref (Free text)	HMCG GIN (Number)	UKBF Ref (Free text)	 Reported POB (Number)
ALPHA	FOXTROT	R	DOVER PORT		41381		
BRAVO	CHARLIE	R	FLAMANT	1	41383		40
CHARLIE	BRAVO	O	GRIS NEZ	7	41384	M957	30
DELTA		O	FLAMANT	3	41385		30
ECHO		O	GRIS NEZ	6	41387		30
FOXTROT	ALPHA	O	DOVER PORT		41386		
GOLF			NO INCIDENT				
HOTEL		O		8	41388		30 OR 40
INDIA	CHARLIE	R		9	41389		33
JULIET	LIMA	R		10			40
KILO		O	POLICE		41392		
LIMA		O	FLAMANT	10	41394		40
MIKE		O	FLAMANT	11	41398		
NOVEMBER		O	999 CALL		41401		32
OSCAR	NOVEMBER		KENT POLICE		41400		32

Asset Tasked (Free text)	Notes (Free text)	Outcome (Free text)
	LINE CUT OUT / INTERNATIONAL RING TONE / BELIEVED TO BE IN FRENCH WATERS	REPEAT OF FOXTROT GRIS-NEZ REPORTED SAR COMPLETE REPEAT OF CHARL;IE
VALIANT		
	272 DEGREES, 6 KNOTS	
	276 DEGREES, 4 KNOTS	
	CALLS GOING TO PORT OF DOVER X 3	
	3 INFANTS, 6 FEMALE - LEFT DUNKERQUE	GRIS-NEZ REPORTED SAR COMPLETE REPEAT OF CHARL;IE
		RECOVERED BY VALIANT 0436UT BOAT ABANDONED AND MARKED WITH STROBE
	SAME PHONE NUMBER AS NOVEMBER	

- 8.120** At 05:53, the Valiant told MRCC Dover that all the people who were on board M958 had been embarked.²⁸⁰ At 05:56, the Valiant told MRCC Dover that two of the people it had embarked spoke reasonable English and did not claim to have called the UK authorities.²⁸¹ A head count of 31 adult males was called in by the Valiant to MRCC Dover at 06:04.²⁸² MRCC Dover asked the Valiant if it had any names for the English speakers, to which Valiant responded negatively but said that “one of them did say that they saw someone make a call”.²⁸³ As with the information for M957, the information about the Valiant’s second event was entered by Mr Downs into the ViSION log for incident ‘Charlie’. However, it was not positively identified as relating to that incident.
- 8.121** There is no contemporaneous evidence from the night of 23 to 24 November 2021 that MRCC Dover positively attributed small boat M958 to any incident. Mr Gibson has told the Inquiry that he believed that M958 was incident ‘Charlie’, despite the obvious conflict between the information known to HM Coastguard about incident ‘Charlie’ and M958.²⁸⁴ Mr Downs and Mr Cockerill do not recall being told this by Mr Gibson.²⁸⁵ Mr Gibson accepts that he did not make any written record in relation to the reconciliation of M958.²⁸⁶ He attributed this failure to tiredness and fatigue.²⁸⁷
- 8.122** After embarking M958, at around 06:06, MRCC Dover tasked the Valiant to proceed to a third small boat in the vicinity of Southwest Goodwin, which is in a different area of the Dover Strait, to the west of the Sandettie Light Vessel and on the other side of the Traffic Separation Scheme.²⁸⁸ The small boat had been identified by R163 and described as having no visible signs of distress or danger.²⁸⁹
- 8.123** Also by 06:06, R163 had completed its search and left the scene to return to base, landing at Lydd at 06:25.²⁹⁰
- 8.124** At or around 06:29, the Valiant engaged with this third small boat in the Southwest Goodwin area.²⁹¹ At 06:31, the ‘M’ number of M959 was provided for this small boat by Border Force MCC.²⁹² MRCC Dover identified it as incident ‘November’ (which was reconciled by MRCC Dover as a repeat of incidents ‘Delta’ and ‘Papa’).²⁹³ The chart at Figure 18 shows the position of the Valiant when it was alongside M959, in the Southwest Goodwin area.

280 INQ007505/2.

281 INQ007474/2.

282 INQ007479/2.

283 INQ007480/2, INQ007481/2.

284 INQ010715/162/ln1-2. See also paragraphs 12.12 to 12.14.

285 INQ010208/33/par141, INQ010720/164/ln16-24.

286 INQ010392/96/par191.

287 INQ010715/164-165/ln24-4.

288 INQ007484/2, INQ007485/2.

289 INQ000235/9, INQ000252/5.

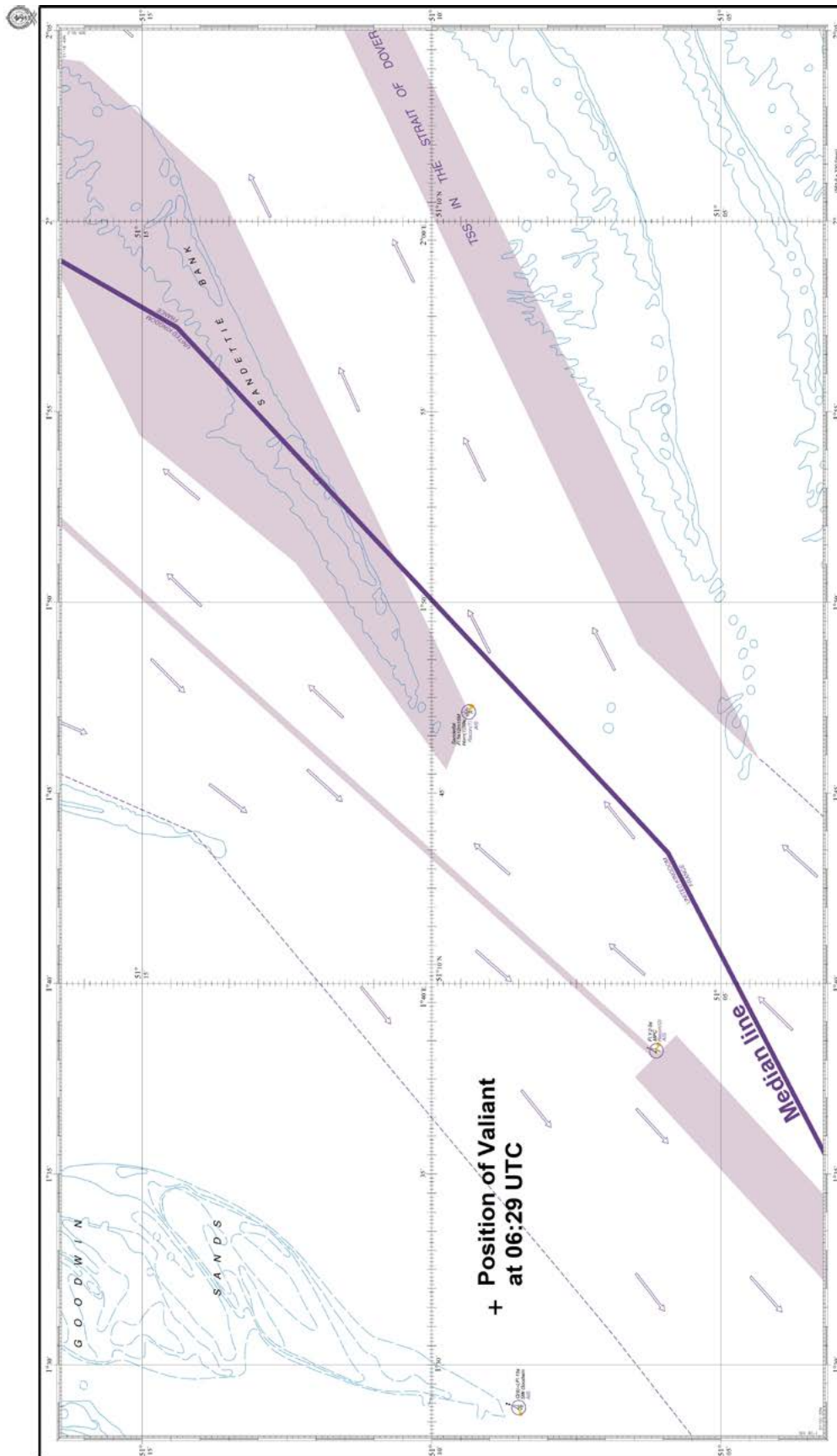
290 INQ000700/1.

291 INQ000237/12-13.

292 INQ000237/13.

293 INQ000252/5, INQ000254/4, INQ000238/5.

Figure 18: Position of the Valiant alongside M959 at 06:29 on 24 November 2021



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- 8.125** At 06:46, the Valiant was simultaneously cleared from incident ‘Charlie’ and assigned to incident ‘November’.²⁹⁴ As with M957 and M958, up until the point at which the Valiant was cleared from incident ‘Charlie’, Mr Downs recorded information about M959 in the ViSION log for incident ‘Charlie’.²⁹⁵ Except for recording that the Valiant was assigned to incident ‘November’, Mr Downs did not record that incident ‘November’ had been identified as M959.
- 8.126** While the Valiant was alongside M959 (incident ‘November’/‘Delta’/‘Papa’), at 06:30, the next iteration of the French tracker was sent.²⁹⁶ This contained 20 entries, showing six incidents that were ongoing in the French search and rescue region.
- 8.127** At 07:00, Border Force updated its tracker.²⁹⁷ It identified incidents ‘C’ (‘Charlie’), ‘E’ (‘Echo’) and ‘N’ (‘November’) as having been located and embarked by the Valiant. As with the 04:50 version of the Border Force tracker, it assigned incident ‘Charlie’ to small boat M957.²⁹⁸ Incident ‘Echo’ was assigned to small boat M958 and incident ‘November’ to small boat M959. There is no evidence that HM Coastguard had identified M958 as ‘E’/‘Echo’.
- 8.128** Dawn broke at around 07:00 on 24 November 2021. At this point the Valiant was alongside M959, far from the Sandettie Light Vessel area. R163 had landed at Lydd. As the sun rose, Mr Omar was in the water, holding onto the deflated small boat. He has described to the Inquiry the horror and desperation of the situation. As light returned, he could see that there were others still alive at dawn, all clinging on to the remains of the small boat. Others had died. There were bodies floating around him.²⁹⁹ At a point soon after dawn broke, he swam away from the small boat, alternating between swimming and floating. As he swam away from the group, he saw a Kurdish woman swimming nearby him, screaming and searching for her children. Mr Omar has described his mental anguish and physical pain from the prolonged exposure to cold saltwater.³⁰⁰

294 INQ000237/13, INQ000252/6.

295 INQ000237/12-13.

296 INQ007697.

297 INQ001231 with the cover email at INQ001230.

298 See paragraph 8.114.

299 INQ010388/19/par109.

300 INQ010388/par111-113.

- 8.129** At dawn, HM Coastguard did not know that there were multiple people in the water, some of whom had already died and that others were at imminent risk of doing so. Neither the Valiant nor R163, nor any passing vessels of which it was aware, had located them.
- 8.130** By around 07:20, in the Southwest Goodwin area, the Valiant had embarked all people from the small boat M959.³⁰¹ The Valiant told MRCC Dover that it would need to return to Dover because it was full.³⁰² At 07:25, it called in a headcount for M959 of 32 people (21 men, four women, and seven minors).³⁰³ The Valiant then returned to Dover to disembark the total of 98 people who had been on board M957, M958 and M959. However, it was not recorded as being clear from incident ‘November’ until later in the morning of the day watch.³⁰⁴
- 8.131** Shortly before the end of the night watch at MRCC Dover, the outgoing SMC, Mr Gibson, gave a handover briefing to the incoming SMC, Mr James Crane. There are no written records of the handover briefing because they were live documents and have since been overwritten.³⁰⁵ Neither Mr Gibson nor Mr Crane were able to recall specifics of the handover. Mr Gibson said that he would have gone through the tracker. He would have talked at length about ongoing incidents and given a brief overview of what had been resolved.³⁰⁶ He said that he raised no concerns about incident ‘Charlie’ because he believed it had likely been recovered by the Valiant.³⁰⁷ Mr Crane said that the bare minimum information was given for an overview and that Mr Gibson would have covered the open incidents as best he could.³⁰⁸ He recalled that Mr Gibson mentioned the Mayday relay and would have shown him on ViSION the incident to which the Mayday relay broadcast related.³⁰⁹ Mr Crane recalled Mr Gibson saying that as a result of the Mayday relay broadcast, “assets from both France and the UK had been dispatched to attempt to locate a small boat...and that some boats had been picked up in that area by HMC Valiant”.³¹⁰

301 INQ000252/7.

302 INQ007514/2.

303 INQ007496/2.

304 INQ000252/7.

305 INQ010142/15/par40.

306 INQ010715/166/ln2-6.

307 INQ010392/95/par187, INQ010715/179/ln11-16.

308 INQ010719/137/ln11-25, 142/ln1-7.

309 INQ010142/16/par43.

310 INQ010142/16/par44.

8.132 The Small Boat Tactical Commander, Mr Papadopoulos, confirmed that he and Mr Crane did not believe that there was anything outstanding in relation to incident 'Charlie'.³¹¹ He said that the fact that no sinking small boats had been found despite a Mayday relay having been broadcast would not have changed anything, even if this information had been handed over to the day watch, because the incoming day watch relied on the assessment and decision-making of the night watch SMC.³¹²

8.133 In contrast to the Border Force tracker from 07:00, at the end of the night watch at MRCC Dover at 07:30, HM Coastguard's tracker did not show any incidents as resolved.³¹³ In terms of the three small boats recovered by the Valiant, there remained only two entries: in the row for incident 'Charlie' the 'M' number M957 was recorded under the column entitled 'UKBF ref', and in the row for incident 'Lima' it was recorded in the column entitled 'outcome' that the vessel had been recovered by the Valiant at 04:36.³¹⁴ The error made by the JRCC at 03:57 attributing small boat M957 to incident 'Charlie' had not been corrected by the end of the night watch.³¹⁵ The image at Figure 19 is HM Coastguard's tracker at 07:30.

The day watch of 24 November 2021

07:31 to 10:07 on 24 November 2021

8.134 On the day watch at MRCC Dover, in addition to Mr Crane, who was the SMC and team leader, were Mr Papadopoulos (the Small Boat Tactical Commander), Mr Cockerill (who was acting as a Mission Co-ordinator), another Maritime Operations Officer on search and rescue duty, and a non-operational trainee.³¹⁶ Mr Papadopoulos started his shift in the role of Small Boat Tactical Commander, assuming tactical command for small boat activity. However, around 40 minutes into the shift, he handed tactical command over to the Maritime Tactical Commanders at the JRCC and assumed the role of a Mission Co-ordinator to assist operationally due to the volume of small boat activity.³¹⁷

8.135 As a result of Mr Papadopoulos handing back tactical command to the JRCC, the Maritime Tactical Commanders at the JRCC became involved in MRCC Dover's work. There were initially two Maritime Tactical Commanders on duty at the JRCC. They divided up the tasks and Mr George Close was assigned to small

311 INQ010740/76/ln9-12.

312 INQ010740/76-77/ln13-3.

313 See paragraph 8.127 for Border Force tracker sent at 07:00.

314 INQ006816. See paragraphs 8.106 and 8.119.

315 Figure 19 is an extract of the full spreadsheet. Non-material columns and rows have been omitted.

316 INQ000409, INQ010142/13/par34.

317 INQ010130/2, INQ009632/16-17/par40.

boat work.³¹⁸ However, due to short staffing on the following shift, it was decided that Mr Close would leave work at midday in order to cover the subsequent night watch.³¹⁹

- 8.136** Mr Mike Bill, the Divisional Commander responsible for the East Coast of England which included MRCC Dover, was also on duty. He was based in MRCC Humber. As a Divisional Commander he was not operationally involved in small boat work.³²⁰
- 8.137** At the outset of the day watch, the Valiant returned to Dover to disembark the people who had been on board M957, M958 and M959. The Valiant did not subsequently return to duty during the day watch as a result of suffering an engine problem.³²¹ The only available Border Force surface assets during the day watch of 24 November 2021 were the crew transfer vessel, Hurricane, and the coastal patrol vessel, Hunter.³²² HM Coastguard depended on RNLI lifeboats throughout the day. MRCC Dover told the French Coastguard during a call on the morning of 24 November 2021 that it was “overstretched” and had “limited resources”.³²³ The ViSION incident log relating to aeronautical involvement on 24 November 2021 additionally referred to “limited surface assets”.³²⁴
- 8.138** There was also limited air coverage. The Tekever drone was airborne between 07:10 and 14:00.³²⁵ 2Excel had assigned two aircraft for the day watch of 24 November 2021. However, due to various technical problems, there was aerial coverage only for around two hours throughout the watch.³²⁶
- 8.139** Around one hour into the watch, HM Coastguard’s tracker was updated to reflect the decisions on reconciliation which, although made during the night watch, had not been recorded at that time. At 08:28, the non-operational trainee Maritime Operations Officer at MRCC Dover entered ‘M959’ in the column entitled ‘UKBF ref’ for incident ‘November’.³²⁷ This correctly reflected HM Coastguard’s decision-making from the night watch, as recorded in the incident ‘November’ ViSION log.³²⁸

318 INQ010212/13/par36.

319 INQ010212/13/par35.

320 INQ010097/3/par9.

321 INQ010719/146/ln4-6.

322 INQ000566.

323 INQ007733/3.

324 INQ000228/5.

325 INQ003884/4.

326 INQ003735/2, INQ010335/27-29/par110-118.

327 INQ006830.

328 INQ000252/7.

Figure 19: Extract of the HM Coastguard tracker at 07:30 on 24 November 2021

Migrant Vessel (Alphabetical)	Duplicate of Migrant Vessel (Alphabetical)	Resolved / Ongoing	Initial Report Source (Free text)	FRENCH Ref (Free text)	HMC GIN (Number)	UKBF Ref (Free text)	 Reported POB (Number)
ALPHA	FOXTROT	R	DOVER PORT		41381		
BRAVO	CHARLIE	R	FLAMANT	1	41383		40
CHARLIE	BRAVO	O	GRIS NEZ	7	41384	M957	30
DELTA		O	FLAMANT	3	41385		30
ECHO		O	GRIS NEZ	6	41387		30
FOXTROT	ALPHA	O	DOVER PORT		41386		
GOLF			NO INCIDENT				
HOTEL		O		8	41388		30 OR 40
INDIA	CHARLIE	R		9	41389		33
JULIET	LIMA	R		10			40
KILO		O	POLICE		41392		
LIMA		O	FLAMANT	10	41394		40
MIKE		O	FLAMANT	11	41398		
NOVEMBER	DELTA	O	999 CALL		41401		32
OSCAR	NOVEMBER	O	KENT POLICE		41400		32
PAPA	NOVEMBER	O	999 CALL		41403		
QUEBEC		O	GRIZ NEZ		41404		40

Asset Tasked (Free text)	Notes (Free text)	Outcome (Free text)
	LINE CUT OUT / INTERNATIONAL RING TONE / BELIEVED TO BE IN FRENCH WATERS	REPEAT OF FOXTROT GRIS-NEZ REPORTED SAR COMPLETE REPEAT OF CHARL;IE
VALIANT		
	272 DEGREES, 6 KNOTS	
	276 DEGREES, 4 KNOTS	
	CALLS GOING TO PORT OF DOVER X 3	
	3 INFANTS, 6 FEMALE - LEFT DUNKERQUE	GRIS-NEZ REPORTED SAR COMPLETE REPEAT OF CHARL;IE
		RECOVERED BY VALIANT 0436UT BOAT ABANDONED AND MARKED WITH STROBE
VALIANT	POSS REPEAT OF DELTA	
	SAME PHONE NUMBER AS NOVEMBER	
	SAME PHONE NUMBER AS NOVEMBER	
FLAMONT	HUNTER BEING TASKED	

8.140 At 08:35, the Divisional Commander located at MRCC Humber entered ‘M958’ in the column entitled ‘UKBF ref’ for incident ‘Lima’.³²⁹ This was incorrect and the Divisional Commander was unable to recall the source of this entry.³³⁰ Mr Gibson had identified M957 as incident ‘Lima’. However, Mr Gibson’s decision on reconciliation was not apparent from the incident ‘Lima’ ViSION log, which recorded the time that those on board incident ‘Lima’ had been embarked by the Valiant (at 04:36) but did not record the corresponding ‘M’ reference.³³¹ Equally, it was not apparent from HM Coastguard’s tracker. That also recorded that incident ‘Lima’ had been recovered at 04:36 but did not record a corresponding ‘M’ reference.³³² The image at Figure 20 is is HM Coastguard’s tracker at 08:35.

Figure 20: Extract of the HM Coastguard tracker at 08:35 on 24 November 2021

Migrant Vessel (Alphabetical)	Duplicate of Migrant Vessel (Alphabetical)	Resolved / Ongoing	Initial Report Source (Free text)	FRENCH Ref (Free text)	HMCG GIN (Number)	UKBF Ref (Free text)
<i>Example:</i>	<i>Charlie</i>	<i>R / O</i>	<i>CG21 / Drone / Vessel</i>		<i>25653</i>	<i>M148</i>
ALPHA	FOXTROT	R	DOVER PORT		41381	
BRAVO	CHARLIE	R	FLAMANT	1	41383	
CHARLIE	BRAVO	O	GRIS NEZ	7	41384	M957
DELTA		O	FLAMANT	3	41385	
ECHO		O	GRIS NEZ	6	41387	
FOXTROT	ALPHA	O	DOVER PORT		41386	
GOLF			NO INCIDENT			
HOTEL		O		8	41388	
INDIA	CHARLIE	R		9	41389	
JULIET	LIMA	R		10		
KILO		O	POLICE		41392	
LIMA		O	FLAMANT	10	41394	M958
MIKE		O	FLAMANT	11	41398	
NOVEMBER	DELTA	O	999 CALL		41401	M959

329 INQ006835.

330 INQ010719/40/ln13-19, 42/ln18-23.

331 INQ000246/4.

332 Figure 20 is an extract of the full spreadsheet. Non-material columns and rows have been omitted.

- 8.141** At 09:00, Border Force updated its tracker.³³³ This contained the same content in relation to small boats M957, M958 and M959 as the tracker that had been circulated at 07:00, except that it identified incident 'L' ('Lima') as corresponding to M958. Therefore, this amended the entry on the 07:00 iteration of the tracker, which had identified M958 as incident 'Echo'.³³⁴ Border Force Higher Officer, Ms Whitehouse, told the Inquiry that the amendment to the Border Force tracker was likely made by reference to the corresponding change in HM Coastguard's tracker at 08:35, whereby M958 was attributed to incident 'Lima'.³³⁵
- 8.142** At 09:09, Mr Papadopoulos marked incidents 'Lima' and 'November' as resolved in HM Coastguard's tracker. Shortly afterwards, at 09:11, Mr Crane marked incident 'Charlie' as resolved.³³⁶ Mr Crane and Mr Papadopoulos have both told the Inquiry that they did not see, and did not have access to, the Border Force tracker.³³⁷ The image at Figure 21 is an extract of HM Coastguard's tracker at 09:11.³³⁸
- 8.143** Therefore, by 09:11, both the HM Coastguard and Border Force trackers showed that incidents 'Charlie', 'Lima' and 'November' had been resolved and corresponded to the small boats identified as M957, M958 and M959, respectively.
- 8.144** Accordingly, on the morning of the day watch, the trackers contained errors in respect of incidents 'Charlie' and 'Lima'. The small boat M957 did not correspond to incident 'Charlie'. It had been identified by Mr Gibson during the night watch as incident 'Lima'. The small boat M958 had not been recorded to relate to any incident during the night watch but had been recorded in the trackers as incident 'Lima' during the day watch. Contrary to what the trackers recorded, incident 'Charlie' had not been located and embarked by the Valiant. It had not been resolved.

333 INQ001246 with the cover email INQ001245.

334 See paragraph 8.127.

335 INQ010135/27/par69. See paragraph 8.140.

336 INQ006845.

337 INQ010142/10/par24, INQ009632/26/par67.

338 Non-material columns and rows on the full spreadsheet have been omitted.

Figure 21: Extract of the HM Coastguard tracker at 09:11 on 24 November 2021

Migrant Vessel (Alphabetical)	Duplicate of Migrant Vessel (Alphabetical)	Resolv ed / Ongoing	Initial Report Source (Free text)	FRENCH Ref (Free text)	HMCG GN (Number)	UKBF Ref (Free text)	Reported POB (Number)
ALPHA	FOXTROT	R	DOVER PORT		41381		
BRAVO	CHARLIE	R	FLAMANT	1	41383		40
CHARLIE	BRAVO	R	GRIS NEZ	7	41384	M957	30
DELTA		O	FLAMANT	3	41385		30
ECHO		O	GRIS NEZ	6	41387		30
FOXTROT	ALPHA	R	DOVER PORT		41386		
GOLF			NO INCIDENT				
HOTEL		O		8	41388		30 OR 40
INDIA	CHARLIE	R		9	41389		33
JULIET	LIMA	R		10			40
KILO		O	POLICE		41392		
LIMA		R	FLAMANT	10	41394	M958	40
MIKE		O	FLAMANT	11	41398		
NOVEMBER	DELTA	R	999 CALL		41401	M959	32
OSCAR	NOVEMBER	R	KENT POLICE		41400		32
PAPA	NOVEMBER	R	999 CALL		41403		
QUEBEC		R	GRIZ NEZ		41404		40
ROMEO		O	999 CALL		41411		35
SIERRA		O	VESSEL		41416		
TANGO		O	GRIS NEZ	13	41413	M960	30
UNIFORM		O	999 CALL		941414		20
VICTOR		O	VESSEL		41417		30
WHISKEY	ROMEO	R					
X-RAY		O	GRIS NEZ	12	41421		50
YANKEE		O	CNS			M962	
ZULU		O			41423		
ALPHA 1		O	999 Call		41427		
BRAVO 1	ALPHA 1	R	999 CALL		41426		

Asset Tasked (Free text)	Notes (Free text)	Outcome (Free text)
VALIANT	LINE CUT OUT / INTERNATIONAL RING TONE / BELIEVED TO BE IN FRENCH WATERS	REPEAT OF FOXTROT GRIS-NEZ REPORTED SAR COMPLETE REPEAT OF CHARL;IE
	272 DEGREES, 6 KNOTS	
	276 DEGREES, 4 KNOTS	
	CALLS GOING TO PORT OF DOVER X3	
	3 INFANTS, 6 FEMALE - LEFT DUNKERQUE	GRIS-NEZ REPORTED SAR COMPLETE REPEAT OF CHARL;IE
		RECOVERED BY VALIANT 0436UT BOAT ABANDONED AND MARKED WITH STROBE
VALIANT & SAFEGUARD	POSS REPEAT OF DELTA SAME PHONE NUMBER AS NOVEMBER SAME PHONE NUMBER AS NOVEMBER	
FLAMONT	HUNTER BEING TASKED	HUNTER RECOVERED
REPORTED TO GRIS NEZ	VIA EMAIL FROM SPIRIT OF FRANCE	
FKCRT INVESTINGTING FIF POSITION		
AR 3 TASKED TO LOCATE	REPORTED BY SILVIER BOWERS	
HURRICANE	EDZARD CIRKSENA VIA CNIS	
DUALB		
	LOTS OF VOICES IN BACKGROUND - CALL DROPPED	

10:08 to 12:56 on 24 November 2021

8.145 At around 10:00 on the morning of 24 November 2021, the Maritime Tactical Commander, Mr Close, conducted a RAG review of incident ‘Charlie’.³³⁹ At 10:08 he made an entry in the ViSION log for incident ‘Charlie’ as follows:³⁴⁰

Figure 22: Extract of the ViSION log for incident ‘Charlie’ at 10:08 on 24 November 2021 (recreated from the original source material)

24/11/21 10:08:47 GCLOSE	Commander Message NOTE FROM TRACKER THIS INCIDENT SHOWS AS RESOLVED – VALIANT TASKED – CONFIRMED 41 RECOVERED AND VSL ABANDONED AND MARKED

8.146 Mr Close has told the Inquiry that his reference to the tracker referred to HM Coastguard’s tracker.³⁴¹ He does not believe that he would have consulted the Border Force tracker.³⁴² Mr Close has told the Inquiry that his entry merely reiterated what was already recorded and was “not in reality stating anything that was not already deduced by the operations team at Dover, namely that Charlie had been discovered, as they had reflected in the Tracker”.³⁴³

8.147 Mr Close also said that he used the incident ‘Charlie’ ViSION log, in which Mr Downs had recorded information about all three small boats embarked by the Valiant, to form the view that the incident had been resolved, although he accepted that the information on the log did not enable him to confirm which of those vessels corresponded to incident ‘Charlie’.³⁴⁴ Mr Close told the Inquiry that he believed that “it was reasonable at the time to deduce by geographic location that one of the vessels recovered was Charlie”.³⁴⁵ There were no further entries on the incident ‘Charlie’ log until it was closed later that afternoon.

8.148 Mr Close conducted a RAG review of incident ‘Mike’ immediately after making the entry in the ViSION log for incident ‘Charlie’. He made an entry at 10:09 in the ‘Mike’ ViSION log which said: “[n]ote Valiant on scene w/Charlie & numerous vsls around possible migrant incident Mike – R175 & CG22 is [sic] proceeding

339 INQ000237/13.

340 INQ000237/13. The number of people on board recorded by Mr Close (41) did not match any of the headcounts for the vessels recovered by the Valiant as recorded in the ViSION log or trackers. It has no source in the contemporaneous evidence and it may have been a typographical error.

341 INQ010490/8-9/par19-21.

342 INQ010490/9/par22.

343 INQ010490/11/par26.

344 INQ010490/6-7/par13-14.

345 INQ010490/7/par14.

for domain awareness...”.³⁴⁶ Mr Close has told the Inquiry that by this, he meant that he had concluded that incident ‘Mike’ may be one of the vessels located by the Valiant.³⁴⁷ He said that this entry may have prompted further investigation by MRCC Dover to understand whether incident ‘Mike’ (French reference ‘11’) had been located by the Valiant.³⁴⁸ However, this did not happen during the day watch. Despite being identified as one of the four vessels in the Sandettie area at the time that the Valiant had arrived on scene, incident ‘Mike’ was never reconciled and was closed with the following generic message added by the non-operational trainee at MRCC Dover:

Figure 23: Extract of the ViSION log for incident ‘Mike’ at 18:00 on 24 November 2021 (recreated from the original source material)

24/11/21 18:00:04	MOO	Officer Message AFTER THE CESSATION OF MULTIPLE MIGRANT INCIDENTS DURING TODAY. NO FURTHER CALLS HAVE BEEN RECEIVED FOR THIS INCIDENT OR FURTHER CONFIRMED SIGHTINGS. AREAS OF INTEREST HAVE BEEN SEARCHED WITH NOTHING UNTOWARD FOUND. WITH THIS IN MIND, IT IS BEING CLOSED PENDING FURTHER INFORMATION. AS DISCUSSED WITH JAMES CRANE AND GEORGE PAPADOPOLOS
24/11/21 18:00:13	MOO	Incident Closed

- 8.149** The generic message was used across multiple ViSION logs on 24 November 2021. The form of wording had been agreed between Mr Crane and Mr Papadopoulos.³⁴⁹ Mr Papadopoulos told the Inquiry that this was done due to the operational demand on that day.³⁵⁰ He and Mr Crane acknowledged that it was not best practice and bespoke conclusions and reasons would have been preferable.³⁵¹

³⁴⁶ INQ000250/4.

³⁴⁷ INQ010490/5/par9.

³⁴⁸ INQ010490/6/par11.

³⁴⁹ INQ010349/1.

³⁵⁰ INQ009632/30/par82.

³⁵¹ INQ009632/30/par82, INQ010142/40-41/par133.

- 8.150** Mr Papadopoulos said that following the discussion and agreement of a generic form of words between him and Mr Crane, the non-operational trainee was authorised by them to close identified incident reports.³⁵² An email sent to the trainee by Mr Crane at 17:41 requested that the “generic closing statement” be “use[d] on as many of the opening [sic] migrant incidents as we can before 1930”.³⁵³ As a result, the trainee closed 32 incidents.³⁵⁴
- 8.151** The generic closure message was also used on incidents which had been identified as embarked by the Valiant, including incidents ‘Lima’ and ‘November’.³⁵⁵ Mr Crane accepted that specific reasons were available in these incidents and should have been used to close them, rather than the generic message. He told the Inquiry that the use of the generic message was an error made by the non-operational trainee.³⁵⁶

12:57 to 19:29 on 24 November 2021

- 8.152** At 12:57, MRCC Dover received a call from the French Coastguard at CROSS Gris-Nez. The French Coastguard relayed a report from a fishing vessel (‘Saint Jacques II’) that there were 10 to 15 people in the water at the position 51° 05.58N, 001° 43.41E, who were possibly unconscious and requested that HM Coastguard send an aircraft.³⁵⁷ This was approximately 0.2nm from the boundary with the UK search and rescue region.³⁵⁸ This was recorded as a new incident in the ViSION logs: incident ‘Xray 2’.³⁵⁹ In fact, this was incident ‘Charlie’. No one present on the day watch made the connection.
- 8.153** The rescue operation was co-ordinated by the French Coastguard because the people were discovered in French waters. The operation involved assets from France, Belgium and the UK. Between 12:57 and 13:30, three French maritime assets were tasked – ‘Flamant’, ‘Escaut’ and ‘Notredame du Risban’ – and the French helicopter ‘Rescue Guépard Whiskey’ was dispatched.³⁶⁰ A Belgian helicopter was tasked and the French Coastguard also requested that HM Coastguard task a search and rescue helicopter to the incident.³⁶¹ R163 was tasked at 13:03.³⁶² At 13:07, the French Coastguard broadcast a Mayday relay.

352 INQ009632/36/par104.

353 INQ010351.

354 INQ009632/36/par106.

355 INQ000246/5, INQ000252/8-9.

356 INQ010142/34-35/par109, 37/par117, 40-41/par133.

357 INQ007810/2.

358 INQ009951/1.

359 INQ000320.

360 INQ001284/2.

361 INQ009951/1.

362 INQ001284/2.

- 8.154** Directly after HM Coastguard was alerted about the mass casualties, the Maritime Tactical Commander requested that search modelling be undertaken to determine whether the incident could cross into the UK search and rescue region. It was recorded that this was a possibility after three hours but that there was no information that any of the casualties were in the UK search and rescue region at the current time.³⁶³
- 8.155** At 13:11, the Flamant was on scene and, at 13:15, recovered three people (two conscious and one unconscious) from the water.³⁶⁴ R163 arrived on scene soon after, at 13:25, and conducted a search using the sector search pattern. It reported locating five people in the water, who were either submerged or face down and appeared to be unconscious, to the French Coastguard. They were then recovered by French surface assets with R163 providing location information.³⁶⁵ R163 was released by the French Coastguard at 14:35 on completion of its sector search.
- 8.156** A deflated dinghy was located at 14:32 by one of the French maritime vessels.³⁶⁶ By 15:29, the French Coastguard had located 28 people. It reported that two people had been evacuated to hospital in Calais by the French helicopter, Rescue Guépard Whiskey, and 26 people were on board the maritime vessels, two of whom were conscious.³⁶⁷ Those on board the maritime assets were taken to Calais for disembarkation.³⁶⁸ The two conscious people who had been taken by helicopter were reported to be suffering cardiopulmonary arrest.³⁶⁹
- 8.157** Mr Omar was one of the survivors. After some hours, he was rescued by people on board a fishing boat and then transferred to a different French vessel and later taken to hospital in France.³⁷⁰
- 8.158** While the search for the people in the water, co-ordinated by the French Coastguard was ongoing, incident 'Charlie' was closed between 15:09 and 15:21 by the non-operational trainee at MRCC Dover.³⁷¹ The entry in the 'Charlie' ViSION log at 15:16 repeated the (incorrect) information contained in the 10:08 entry by the Maritime Tactical Commander. The next entry in the log, at 15:21, formally closed incident 'Charlie'. No new information was entered by the non-operational trainee when closing the incident (see Figure 24).

363 INQ000320/4-5.

364 INQ001284/2.

365 INQ009951/1, INQ000701.

366 INQ001294/3.

367 INQ001294/3.

368 INQ001294/3.

369 INQ001294/3.

370 INQ010388/20/ln114-115.

371 INQ000237/14.

Figure 24: Extracts of the ViSION log for incident ‘Charlie’ at 15:16 and 15:21 on 24 November 2021 (recreated from the original source material)

24/11/21 15:16:27	MOO	Summary 240115UTC to 241008UTC DOVR 041384 MIGRANT. UKBF CUTTER VALIANT tasked to migrant vessel with 41 pob. Occupants recovered to Dover tug haven.
24/11/21 15:21:37	MOO	Incident Closed

- 8.159** At 15:40, R163 was re-tasked for a further search in order to use its forward-looking infrared capabilities due to the onset of darkness.³⁷² R163 returned to the scene between 16:22 and 17:45, after which it was stood down. No further people were found but an empty small boat was located, with details passed to the French Coastguard. The mission summary disclosed by Bristow said of this additional search in darkness: “low mlx [millilux] levels for [night vision goggles], plus casualties had been in the water a prolonged period therefore poor thermal contrast for [forward looking infrared]”.³⁷³
- 8.160** At 15:51, the French vessel, Escaut, was reported by the French to have located a further person, giving a total of 29 people recovered.³⁷⁴
- 8.161** At 16:27, the French Coastguard held a conference with a survivor on board the Flamant, assisted by an interpreter. This person indicated that there were 32 to 33 people aboard the small boat initially. An earlier report at 14:19 had recorded that one conscious person had reported that there had been 33 to 34 people on board.³⁷⁵
- 8.162** A French situation report sent to HM Coastguard at 17:08 confirmed that by that time 29 people had been recovered, of whom two were conscious.³⁷⁶
- 8.163** At around 19:00, the Maritime Tactical Commander and the SMC, Mr Crane, decided to task an RNLI lifeboat to the incident. Their reasoning was that the modelling had shown that the incident may have drifted into UK waters, the French Coastguard had reported that some casualties were wearing lifejackets,

372 INQ009951/1.

373 A millilux is a unit of illuminance. INQ000702/1.

374 INQ001294/3.

375 INQ001294/3. It is unclear whether this is a revised estimate by the same person or whether two survivors provided different information.

376 INQ001294/2.

and that there were people who remained missing and survivability had been calculated at 19 hours.³⁷⁷ Therefore, there remained a possibility that some people remained alive and could have drifted into the UK search and rescue region.

8.164 At 19:06, the Ramsgate lifeboat was tasked to the incident. It arrived on scene at 20:27.³⁷⁸

19:30 to 23:59 on 24 November 2021

8.165 At 19:30, the night watch started at MRCC Dover. Mr Gibson and Mr Downs were on duty again. Mr Gibson became SMC for incident 'Xray 2'.³⁷⁹ In his statement to the Inquiry, Mr Downs said that it was challenging to be back on duty for the next shift with the same shift team members and "going through what felt like a re-run of the previous night".³⁸⁰

8.166 At 19:43 the information from CROSS Gris-Nez was updated to 33 people believed to have been on board the small boat, with 27 recovered dead, two recovered alive and four believed missing.³⁸¹

8.167 The Ramsgate lifeboat was released at 23:59. It had not located any people in the water. HM Coastguard did not task any further assets to the mass casualty event following this.³⁸²

25 November 2021 to 1 December 2021

8.168 In the morning of 25 November 2021, HM Coastguard was informed that the French helicopter was tasked to search an updated area and that this was expected to be the final search.³⁸³ There were confirmed to be two survivors and 27 fatalities, and the French authorities considered that four people remained missing.³⁸⁴

8.169 Several days after the incident, on 29 November 2021, Mr Gibson raised internally within HM Coastguard what he called "a few niggles" regarding incidents 'Charlie' and 'Xray2'.³⁸⁵ This was the first time that there is any record of a connection having been made between the two incidents. Mr Gibson raised press reports mentioning the name 'Mubin', which he considered, correctly,

³⁷⁷ INQ000320/14.

³⁷⁸ INQ000320/18.

³⁷⁹ INQ000320/17.

³⁸⁰ INQ010208/35/par151.

³⁸¹ INQ000320/17.

³⁸² INQ000320/20.

³⁸³ INQ000320/20.

³⁸⁴ INQ000320/20.

³⁸⁵ INQ010358/1.

could refer to someone on board the small boat associated with incident 'Charlie'. He also said that he had conducted some drift modelling which suggested that incidents 'Xray 2' and 'Charlie' could be the same event.³⁸⁶

- 8.170** By 1 December 2021, the Maritime and Coastguard Agency (MCA) had accepted that incidents 'Charlie' and 'Xray 2' were the same and, therefore, that the small boat had been in UK waters. On 1 December, the MCA sent a briefing to the then Secretary of State for Transport, the Rt Hon Grant Shapps MP, and the then Parliamentary Under Secretary (Department for Transport), Robert Courts MP.³⁸⁷ The briefing said that senior HM Coastguard officers had reviewed numerous recordings, including 999 calls, and had accepted on the balance of probabilities that HM Coastguard was contacted by at least one caller on board the small boat that sank.³⁸⁸ The briefing concluded that "[e]verything was done to find that boat – searches were carried out by helicopter and the Border Force cutter Valiant and ships in the search area were alerted. Nothing was found".³⁸⁹

386 INQ010358/1.

387 INQ001339 and see cover email: INQ010466.

388 INQ001339/1/par3.

389 INQ001339/1/par3.

Chapter 9:

Resources for small boat search and rescue

9.1 This chapter considers the adequacy of resources available to HM Coastguard on 23 to 24 November 2021 for small boat search and rescue. The background was the high increase in the number of small boat arrivals in 2021, as discussed in Part 2, and the inevitable pressure placed on HM Coastguard and its partner organisations in small boat search and rescue. By 23 November 2021, contrary to expectations, there had been no seasonal downturn in the number of arrivals. A key question for the Inquiry, to be addressed in this chapter, is whether there were adequate resources available to HM Coastguard to mount an effective search and rescue response to incident ‘Charlie’, taking account of the sharp increase in small boat arrivals in 2021.

Were there adequate staffing levels?

9.2 The first issue regarding resources concerns whether there were adequate staffing levels within HM Coastguard on the night of 23 to 24 November 2021 for small boat search and rescue. Although staffing across the national network as a whole was in excess of what was required, the recommended seasonal staffing level at MRCC Dover, namely three operational staff for search and rescue, was not satisfied.¹ Only two operational HM Coastguard personnel were working on search and rescue that night: Mr Neal Gibson, the SMC and team leader, and Mr Stuart Downs, a trainee Maritime Operations Officer. There was also another trainee present. However, in contrast with Mr Downs, this trainee was non-operational and only 30 days into a nine-month training programme.² On the previous day, 22 November 2021, at a meeting involving HM Coastguard’s senior management, it had been recognised that it was insufficient to have only two operational members of staff at MRCC Dover during the night watch.³ However, a subsequent request for volunteers to join the watch was unsuccessful, except that an SMC from another station, Mr Richard Cockerill, altered his hours so that his shift at MRCC Dover on 24 November 2021 started two hours earlier than intended, at 05:00.⁴

¹ See paragraphs 6.3-6.4. See also INQ000409.

² INQ010715/33/ln4-11.

³ INQ000206/4.

⁴ INQ006765/1. See also paragraph 8.116.

- 9.3** This low staffing for search and rescue at MRCC Dover on the night was compounded by the unexpected absence, due to illness, of a staff member on the separate VTS team at MRCC Dover, which manages the safe navigation of vessels passing through the Dover Strait.⁵ As a result, the VTS team which, at that time, was co-located in the same operations room as the search and rescue team at MRCC Dover, was also one team member down. Therefore, Mr Gibson – who was VTS qualified – needed to provide cover while the staff in that team were on breaks.⁶ This situation, coupled with the small boat activity during the night, meant that Mr Gibson was unable to take a break throughout his 12-hour night shift.⁷ Unsurprisingly, Mr Gibson has accepted that the absence of a break had an impact on his performance. In his interview for HM Coastguard’s internal investigation into incident ‘Charlie’, he observed that he had become tired by 04:30 and that he “needed to swap out” but was unable to do so.⁸ Mr Gibson also accepted in his oral evidence to the Inquiry that he felt overwhelmed and fatigued on that night due to the inability to take a break.⁹ He said, understandably, that his failure to record relevant information and his decision-making on the night, contrary to HM Coastguard’s standard operating procedures, was because of his fatigue and tiredness.¹⁰
- 9.4** 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.¹¹ This is corroborated by the contemporaneous evidence which shows that, by at least August 2021, HM Coastguard was aware that staff at Dover were facing “tiredness bordering on exhaustion” and had inadequate time for breaks. There was a consequent drop in performance and a significant concern for staff welfare.¹² In his oral evidence, the Divisional Commander covering MRCC Dover, Mr Mike Bill, also recognised that operational performance could be impacted negatively by staff at MRCC Dover regularly missing their breaks, and that this created a wider risk of stress-related absence.¹³ Despite clear warnings some months before November 2021, Mr Gibson (and his counterparts on the subsequent day watch) were nonetheless unable to take breaks. The risks identified in the summer of 2021 had not been resolved by November 2021.

5 INQ010715/29/ln16-25. See also paragraph 4.24.

6 INQ010715/30/ln6-21.

7 INQ010715/31/ln12-18. I note that Mr Gibson was not alone in being unable to take a break that night. The Aviation Tactical Commander, Dominic Golden, did not recall taking a break during his shift and, due to low staffing, needed to cover the breaks of others in his team: INQ010718/131/ln10-20. Also, officers working at the Border Force MCC did not take their full breaks during the shift and told the Inquiry that this was normal practice: INQ010718/32/ln7-24, INQ010720/28/ln4-22.

8 INQ004724/3.

9 INQ010715/49/ln3-6.

10 INQ010715/164-165/ln24-4.

11 INQ010740/85/ln22-23; INQ010719/21/ln11-16.

12 INQ007279/4, INQ003379/2, INQ003322/2-4.

13 INQ010719/21-22/ln17-9.

- 9.5** In his oral evidence to the Inquiry, the MCA's corporate witness said that HM Coastguard staff would often voluntarily decide to miss their breaks in order to assist in saving lives, and that this reflected HM Coastguard's culture.¹⁴ It was surprising to hear HM Coastguard's view expressed in these terms. While, of course, as a life-saving organisation, it is correct – and indeed commendable – for HM Coastguard's culture to promote such values, it somewhat misses the point. The contemporaneous evidence and the evidence from operational witnesses does not suggest that there was any real choice facing HM Coastguard staff when they missed their breaks. Rather, they were unable to take breaks due to the volume of work. Further, there is no acknowledgement in the MCA's corporate witness' evidence of the negative impact on staff performance and wellbeing of a regular failure to take breaks. I am concerned that the organisational view appears to rely on staff goodwill to the detriment of staff welfare.
- 9.6** In short, although national staffing requirements had been exceeded, the number of HM Coastguard staff physically present at MRCC Dover on that night was insufficient. HM Coastguard's position is that the low numbers at MRCC Dover did not pose a problem because there was adequate resource within the national HM Coastguard network as a whole. In particular, the JRCC, HM Coastguard's national command and control centre at Fareham, provided assistance to Dover throughout the night.¹⁵
- 9.7** Support was provided from the JRCC to MRCC Dover in three distinct phases. Firstly, between 22:30 and midnight, when Mr Gibson was covering VTS and Mr Downs was taking his break, all operations at MRCC Dover moved to the JRCC, led by Mr Christopher ('Tom') Barnett, the SMC there. Secondly, when Mr Downs returned at midnight, Mr Barnett provided SMC cover to Dover remotely. Finally, after Mr Gibson returned from the VTS team at around 01:30, Mr Barnett's remote SMC cover ended but three staff members from the JRCC, including Mr Barnett, remained involved in Dover's work in a supporting capacity for the remainder of the shift.¹⁶ That involved one JRCC staff member monitoring Channel 16 on VHF radio (the primary channel for emergencies and the initial calling of other vessels) on Dover's behalf, and Mr Barnett and the other staff member providing general assistance in search and rescue, which included updating the tracker and ViSION incident logs, and answering calls.¹⁷
- 9.8** In contrast to the MCA's corporate position, it is clear from a call on the evening of 23 November 2021 between Mr Gibson and Mr Barnett that it was Mr Gibson's preference to have more staff physically present at Dover, rather than remotely

14 INQ010746/29/ln13-24.

15 INQ010746/67/ln9-23, 82/ln11-15.

16 INQ010140/7-8/par21-26, INQ010392/24-26/par56-57.

17 INQ010138/10/40(d).

from the JRCC.¹⁸ When asked in oral evidence about the reasons for this, Mr Barnett said that it was often easier to have staff under direct supervision.¹⁹ Other operational HM Coastguard witnesses agreed that it was preferable to have staff co-located in the same operations room, in particular for maintaining situational awareness and for effective information sharing within an operational team.²⁰ Moreover, reports on small boat search and rescue from summer 2021 identified the challenges and problems in maintaining situational awareness when the SMC was remote.²¹ Given the general consensus, the oral evidence of the MCA's corporate witness – that remote cover provided enhanced overall oversight – needs qualification.²² As HM Coastguard witnesses explained, there is an obvious benefit of remote cover for maintaining operational continuity in the event of staff sickness, demonstrated especially during the COVID-19 pandemic.²³ However, the evidence is that remote SMC cover is not as good as physical presence in terms of overall oversight, situational awareness and operational effectiveness.

9.9 The MCA's corporate witness also said that Mr Gibson could have asked for support if required on 23 to 24 November 2021 and that there were mechanisms in place to provide it.²⁴ However, Mr Gibson had requested assistance both from Mr Barnett at the JRCC and the Maritime Tactical Commander, Mr David Jones, at the start of the shift.²⁵ He had also attempted to find out whether the Small Boat Tactical Commander, Mr George Papadopoulos, would be working.²⁶ Support from the JRCC had been allocated in response to these requests for assistance at the 21:00 network management meeting.²⁷ Therefore, the events of the night show that Mr Gibson did request support and that remote support was provided. However, the remote support from the JRCC was not a complete answer to the staffing shortage at MRCC Dover that night in view of the disadvantages for situational awareness and information sharing within the search and rescue team. The majority of emergency calls that night were answered by Mr Gibson and Mr Downs at MRCC Dover, which placed the onus on them to update the ViSION incident logs with information obtained from the calls. As Mr Barnett said in his oral evidence, he and others at the JRCC who were working remotely relied on updates to the ViSION incident logs for their situational awareness and in order to complete other tasks, such as updating

18 INQ010128/2.

19 INQ010719/74-75/ln23-2.

20 INQ010719/20/ln2-24, INQ010715/8-9/ln22-3, INQ010719/198-199/ln21-4, INQ010720/115/ln7-25, INQ010719/75/ln1-2, INQ010720/177-178/ln19 -15 and INQ010740/9/ln7-23.

21 INQ007279/2-4, INQ003322/1-3. See paragraphs 6.11 and 6.15.

22 INQ010746/69/ln4-12.

23 For example, see INQ010715/41-42/ln21-8.

24 INQ010746/75/ln2-4.

25 INQ010128/2-7, INQ010129/2-3.

26 INQ010129/2-3.

27 INQ008822/5.

the HM Coastguard tracker spreadsheet.²⁸ However, this was unreliable in circumstances where the ViSION logs were not updated fully or correctly by staff at Dover, who were overwhelmed by other tasks. A record-keeping failure at MRCC Dover reduced the situational awareness of staff working remotely, which led to misunderstandings and mistakes being made.²⁹

Were staff at MRCC Dover sufficiently experienced and competent on the night of 23 to 24 November 2021?

- 9.10** In addition to the problem of the shortage of staff on duty at MRCC Dover and the shortcomings of remote assistance from the JRCC, the other challenge Mr Gibson faced that night was the lack of experience and competence in his search and rescue team. Mr Gibson himself was fully qualified and had substantial experience. However, this was not the case for the other members on his team. Mr Downs, who had started employment with HM Coastguard in March 2021, was only partially qualified as a Maritime Operations Officer in November 2021. He had passed his communications qualification, which permitted him to answer emergency calls, but he had not yet completed his Maritime Operations Officer training and, in particular, his incident response qualification.³⁰ Therefore, Mr Downs remained a trainee in November 2021 and in this sense was not fully competent. As he said in his oral evidence, staff shortages meant that there were fewer experienced staff members to learn from, but trainees were still expected to be actively involved in incidents and he primarily learned on the job.³¹ Understandably, he also said that it was not uncommon to feel overwhelmed.³²
- 9.11** In addition to the partially qualified Mr Downs, the other person in Mr Gibson's team that night was the non-operational trainee. In his oral evidence, Mr Barnett – who also supervised a non-operational trainee at the JRCC – said that he would expect a non-operational trainee essentially to observe.³³ However, on the night in question, the non-operational trainee at MRCC Dover did more than observe. She was tasked to monitor MRCC Dover's mobile phone and while doing so answered a call from the small boat associated with incident 'Charlie'. Given that she did not hold a communications qualification, she clearly should not have been told to answer what was effectively an emergency call.

28 INQ010719/61/ln9-18, 73/ln8-18.

29 See also paragraph 12.30.

30 INQ010392/24/par55.

31 INQ010720/96/ln16-20, 109/ln7-13.

32 INQ010720/109/ln18-19.

33 INQ010719/78/ln4-9, 83/ln12-14.

- 9.12** The non-operational trainee also made a phone call to the French Coastguard at 01:06 and then relayed the information obtained to Mr Downs on paper.³⁴ The potential risks of obtaining and recording information in this manner are highlighted by the subsequent entry made by Mr Downs in the ViSION incident system, which did not accurately reflect the content of the call.³⁵
- 9.13** There was a conflict in the evidence as to the appropriateness of a non-operational trainee making telephone calls to the French Coastguard. The MCA's corporate witness said that an SMC is empowered to permit a non-operational trainee to call a search and rescue partner since this was a routine call with another professional organisation.³⁶ There is no evidence that either SMC on duty on the night granted such permission. At the time of the call (01:06), Mr Barnett was the SMC at Dover, working remotely, and he was clear in his oral evidence that he did not believe it was appropriate for a non-operational trainee to make calls to the French Coastguard.³⁷ This view was supported by Mr Gibson and by Mr James Crane, the SMC and team leader at MRCC Dover on the subsequent day watch.³⁸ Therefore, it is likely that Mr Barnett did not tell the non-operational trainee to call the French Coastguard. Mr Gibson could not have done so as he was covering VTS at that time. What seems to have happened, as Mr Downs accepted in the course of his oral evidence, is that he may have asked the non-operational trainee to make the call because, as he said, he had been asked to undertake such tasks when he was non-operational.³⁹ Of course Mr Downs was not an SMC.
- 9.14** The MCA's corporate witness said that he did not believe that the involvement of the non-operational trainee in operational work at MRCC Dover resulted from low staffing but was because gaining practical experience under supervision was an appropriate way of conducting training.⁴⁰ The value of gaining practical experience during training, under appropriate supervision and support, is obvious.⁴¹ However, this was not what happened on the night. If, as appears likely, it was Mr Downs who asked the non-operational trainee to call the French Coastguard, this was not a case of appropriate supervision. Mr Downs

34 INQ004737/1, INQ010720/133/ln4-17.

35 On the call at 01:06, the French Coastguard referred to French small boat 'Migrant 1' as being in good condition (INQ007647/3). However, Mr Downs instead recorded that incident 'Charlie' (French 'Migrant 7') was in good condition (INQ000237/3). See also paragraph 8.43.

36 INQ010746/85/ln7-20.

37 INQ010719/87/ln14-20.

38 INQ010715/36/ln8-18, INQ010719/139/ln18-21.

39 INQ010720/126-128/ln22-2.

40 INQ010746/85-86/ln25-6.

41 As recognised in the International Aeronautical and Maritime Search and Rescue (IAMSAR) Manual guidance which states that "on the job training", where trainees learn and at the same time contribute to the aims of the organisation, is an "economical approach" which "requires competent specialists who can teach and coach trainees". See: International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 1', paragraph 3.2.19.

was himself not fully qualified. Moreover, as considered in more detail in Chapter 10, Mr Gibson and Mr Downs were engaged in emergency call handling, which diverted Mr Gibson from his SMC role. In particular, there was no one available to provide supervision to the non-operational trainee while she was operating the mobile phone. I also note Mr Barnett's evidence that the non-operational trainee on his team at the JRCC was not tasked to specific duties but observed by listening into calls and shadowing colleagues.⁴² The essential difference between the operational situation at the JRCC and at Dover MRCC was the scale of the short staffing at Dover. On the night in question, the most likely reason for the non-operational trainee's operational involvement and the absence of appropriate supervision related directly to the staffing situation at Dover.

- 9.15** An additional dimension in relation to staff members on the search and rescue team at MRCC Dover was their level of experience and training in relation to small boat search and rescue. Both Mr Gibson and Mr Downs had substantial experience of small boat activity. Mr Gibson told the Inquiry that he had performed multiple day and night shifts which involved small boats.⁴³ He observed that from around 2020, some 50% of shifts had involved small boats.⁴⁴ From the outset of his training with HM Coastguard in March 2021, Mr Downs had also been exposed to substantial small boat search and rescue. It was his evidence that he learned about small boat work on the job.⁴⁵
- 9.16** However, both Mr Gibson and Mr Downs said that they had not had any training specifically tailored to small boat search and rescue.⁴⁶ Indeed, this was consistent with evidence of other operational HM Coastguard witnesses, who said that they had not been trained specifically in small boat search and rescue by 23 November 2021.⁴⁷ The MCA's corporate witness said that there had been training held in Dover, Humber and the JRCC at Fareham in August and September 2021.⁴⁸ Since many of the HM Coastguard witnesses who worked on small boat search and rescue did not attend this training, it would appear that it was not made widely available. If, as appears to be the case, the training did not reach those staff members who were most involved in small boat search and rescue, it was not effective.
- 9.17** The Inquiry also heard evidence that the standard operating procedures that were specific to small boat search and rescue were not the subject of

⁴² INQ010719/78/ln4-9.

⁴³ INQ010715/7/ln1-5.

⁴⁴ INQ010715/7/ln9-22.

⁴⁵ INQ010720/96/ln9-24.

⁴⁶ INQ010715/6/ln6-13, INQ010720/95/ln4-16.

⁴⁷ For example, see INQ010720/175/ln8-17, INQ010740/29/ln21-25, INQ010140/2-3/par6, INQ010142/5/par12.

⁴⁸ INQ010098/61/par3.70.

any specific training at the point at which they were introduced. Rather, HM Coastguard staff, monitored by team leaders, were required to read and update themselves on anything new through the intranet.⁴⁹ The reliance on self-learning in a context where staff at MRCC Dover were known to be overwhelmed by the volume of work ran the obvious risk that the detail of the standard operating procedures would be missed or misunderstood.

- 9.18** In the absence of effective specific training for those working on small boat search and rescue, including on the new standard operating procedures specific to that work, there was a risk that knowledge about relevant processes would not be spread adequately or evenly among HM Coastguard staff working on small boats. Additionally, the focus placed on learning on the job at MRCC Dover relied on there being experienced and competent staff from whom the trainees could learn. However, the short staffing situation there frustrated this. This facilitated a climate in which individual practices could develop at MRCC Dover which were not reflected in HM Coastguard's standard operating procedures.⁵⁰

Was there adequate oversight of decision-making at MRCC Dover?

- 9.19** A further point relevant to the adequacy of staffing within HM Coastguard on the night relates to the oversight of decision-making at MRCC Dover, in particular the support and supervision of Mr Gibson himself. As we saw previously, as a result of short staffing he was initially diverted from his search and rescue team. Then, after he returned from VTS, he was diverted from his strategic role as SMC when he was required to undertake emergency call handling. This challenged his ability to maintain operational oversight as SMC. HM Coastguard's systems intended to apply a check in these circumstances, namely, that Mr Gibson's decision-making would be reviewed and supported at a strategic level by a Maritime Tactical Commander. However, this did not happen on the night watch of 23 to 24 November 2021.
- 9.20** The reasons underlying this failure again relate to resourcing. In addition to the staffing problems at MRCC Dover, there was a shortage that night at the JRCC Commander level. As a result of unexpected sick leave, there was only one Maritime Tactical Commander on duty, Mr David Jones.⁵¹ The shortage at Commander level could not be addressed by the overall resource within the national HM Coastguard network, which did not have any additional Maritime Tactical Commanders on duty that night. As well, Mr Papadopoulos, the Small Boat Tactical Commander, was not on duty. This was because there was only

⁴⁹ INQ010715/18-19/ln20-3, INQ010720/95-96/ln17-3.

⁵⁰ See also paragraphs 10.22 to 10.24 and 10.33.

⁵¹ INQ010138/8/par35.

one person in his role.⁵² Sensibly, Mr Papadopoulos prioritised being on duty for shifts where small boat activity was forecast to be highly likely, such as the day shift on 24 November 2021.⁵³ However, he could not work back-to-back shifts even if there was high small boat activity in each of them. Mr Jones' evidence to the Inquiry was that as the sole Maritime Tactical Commander on duty for the whole of the UK, he was unable to exercise any oversight of small boat search and rescue that night, given his responsibility for managing the national network. He said that the workload overseeing small boat search and rescue would be overwhelming for a single Tactical Commander managing the whole national network.⁵⁴

9.21 Therefore, Mr Jones did not conduct any review of small boat distress incidents during the night watch. He accepted that HM Coastguard's standard operating procedures required a review of each small boat distress incident, using the acronym 'RAG' ('review mission, assess response, give guidance').⁵⁵ In his oral evidence he explained that it was not possible to review all incidents proactively as the sole Maritime Tactical Commander on shift.⁵⁶ He said that if he had focused on small boat activity at Dover, he would have lost oversight of the national network.⁵⁷ The MCA's corporate witness questioned Mr Jones' account. In his oral evidence, he said that he could not understand why the RAG reviews were not undertaken by Mr Jones because, early in the evening, activity across the national network was not significant.⁵⁸

9.22 I cannot accept this evidence. Rather, I accept Mr Jones' explanation as to why he could not conduct the RAG reviews. As the individual in the role at the time, he seems best placed to explain his reasons for not conducting the RAG reviews. As well, the fact that activity across the network may not have been significant early in the evening would not have assisted Mr Jones given that the distress incidents were not recorded, and therefore available for review, until later in the night. Additionally, Mr Jones' evidence is supported by a document from August 2020, where the challenges facing a sole Maritime Tactical Commander on duty without any backup had been raised by another Maritime Tactical Commander.⁵⁹ Therefore, Mr Jones' concerns were shared with other operational personnel at the same level. In other words, HM Coastguard was on notice of the problems

52 In oral evidence, Mr Papadopoulos said that it became evident a few months after the role of Small Boat Tactical Commander was created that one person was insufficient and there were discussions and attempts to recruit a second person. However, this was ultimately unsuccessful: INQ010740/16/ln1-12.

53 INQ010740/10/ln16-23.

54 INQ010719/167/ln4-7, 169/ln15-20.

55 INQ010138/21/par70.

56 INQ010719/166/ln14-22, 219-220/ln6-1.

57 INQ010719/193/ln20-25, 194/ln1-6.

58 INQ010746/89/ln13-25.

59 INQ009932/1.

associated with having a sole Maritime Tactical Commander on duty during night watches well before November 2021.

- 9.23** Mr Jones also raised the wider question of the suitability of the RAG review process for small boat search and rescue operations. As he observed, “the process was designed for a time when [HM Coastguard] would be dealing with a fairly small number of [distress] incidents”.⁶⁰ In small boat search and rescue, the number of distress incidents is likely to be far higher given the unseaworthy nature of the vessels themselves and HM Coastguard’s policy to classify every small boat that enters UK waters as in the distress phase. Accordingly, the requirement to undertake a formal RAG review of each distress incident meant that there were a large, and sometimes overwhelming, number of small boat incidents requiring a RAG review.⁶¹ As Mr Jones told the Inquiry, this did not reflect the circumstances when the RAG review process was designed.
- 9.24** Mr Jones’ view was that his failure to conduct a RAG review of incident ‘Charlie’ did not have a material impact on decision-making that night.⁶² However, a review of the information in the incident logs may have prompted questions about some of the record-keeping failures that were evident on the night.⁶³ In other words, it would have ensured that the decision-making on incident ‘Charlie’ during the night watch was not insulated from the oversight and understanding of superior officers in HM Coastguard’s command chain. The key point is that if the RAG review had taken place, it would have provided an opportunity for Mr Gibson’s decision-making to be understood and, if necessary, questioned, and for potential errors to be corrected. This oversight mechanism was an important part of HM Coastguard’s accountability processes. It was missing on the night. As I have indicated, the failure resulted from insufficient staffing at the Maritime Tactical Commander level during the night watch.
- 9.25** Mr Jones told the Inquiry that since as Maritime Tactical Commander he could not review each incident log proactively, the onus was on SMCs to notify him about any incident that required his attention.⁶⁴ Mr Gibson did not speak to Mr Jones after they spoke initially during the early evening of 23 November 2021. Mr Gibson said that he did not consider it necessary to tell Mr Jones about the Mayday relay broadcast for incident ‘Charlie’.⁶⁵ However, Mr Jones said that he would expect to be notified if there was a Mayday relay broadcast, a vessel reported to be taking on water or sinking, or if people had entered the water.⁶⁶ Therefore, there was a mismatch between the information that

60 INQ010138/21/par70.

61 INQ010138/21-22/par71.

62 INQ010138/22/par72.

63 See also paragraph 12.42.

64 INQ010719/166/ln2-22.

65 INQ010715/104/ln14-23.

66 INQ010719/171/ln1-13, 214-215/ln21-11.

Mr Gibson considered he should pass on and what Mr Jones as a Maritime Tactical Commander expected to be told. Given that Mr Jones was not conducting any proactive reviews of the small boat distress incidents, direct contact from Mr Gibson would have been the only means of making him aware of incident 'Charlie' and obtaining tactical support. In the event, since he was not contacted, Mr Jones never became aware of incident 'Charlie' during the night watch.⁶⁷ As a result, there was no tactical support for MRCC Dover during the night watch in circumstances where HM Coastguard's processes mandated that there should have been. This was a failing which derived from a breakdown in communications and a discrepancy in understandings.

- 9.26** The Marine Accident Investigation Branch (MAIB) report observed that Mr Jones did not provide tactical support when he took a meal break.⁶⁸ The fact that Mr Jones took a break at an important time for the search and rescue response to incident 'Charlie' is not the point. The point is that Mr Jones did not provide tactical support on the night because he was unaware of incident 'Charlie'. The ultimate reason for this was the staffing situation within HM Coastguard, both at Maritime Tactical Commander level and at MRCC Dover. As the sole Maritime Tactical Commander on shift, Mr Jones was simply unable to review small boat distress incidents proactively. At MRCC Dover, the overwhelm which Mr Gibson was experiencing given the low staffing there may have contributed, at least in part, to his failure to bring incident 'Charlie' to Mr Jones' attention.

Was the resourcing of surface assets adequate?

- 9.27** The adequacy of the maritime and aerial assets available to HM Coastguard on 23 to 24 November 2021 was also relevant to the effectiveness of the search and rescue response to incident 'Charlie'. HM Coastguard relied on maritime assets provided by Border Force and RNLI to be available for small boat search and rescue. In November 2021, both organisations were under significant pressure given the large numbers of small boat arrivals that year, which continued into the winter months. The minutes of a meeting between HM Coastguard and Border Force which took place a few days before 23 to 24 November 2021 record that Border Force and RNLI were operating at the highest level of their capacity. The situation was critical and unsustainable for Border Force.⁶⁹ In his oral evidence to the Inquiry, the Home Office's corporate witness, Mr Stephen Whitton, accepted that in November 2021 there were insufficient assets to respond to the

67 INQ010719/218/ln4-9.

68 INQ010445/50-51/par1.11.5, 84-86/par2.6.2. In his witness statement to the Inquiry, Mr Jones corrected the length of his break, noting that the log of his key pass data shows that it was in fact slightly over 90 minutes, but it appeared longer because his message in the ViSION system to indicate that he had returned was sent later: INQ010138/19-20/par59.

69 INQ009957/2-3.

demand for search and rescue.⁷⁰ He added that crews were rarely getting breaks, working long hours under significant pressure and in a high risk environment.⁷¹ Understandably, Mr Gibson at MRCC Dover had concerns around managing finite resources in making tasking decisions. He was mindful not to exhaust or fatigue what he had available to him and conscious that there was no back up if the RNLI was unavailable due to repeat taskings.⁷²

- 9.28** In terms of available maritime assets on the night watch of 23 to 24 November 2021, there were two Border Force vessels on standby: the Valiant and the smaller coastal patrol vessel, Hunter, with the Valiant designated as the primary responder. The crew transfer vessel catamaran, Hurricane, was also available from 06:00.⁷³ Additionally, there were no planned off-service periods for RNLI lifeboats, all of which were available to be tasked by HM Coastguard.⁷⁴ Therefore, while two Border Force maritime assets and all RNLI assets were theoretically available during the night watch, assets that were used during the night watch would have had an impact on what was available during the following day watch, which was expected to be even busier.
- 9.29** Accordingly, the question of whether there were adequate vessels available during the night watch cannot be answered by a simple consideration of the numbers of assets on standby that night. What was available in practice during the night watch was bound up with the concern of HM Coastguard staff like Mr Gibson to preserve limited resources for the following day shift, which had an Operation DEVERAN ‘red’ rating. In an email sent on 26 November 2021 to the Small Boat Tactical Commander, Mr Papadopoulos, the day watch SMC, Mr Crane, said that it had been apparent during the day shift on 23 November that there would be insufficient surface assets for the busy day expected on 24 November.⁷⁵ This concern inevitably operated on the minds of HM Coastguard staff when making tasking decisions.
- 9.30** Border Force Higher Officer, Ms Karen Whitehouse, who was on duty during the night watch, told the Inquiry that further resources could have been sent if Border Force had been asked to provide them.⁷⁶ Indeed, this is consistent with the Hunter being on standby throughout the night watch. However, it does not accord with the contemporaneous calls from the night watch and in particular, a call at 03:11 between Mr Gibson and Ms Whitehouse’s colleague at Border Force, Mr Thomas Willows.⁷⁷ During this call, Mr Gibson informed Mr Willows that

70 INQ010742/89/ln17-23.

71 INQ010742/78/ln6-10.

72 INQ010715/129/ln6-8, 131/ln1-12.

73 INQ000566/1, INQ000582/2 .

74 INQ000206/2, INQ010741/85/ln1-8.

75 INQ003735/2.

76 INQ010135/31/par77.

77 INQ007602.

there were potentially other small boats in addition to incident ‘Charlie’ in the vicinity of the Sandettie Light Vessel. Mr Willows replied that they did not want to call any other assets out at that point but would wait to see what developed.⁷⁸ They both agreed that it was “the dream” only to task one asset. In their witness statements to the Inquiry, both Mr Gibson and Mr Willows said that their views expressed on the call were motivated by the need to preserve sufficient resources for later in the day.⁷⁹ Accordingly, the contemporaneous evidence suggests that Border Force, as well as HM Coastguard, was reluctant to deploy further assets during the night watch.

- 9.31** Notwithstanding the fact that assets were preserved on the night watch, with only one maritime asset having been tasked, there remained insufficient surface assets available during the day watch on 24 November 2021. In Mr Crane’s email to Mr Papadopoulos of 26 November 2021, Mr Crane stated that the two Border Force surface assets that were available on the day watch of 24 November (Hurricane and Hunter, the Valiant having gone off service on the morning of 24 November 2021) were insufficient.⁸⁰ He noted that the lack of surface assets contributed to some of the beach landings that day and said that it was not sustainable for HM Coastguard to have only two Border Force surface assets available with such high levels of small boat activity, which put additional pressure on the RNLI.⁸¹ Indeed, the two Border Force surface assets available on the day watch of 24 November were below what the Home Office’s other corporate witness, Mr Daniel O’Mahoney, called the standard deployment of three or four Border Force vessels on days on which crossings were highly likely.⁸²
- 9.32** The inadequacy of surface asset availability on the day watch is supported by contemporaneous calls that day which referred to the limited resources available and being overstretched.⁸³ Mr Crane’s email also observed that RNLI was “already stretched” and that crews were “becoming more reluctant to turn out for migrant taskings”.⁸⁴ Indeed, three days before the night in question, on 20 November 2021, RNLI at Ramsgate had refused to respond to a small boat incident which was not facing an immediate emergency.⁸⁵ The basis was that Border Force should have had sufficient assets available to attend.⁸⁶ In other words, if Mr Gibson had tasked Hunter or a RNLI lifeboat on the night of 23 to 24 November 2021, this would have further reduced the already insufficient resources available on 24 November 2021. As Mr Gibson’s evidence made clear,

78 INQ007602/3.

79 INQ010392/69-70/par133, INQ010214/3-4/par10.

80 INQ003735/2.

81 See also INQ010719/145-146/ln18-11.

82 INQ010742/180-181/ln2-7.

83 For example, INQ007733/3.

84 INQ003735/2.

85 See paragraph 7.62.

86 INQ004359/2.

his knowledge of the limited resources impacted on his tasking decisions on the night. As he put it in oral evidence, when asked whether he was intentionally minimising the use of assets, he said that he was being as efficient as he possibly could be.⁸⁷

- 9.33** There is the additional point about the inherent unsuitability of Border Force vessels for use as search and rescue assets.⁸⁸ In his statement on behalf of the Home Office, Mr Whitton explained how the Border Force cutters, such as the Valiant, would deploy their rigid hull inflatable boat to rescue people on board small boats and relay them in small groups back to the cutter. That was a lengthy process and the long waits for those left on board the small boat could lead to panic and an even more dangerous situation.⁸⁹ Commander Kevin Toy, the Valiant's Commander, agreed that it was extremely challenging to embark people from small boats on to the Valiant.⁹⁰ Mr Whitton said that the catamaran crew transfer vessel, Hurricane, which had been trialled in 2021, was better suited to search and rescue and could carry larger numbers.⁹¹ However, Hurricane was not available during the night of 23 to 24 November 2021. Mr Whitton told the Inquiry that in 2021 there was a recognition within Border Force that its cutters and coastal patrol vessels were increasingly proving not to be suited to search and rescue.⁹² In his oral evidence on behalf of the Home Office, Mr O'Mahoney also said that it became clear in 2021 that a different kind of surface asset was required and, more fundamentally, that they "just needed more boats".⁹³ However, additional crew transfer vessels did not become available until 2022.⁹⁴ Given this evidence of the Home Office corporate witnesses and of an experienced Commander like Mr Toy, who have most knowledge of the Border Force vessels, I was surprised that the MCA's corporate witness asserted that the assets available to HM Coastguard in 2021, including the Border Force vessels, were "wholly suited" to search and rescue.⁹⁵
- 9.34** In summary, in November 2021 Border Force Maritime was under-resourced and the RNLI was stretched to its limits. This impacted on the tasking decisions taken on the night of 23 to 24 November 2021. Despite what appears to be seemingly healthy numbers of maritime assets available on standby during the night watch, in practice Mr Gibson and Border Force were reluctant to use any more than one surface asset that night. They knew that the assets used then would reduce the

87 INQ010715/135-136/ln19-1.

88 INQ010137/27-28/par73.

89 INQ010137/27-28/par73.

90 INQ010717/31-32/ln8-8.

91 INQ010137/27-28/par73.

92 INQ010742/61/ln11-13.

93 INQ010742/196/ln15-24.

94 INQ010137/10/par21.

95 INQ010746/44/ln3-19.

availability of an already insufficient number of assets the following day, a day forecast to be even busier.

Was the resourcing of aerial assets adequate?

- 9.35** In addition to maritime assets, HM Coastguard relied on aerial assets provided by its contracted commercial partners to assist with small boat activity. These furnished both surveillance and search and rescue. The provider of fixed-wing surveillance aircraft, 2Excel, was scheduled to supply a continuous fixed-wing presence giving surveillance over the Dover Strait from around 00:30. However, there were no fixed-wing flights undertaken by 2Excel that night. The reasons were outside 2Excel's control. As the company explained to the Inquiry, in the poor weather conditions over the south coast of the UK that evening, its operating manual required that there be two diversion airports available. There were only two airports within range of the tasking area which were above the required weather limits. One refused 2Excel's request. 2Excel's corporate witness, Mr Christopher Norton, explained in his oral evidence that by 04:54, the weather had improved and 2Excel would have been able to fly. However, at that point the airport from which the aircraft was due to depart was closed.⁹⁶ As a result, the combination of the absence of diversion airfields when the weather was poor and the airport closure when the weather had improved meant that 2Excel's aeroplanes were grounded throughout the night.
- 9.36** HM Coastguard's Aviation Tactical Commander, Mr Dominic Golden, explained in his evidence that the increased numbers of small boat crossings in 2021 and the resulting increased number of flying hours put pressure on all air assets contracted by HM Coastguard.⁹⁷ Further, increased wear and tear and increased mandatory maintenance led to greater gaps in flying programmes.⁹⁸ As we have seen, this did not explain 2Excel's failure to fly on the night in question. Moreover, as HM Coastguard's Maritime Tactical Commander, Mr Jones, said in his oral evidence, it was unusual not to have a fixed-wing surveillance flight and he could not recall being on a shift previously where all flights had been cancelled.⁹⁹
- 9.37** Mr Jones also told the Inquiry that he was unaware of any training or guidance on contingency plans for a situation in which a scheduled fixed-wing flight was cancelled.¹⁰⁰ Similarly, Mr Golden said that 2Excel was the only plan that night and there was no "plan B".¹⁰¹ His oral evidence was consistent with the

96 INQ010716/56/ln19-23.

97 INQ010718/127-128/ln24-8.

98 INQ010718/128/ln6-8.

99 INQ010719/202/ln11-13.

100 INQ010719/202/ln14-17.

101 INQ010718/135-136/ln24-6.

contemporaneous calls in which he had raised, rhetorically, the absence of a contingency plan, suggesting that there was an assumption within HM Coastguard that a fixed-wing flight would always be available, whereas, in his words, “surprise, surprise...the plan doesn’t always work”.¹⁰² Mr Jones and Mr Golden both gave evidence that in the absence of a contingency plan, they worked together on that night to devise a solution to provide surveillance over the Dover Strait, which resulted in the use of the search and rescue helicopter, R163. In light of their evidence, I reject the evidence of the MCA’s corporate witness that the use of R163 was in accordance with a predetermined contingency plan. In fact, he could not confirm whether such a plan was documented and no such plan has been produced to the Inquiry.¹⁰³ The reality is that HM Coastguard did not have a predetermined backup plan if a scheduled surveillance flight was cancelled at short notice.

- 9.38** No other assets were available as a backup to replace the cancelled 2Excel flight. As Mr Golden explained in oral evidence, he dismissed the possibility of using the high-altitude fixed-wing surveillance flight operated by the company RVL. The RVL flight was not on standby but was engaged in flying a different mission for the Home Office.¹⁰⁴ Mr Golden added that he did not consider that the RVL aircrew would have had the competency or capability to fly a low-level flight at night in poor weather conditions.¹⁰⁵ Equally, Mr Golden dismissed the drones operated by the company Tekever, which were also contracted by the Home Office to provide surveillance. Whereas there was no requirement for diversion airfields with drone flights, their performance was more susceptible to poor weather and they would have been unable to fly in any event.¹⁰⁶ Additionally, Tekever was contracted to fly at fixed times and did not have an aircraft or crew on standby.¹⁰⁷
- 9.39** That left the search and rescue helicopter R163. Mr Golden made clear in his oral evidence that he considered helicopters to be the “crown jewels” of the air assets available to him. Not only could they patrol for surveillance purposes, but they could also conduct searches and effect rescues.¹⁰⁸ If the tasking was for a surveillance patrol, Mr Golden said that his preference would be to use another asset. That was to preserve the helicopter’s flying hours in order to keep it in reserve in case another incident arose which could only be responded to with the use of the helicopter.¹⁰⁹

102 INQ007824/7.

103 INQ010746/117/ln15-16.

104 INQ010718/145/ln20-23.

105 INQ010718/145-146/ln23-1.

106 INQ010718/113-114/ln15-22.

107 INQ010718/114-115/ln23-5.

108 INQ010718/125-126/ln23-3.

109 INQ010718/126/ln3-10.

9.40 The failure of the 2Excel flight on the night of 23 to 24 November 2021 was not related to a lack of resources. Rather, it was a result of an unfortunate combination of poor weather and airport unavailability. However, I agree with the MAIB report that it was foreseeable that 2Excel could fail to complete its planned surveillance taskings.¹¹⁰ As Mr Golden's evidence made clear, as with the maritime assets, the increased numbers of small boat crossings in 2021 had put significant pressure on the aerial assets contracted by HM Coastguard. In particular, this had led to increased mandatory maintenance and gaps in the service, some of which were experienced on the day watch of 24 November 2021.¹¹¹ Despite this, HM Coastguard had not drawn up a predetermined contingency plan by November 2021. As a result, time was lost while the two Tactical Commanders devised a plan on the night. That involved using a search and rescue aerial asset, the R163 helicopter, for surveillance purposes, which meant that it was unavailable for search and rescue in the morning of 24 November 2021.¹¹²

Conclusion – were there adequate resources available to HM Coastguard on the night of 23 to 24 November 2021?

9.41 My overall conclusion is the resources available to HM Coastguard on the night of 23 to 24 November 2021 were inadequate and that this affected its response to incident 'Charlie'. The resourcing problems were exacerbated, but not completely explained, by the high increase in small boat crossings in 2021 and, in particular, in November that year. Firstly, the staffing at MRCC Dover on the night watch of 23 to 24 November 2021 was inadequate. Low staffing at MRCC Dover was a chronic problem and HM Coastguard was on notice about it before November 2021. Remote support from the JRCC could not overcome the twin problems of an insufficient number of staff co-located in the same operations room at MRCC Dover and the lack of experience of some of the staff there. Moreover, the evidence suggests that there needed to be more than one Maritime Tactical Commander on duty during a period of high small boat activity. Despite efforts to increase staff numbers, as at 23 to 24 November 2021 the resourcing problem persisted and could not be mitigated completely by reliance on the national HM Coastguard network.

9.42 The staffing situation had a direct impact on the events of the night. Mr Gibson, the SMC, was engaged in call handling work that should have been undertaken by Maritime Operations Officers. That diverted his attention from his main role of maintaining strategic oversight as the SMC. He was also unable to take

110 INQ010445/93/par3.3.13.

111 See Mr Crane's email to Mr Papadopoulos which explained the failure of the scheduled 2Excel flights during the day watch following a series of technical problems: INQ003735/2-3.

112 INQ007728/2.

a break which, unsurprisingly, left him feeling exhausted and overwhelmed. As he accepted, this affected his operational performance. There were no fully qualified Maritime Operations Officers in Mr Gibson's team and some operational tasks were undertaken by a non-operational trainee. Errors occurred. Additionally, staff at the JRCC, who were involved to varying degrees throughout the night, did not share the same level of situational awareness as those physically present at Dover. Further errors occurred in the recording of information by the JRCC at Fareham.¹¹³ There was no opportunity for these to be corrected because Mr Gibson was overwhelmed and there was no additional oversight of MRCC Dover's decision-making on incident 'Charlie'.

9.43 Secondly, the pressure on Border Force and RNLI maritime assets available to HM Coastguard on that night impacted on the tasking decisions made. Border Force and Mr Gibson were reluctant to use more than one maritime asset that night in the knowledge that there were insufficient assets for the following shift, which was forecast to be even busier. HM Coastguard and the Home Office were aware of the strain on Border Force and the RNLI in November 2021. The situation had not been resolved by the time of the night in question.

9.44 As regards aerial assets, there was also pressure on the operators of the aerial assets contracted by HM Coastguard due to the sharp increases in the volume of small boat crossings. As explained earlier, this did not account for the failure of the 2Excel surveillance flight on the night. However, a predetermined contingency plan was not available for a situation in which the fixed-wing surveillance flight was cancelled. This led to a situation in which time was lost in planning and the flying hours of the search and rescue helicopter were used in surveillance. In 2021 an uplift in aerial capability was contemplated through Project CAESAR, but the increase of aerial surveillance was not achieved until 2022.¹¹⁴ It was the same as with staffing and the availability of maritime assets: measures which were envisaged as addressing shortfalls had not been achieved by November 2021.

¹¹³ See also paragraph 12.42.

¹¹⁴ See paragraphs 4.99 and 6.50.

Chapter 10:

Initial search response to incident ‘Charlie’: information gathering

10.1 This chapter considers the adequacy of the initial search and rescue response to incident ‘Charlie’ and, in particular, of the information gathering conducted by HM Coastguard. In the absence of aerial surveillance and advance intelligence on small boat activity from the French Coastguard, HM Coastguard had no knowledge of the progress of any small boats across the Dover Strait until it started to receive distress calls. When the French Coastguard first informed HM Coastguard about incident ‘Charlie’, it did not share any information about the condition of the small boat.¹ Therefore, before the Valiant and R163 arrived on scene, the only available sources of information for HM Coastguard about the condition of incident ‘Charlie’ were communication from those on board and any responses to the Mayday relay broadcast. This chapter will consider the adequacy of information sharing on that night, of communication with people on board incident ‘Charlie’, and of the Mayday relay broadcast and response to it.

Was there adequate information sharing about small boat activity?

10.2 As observed previously, the cancellation of the scheduled fixed-wing surveillance flights meant that HM Coastguard could not obtain an aerial maritime picture alerting it to small boat activity in the Dover Strait.² It was effectively blind, as recognised by the Maritime Tactical Commander and the Aviation Tactical Commander on that night, and their concerns about the dangerous situation this created for HM Coastguard were recorded as a controller message in the migrant administration VISION log at 00:41.³ However, the SMC at MRCC Dover, Mr Neal Gibson, does not recall seeing the message.⁴ As he explained, he was covering for the VTS team at the time and when he returned, he was focused on distress incidents.⁵ He said that he would have been more likely to have seen it if it had been in the national network management log, as he would have looked at it to record his return from VTS.⁶ However, the Maritime Tactical Commander, Mr David Jones, explained that he recorded the

1 Paragraph 8.42-8.43.

2 See also paragraphs 7.53, 8.35 and 8.68.

3 INQ000235/2-3.

4 INQ010715/71-72/ln8-2.

5 INQ010715/72/ln2-15.

6 INQ010715/74/ln19-25.

message in the migrant administration log because anyone working on small boats, including Mr Gibson, would be expected to review that log.⁷ This was a reasonable assumption for Mr Jones to have made given that Mr Gibson's role as SMC for zone 14 required him to remain informed of the ViSION logs for small boat activity, including the generic migrant administration log.

10.3 However, the Inquiry heard evidence that when Mr Gibson returned from covering VTS, he was immediately busy with distress incidents and call handling and would not have had sufficient time to review previous entries on the ViSION logs.⁸ Mr Christopher ('Tom') Barnett, who was providing remote SMC cover at the time that the controller message was sent, was aware of it and had conversations with Mr Jones about it directly, given that they were both co-located at the JRCC.⁹ However, it is unlikely that Mr Barnett passed this information on to Mr Gibson when handing back the SMC role at around 01:30. Neither witness could recall whether any handover took place, and Mr Barnett said that it was likely that any conversation they had was shortened or omitted due to the operational demands on Mr Gibson as soon as he returned.¹⁰ However, despite being unaware of the Maritime Tactical Commander's concerns, Mr Gibson said that he would have probably been told by the MRCC Dover search and rescue team on his return that the planned flights were unlikely to take place because of the weather and he was very aware of the dangers that night.¹¹

10.4 Notwithstanding the absence of the surveillance flight, two of HM Coastguard's search and rescue partners did hold advance information about small boat activity. Firstly, the Clandestine Channel Threat Command within the Home Office had received intelligence at 18:22 on 23 November 2021 estimating there could be hundreds of people arriving by small boat in the UK search and rescue region by 24 November 2021.¹² While this was not live information in the sense that it was not shared in real time, it was important. The Inquiry has seen no evidence that it was shared with HM Coastguard. Indeed, it appears that it was not shared more widely even within the Home Office. Ms Karen Whitehouse, the Higher Officer on duty within Border Force MCC on that night, could not recall receiving the information.¹³ It is concerning that valuable intelligence that was directly relevant to HM Coastguard's search and rescue response was not shared by the Clandestine Channel Threat Command. The absence of a reliable mechanism for the sharing of intelligence between the Home Office and HM Coastguard as to the estimated numbers of arrivals created a preventable weakness in HM Coastguard's situational awareness.

7 INQ010719/203/ln1-10.

8 INQ010719/80/ln1-8.

9 INQ010140/13/par29.

10 INQ010715/67/ln13-15, INQ010719/80/ln1-8.

11 INQ010715/73/ln5-25.

12 INQ002267/1.

13 INQ010718/46-47/ln14-20.

- 10.5** The other of HM Coastguard's search and rescue partners to hold advance information about small boat activity that night was the French Coastguard. However, the French Coastguard's operational tracker, which recorded small boat activity, was not proactively sent to HM Coastguard. It was requested by HM Coastguard during a call with the French Coastguard at around 00:35 when it became apparent that the French Coastguard was aware of four small boats making their way towards UK waters.¹⁴ It was only after this prompting that HM Coastguard was sent the French tracker for the first time at around 00:56.¹⁵ The tracker showed that six small boats had been detected by the French authorities, of which two had been prevented from launching. Of those that had not been intercepted, the tracker showed that the French Coastguard had detected the first small boat at 21:00 on 23 November 2021, the second and third at 22:24, and the fourth at 00:13 on 24 November 2021. Other information including location co-ordinates and numbers of people on board was also included. In the absence of aerial surveillance, this was self-evidently vital information for HM Coastguard.
- 10.6** The reasons for the French Coastguard's failure to send its tracker proactively and promptly are questions for the French investigation. However, it is worth noting that the failure to do so was not uncommon. Delays in sending the French tracker were frequently raised in bilateral meetings between HM Coastguard and the French Coastguard since at least the end of 2020.¹⁶ On the evening of 23 November 2021, in a call between Mr Gibson and Mr Barnett, Mr Gibson expressed a concern that, given past experience, HM Coastguard may be sent French intelligence late (or in his words, a "Gris-Nez bomb").¹⁷ In his evidence to the Inquiry, Mr Gibson said the frequent delays were mitigated by a common practice at MRCC Dover of calling the French Coastguard to check whether it was aware of any small boat activity.¹⁸ However, this did not happen on the night. When asked why, Mr Gibson said that he was distracted from doing so by the administrative requirements related to the staff member on sick leave.¹⁹ Additionally, he was not on duty for search and rescue during the most relevant time, from 22:30, when he began his period of cover for the VTS team.
- 10.7** Mr Stuart Downs, the trainee Maritime Operations Officer, said that he would not have called the French Coastguard in the absence of direction from Mr Gibson because this was a question for the SMC.²⁰ Mr Barnett, who was the SMC from 22:30, acknowledged that there were regularly calls made to the French Coastguard to check if there was any small boat activity. However, he observed that there was an awkwardness around repeatedly requesting from a professional

14 INQ007645/2.

15 INQ007691.

16 See paragraph 7.76.

17 INQ010128/3, INQ010715/59-61/ln12-3.

18 INQ010392/31-32/par65, INQ010715/64/ln5-7.

19 INQ010715/64/ln7-15.

20 INQ010720/131/ln11-17.

partner search and rescue organisation information which it had already agreed to provide. He said that there were “only so many times [HM Coastguard] could call before [French Coastguard] see you as questioning their professionalism”.²¹ Given the obvious operational need to maintain good relations with the French Coastguard, Mr Barnett’s concerns were justified. It could not reasonably be expected of HM Coastguard operational staff to be regularly checking on and chasing up its search and rescue partner, another professional coastguard. The problem of routine delays with receiving the French tracker required resolution at a higher level. It is disappointing, to say the least, that despite the problem having been raised in meetings between HM Coastguard and the French Coastguard for many months, it persisted on 23 to 24 November 2021.

- 10.8** The delay in receipt of the French tracker on the search for incident ‘Charlie’, in terms of HM Coastguard’s information gathering about it, had little impact.²² This is because the French tracker received by HM Coastguard at 00:56 did not contain any information about incident ‘Charlie’. It was first mentioned by the French Coastguard in a telephone call at 01:06. However, this did not provide any information about the condition of the small boat.²³ The first time that the French Coastguard passed information about the condition of incident ‘Charlie’ to HM Coastguard was in a call at 02:42.²⁴ Until that later call from the French Coastguard, which was before any search assets arrived on scene, HM Coastguard’s awareness that incident ‘Charlie’ was an emergency requiring immediate assistance was obtained solely from telephone calls from the small boat itself.

Was there adequate communication with those on board the small boat associated with incident ‘Charlie’?

- 10.9** In November 2021, there were two main ways by which HM Coastguard communicated with people on board small boats. First, there were the emergency calls transferred by the 999 switchboard or by other agencies, such as the police. Secondly, there were the text messages sent and received by MRCC Dover’s mobile phone. There were difficulties and weaknesses associated with each of these means of communication. They were apparent on the night of 23 to 24 November.

21 INQ010719/82/In2-20.

22 See also paragraph 11.24.

23 INQ007647. See also paragraph 8.42.

24 INQ007656 during which the French Coastguard relayed to HM Coastguard that those on board incident ‘Charlie’ had said: “Help me, help me, help me. We are in the water.”

The effectiveness of call handling with small boats

- 10.10** In November 2021, call handling with people on board small boats posed significant difficulties for HM Coastguard.²⁵ Firstly, unlike communication between HM Coastguard and commercial or pleasure vessels, there was no means of communicating with small boats via radio. People on board small boats relied on their mobile telephones, with limited battery power, to communicate with HM Coastguard and the French Coastguard. However, mobile telephone network coverage was unreliable in the Dover Strait, particularly when small boats were close to the median line. As a result, calls from small boats were liable to cut out. This happened frequently.
- 10.11** Secondly, the services that provide location information and the number of the calling telephone to the emergency services – the Enhanced Information Service for Emergency Calls and Advanced Mobile Location – were often ineffective in respect of calls from small boats. This was because they did not work when a call was made from a non-UK handset or when a UK handset roamed onto a non-UK network. This particularly affected small boats close to the median line, due to their proximity to French mobile telephone networks.
- 10.12** Thirdly, there was the language barrier which hindered effective communication between HM Coastguard and people on board small boats.²⁶ English was typically not the first language spoken by callers from small boats. However, they were required to speak in English because HM Coastguard's telephone interpretation service was not fit for use with small boats.²⁷ The MCA's corporate witness acknowledged that HM Coastguard was aware in 2021 that its telephone interpretation service, Language Line, was not used in the Channel. He accepted that HM Coastguard had not made any attempts to find alternatives by November 2021. He did not suggest that this could not have been done sooner.²⁸ I find all this surprising.
- 10.13** On the night of 23 to 24 November 2021, the general difficulties faced by HM Coastguard in communicating with small boats were evident. It was often not possible for MRCC Dover to obtain Enhanced Information Service for Emergency Calls or Advanced Mobile Location information. There were evident communication difficulties due to the language barrier.²⁹ Calls were difficult to

25 These challenges also pre-dated November 2021. See also paragraphs 6.55 to 6.60.

26 INQ010740/46/ln17-25, 4/ln1-5, INQ010715/10/ln6-8, INQ010720/154/ln19-25. See also paragraphs 6.61 to 6.67.

27 INQ010746/146/ln5-23, INQ010720/97/ln6-22.

28 INQ010746/146-147/ln5-15.

29 For example, see the call at 01:48 (INQ007630) when Mr Gibson was unable to explain to those on board the small boat associated with incident 'Charlie' that he was not on board the vessel they could see.

hear and cut out multiple times.³⁰ These significant difficulties with call handling on the night of 23 to 24 November 2021 were compounded by the pressures that the staff at MRCC Dover were under at that time, as explained in Chapter 9. Due to inadequate staffing levels on the night, the SMC, Mr Gibson, was required to act as call operator, which self-evidently distracted him from his primary function of maintaining strategic oversight. The only other operational staff member physically present at MRCC Dover, Mr Downs, was not yet fully qualified. Although, at that time, he had passed his communications qualification which allowed him to answer emergency calls, he did not finish his training until 2022. While the JRCC at Fareham provided some remote assistance during the night, the majority of the incoming calls were answered by Mr Gibson and Mr Downs. This put them under significant pressure. The inadequacies in call handling during the night watch, as discussed below, must be considered in this context.

- 10.14** In the absence of aerial surveillance and information from the French Coastguard, communication from the small boat associated with incident ‘Charlie’ itself took on increased importance. Before the arrival of any assets on scene, calls from incident ‘Charlie’ – apart from any responses to the Mayday relay – were the only means by which HM Coastguard could obtain information as to its condition and location. The standard operating procedure entitled ‘VISION – multiple call, scenario and incident functions’, in force at the time of the events, emphasised the importance of fully questioning all callers who were suspected to originate from the same incident “in case they have additional pertinent information to that already received”.³¹ It also warned against the assumption that the same information would be given. It does not appear that this guidance was always followed on the 23 to 24 November 2021.
- 10.15** After the initial call at 01:48 between Mr Gibson and Mubin Rizghar Hussein, the 16-year-old onboard incident ‘Charlie’, which led Mr Gibson to believe there was a real emergency and to broadcast the Mayday relay, the contemporaneous evidence suggests that the further calls made by people on board incident ‘Charlie’ were treated with less urgency by comparison. There was a failure to obtain important and basic information from callers. For example, a call at 02:25, identified by Mr Gibson as originating from incident ‘Charlie’, lasted almost five minutes, but the phone number of the caller and his location were missed.³² As Mr Gibson observed in his oral evidence, obtaining a telephone number for a caller was very important so that HM Coastguard staff could re-establish contact if necessary.³³

30 For example, a call made from a small boat at 01:35, which the operator described as a “man screaming down the phone” and which was later identified as originating from incident ‘Charlie’, cut out before it could be transferred to MRCC Dover (INQ007639). Another call at around 01:45, which was also attributed to incident ‘Charlie’, again cut out before it could be transferred (INQ007592).

31 Version 1.0, 29 March 2021, INQ000435.

32 INQ007654.

33 INQ010715/17/ln2-13.

- 10.16** Equally, up-to-date location information, particularly in the absence of aerial surveillance, was essential to enable surface assets to find a small boat. At 02:31 another call from the small boat associated with incident ‘Charlie’ lasted almost seven minutes. Mr Gibson identified Mubin Rizghar Hussein, to whom he had spoken at 01:48 and who had previously sent geolocation information to the HM Coastguard mobile telephone. Updated geolocation information was not obtained.³⁴
- 10.17** Further, there was a failure to obtain a name and telephone number from two calls received by Mr Downs at 03:06 and 03:12. This was shortly before it is likely that those on board incident ‘Charlie’ fully entered the water.³⁵ The omission was particularly relevant because these calls were unattributed to any incident on the night. However, both contained a narrative and level of distress that was consistent with the condition of incident ‘Charlie’. The caller at 03:06 said that there were 34 or 35 people on board, the boat was sinking, and that “almost half our body [was] in the sea” before the call cut out.³⁶ The caller at 03:12 kept repeating “help me” and said that they were “finished”.³⁷ In the absence of a name or telephone number, neither call was attributed to any incident on the night. The full significance of information received shortly before the small boat associated with incident ‘Charlie’ was swamped was therefore missed.³⁸
- 10.18** Further, during the call between Mr Gibson and people onboard incident ‘Charlie’ at 02:31, he expressed frustration at the repeat calls. He told those on board to stop calling and await the arrival of the rescue boat.³⁹ His reasoning was that each further call created problems for reconciliation, which was distracting him from having an overview of the complicated maritime picture.⁴⁰ His frustration at being distracted from his function as SMC is understandable in the context of the staffing problem he faced. However, it was inconsistent with HM Coastguard’s standard operating procedures not to obtain full information from these repeat calls. The short staffing put Mr Gibson in a very difficult position. He was forced to undertake a call handling role which was not intended for an SMC and which impacted negatively on his situational awareness and strategic oversight. He was required to undertake two roles at once, which impacted his effectiveness both as a call handler as well as an SMC. It was not a fault of Mr Gibson’s making.

34 INQ007655.

35 INQ007657 and INQ007658, respectively.

36 INQ007657/3.

37 INQ007658.

38 The connection to incident ‘Charlie’ cannot be proven definitively as no phone number or caller name was obtained from the call.

39 INQ007655/9.

40 INQ010715/117/10-25, 118/In1-17, INQ010208/22/par97.

- 10.19** A further consequence of the short staffing situation at MRCC Dover was that while on calls with incident ‘Charlie’, Mr Gibson was unable to undertake other tasks. The result was that he provided incorrect information as to the arrival time of the Valiant to those on board incident ‘Charlie’. During the call at 02:31, Mr Gibson said that the rescue boat would be there in less than half an hour, whereas the Valiant arrived at the Mayday relay position (the 02:01 WhatsApp position) almost an hour later, at or around 03:24.⁴¹ In his oral evidence, Mr Gibson explained that he had done a quick calculation based on his experience of transit times and had assumed that the Valiant would arrive within half an hour.⁴² He said that it was not possible both to remain on the call, as he was required to do, and to obtain a precise estimate.⁴³ With Mr Gibson and Mr Downs both engaged in answering emergency calls, there was no one qualified at MRCC Dover to obtain a correct estimate for the Valiant’s arrival on scene. Mr Gibson was forced to rely on a best guess, which was unwittingly wrong.
- 10.20** It is noteworthy that the Border Force Higher Officer on duty that night, Ms Whitehouse, told the Inquiry that Border Force would have updated HM Coastguard as to the Valiant’s estimated time of arrival.⁴⁴ A revised time estimate of one hour was recorded in her daybook at 02:20.⁴⁵ However, there is no contemporaneous evidence that HM Coastguard was updated. In a call between MRCC Dover and MCC Border Force at 02:29, there is no mention of the Valiant’s updated arrival time.⁴⁶ Therefore, it is highly likely that Border Force MCC did not inform HM Coastguard of the revised estimate for the Valiant’s arrival time before or during Mr Gibson’s call with incident ‘Charlie’ at 02:31.
- 10.21** Given the importance of obtaining updated location information from incident ‘Charlie’ in the absence of aerial surveillance, a further concern is that callers from small boats were not told how to obtain location co-ordinates from their mobile telephones.⁴⁷ Instead, they were told to hang up and dial 999. For example, at 01:37, during HM Coastguard’s first connected call from incident ‘Charlie’, the call handler told the caller incorrectly that a location could not be provided without an internet connection, and asked him to hang up and dial 999.⁴⁸ Similarly, in the call at 03:12, Mr Downs’ repeated request to the

41 INQ007655/8.

42 INQ010715/116/ln5-15.

43 INQ010715/116/ln15-17.

44 INQ010135/23/par55-56.

45 INQ000565.

46 INQ007593.

47 The evidence obtained by the Inquiry shows that location co-ordinates can be obtained from mobile handsets without an internet connection. See the report of the communications expert, Mr Iain Ivory: INQ010133/par4.2.2. See also the safety at sea leaflets disclosed to the Inquiry by the non-governmental organisation Utopia 56, which explain that GPS works without signal or data and explain how to open a map application and obtain co-ordinates: INQ008897, INQ008898.

48 This was attributed on the night to incident ‘Foxtrot’ but was later identified as a repeat of incident ‘Charlie’. INQ007591/5.

caller to give his location proved futile. Eventually, the caller was told to call 999 instead.⁴⁹

- 10.22** The instruction to hang up and call 999, rather than assisting callers to read out their location co-ordinates from their phones, was fraught with dangers. These were recognised by the Small Boat Tactical Commander, Mr Papadopoulos, who observed that he would not be confident that a 999 call would connect after a call was ended.⁵⁰ In any event, given the limitations on the provision of Enhanced Information Service for Emergency Calls and Advanced Mobile Location information in respect of calls from small boats, there was no guarantee that a future 999 call would yield any further information. Mr Downs said in oral evidence that asking callers to hang up and dial 999 was not part of his formal training but was a standard practice at MRCC Dover.⁵¹ The contemporaneous evidence suggests that knowledge of how to obtain location co-ordinates without an internet connection was not spread evenly among HM Coastguard staff, and that some staff working on small boats did not have this knowledge.⁵² This was a systemic deficiency in training given the obvious importance of obtaining information about a small boat's location.
- 10.23** Additionally, the Inquiry heard evidence that another standard practice at MRCC Dover was to inform callers from small boats that they were not in UK waters if their mobile phones connected to a French telephone network or did not connect to the UK emergency network. In his oral evidence, Mr Downs said that in his view the ability to connect to a UK network was a reliable indicator of the side of the median line on which a small boat was located.⁵³ He said that he believed that the dial tone would always be aligned with the territorial boundary.⁵⁴ The view he expressed to the Inquiry is consistent with his actions on the night of 23 to 24 November 2021. Early in the night, Mr Downs decided that incident 'Alpha' (which is now known to be a repeat of incident 'Charlie') was not in UK waters based on an international dial tone. Further, at the end of the call at 03:12, Mr Downs informed the caller that if his phone was not connecting to the UK emergency network, he was probably not in UK waters.⁵⁵
- 10.24** Expert evidence received by the Inquiry makes clear that the dial tone and the ability to connect to the UK phone network are not a reliable indicator of an international location.⁵⁶ This was particularly relevant when a small boat was close to the median line in the Dover Strait, which was the case with

49 INQ007658/4.

50 INQ010740/43/ln19-23.

51 INQ010720/157/ln1-7.

52 INQ007754/3.

53 INQ010720/157-158/ln8-2.

54 INQ010720/132/ln20-24.

55 INQ007658/6-7.

56 INQ010133/par4.2.6.1-6.

incident 'Charlie'. In his oral evidence Mr Papadopoulos, the Small Boat Tactical Commander in Dover in November 2021, said, consistently with the expert evidence, that based on his understanding and training, he could not be certain that the inability to connect to the UK emergency network meant that small boats were not in UK waters.⁵⁷ Therefore, it is clear that not all HM Coastguard staff at MRCC Dover followed what Mr Downs called a standard practice. It is impossible to say how widely Mr Downs' incorrect assumptions were shared by others working on small boats. The MCA's corporate position was that HM Coastguard did not know about practices not contained in standard operating procedures and that all staff at all stations should follow such procedures.⁵⁸ It is concerning that in November 2021, practices had developed among at least some staff members at MRCC Dover, which were not contained in standard operating procedures and which were unknown to HM Coastguard senior management. Senior management were not fully in control of the situation on the ground at MRCC Dover in 2021.

The effectiveness of the HM Coastguard mobile phone at MRCC Dover

10.25 HM Coastguard's other means of communicating with small boats was through its mobile phone.⁵⁹ The failure to integrate the mobile phone into HM Coastguard's systems created considerable risk because any calls answered would be unrecorded and any staff working remotely would be unable to see or send any messages.⁶⁰ There was no standard operating procedure or other written procedure on how the mobile phone should be used. While Mr Gibson said that the primary purpose of the mobile phone was for the passing of geolocation information via WhatsApp, this was not formalised in any written procedure or instruction.⁶¹ Mr Downs said that its sole purpose was to send and receive WhatsApp messages and that staff were briefed verbally to ignore the mobile phone if it rang.⁶² It has not been suggested that there was any formal training on use of the mobile phone.

10.26 The wide scope for error in the absence of a standard operating procedure and any formal training is apparent from the events on the night. The trainee who had started work with HM Coastguard some 30 days previously was given the task of monitoring the mobile phone. In his oral evidence, Mr Downs said that he did not operate the mobile phone during the night watch of 23 to 24 November 2021 and that the allocation of duties was a decision for the SMC.⁶³ I accept his

57 INQ010740/44-45/ln6-7.

58 INQ010746/159/ln20-23.

59 See paragraphs 6.57 to 6.60, and 10.9.

60 It was also contrary to IAMSAR guidance: see paragraph 6.60.

61 INQ010715/20/ln11-14.

62 INQ010208/19/par85-86. See also oral evidence at INQ010720/126/ln6-8. Mr Downs could not recall who provided the briefing.

63 INQ010720/125/ln19-25, 126/ln1.

evidence on these points. It was therefore more likely that it was Mr Gibson, as SMC and team leader, who allocated the role of monitoring the mobile phone to the new trainee. The trainee should have been non-operational but was allocated the role due to the short staffing on the night of 23 to 24 November 2021.

Whereas it may have been appropriate for her to undertake mechanistic tasks under supervision by, for example, inputting information provided by Mr Gibson and Mr Downs, it is likely that the staffing situation meant that she was forced to take on more responsibility than she should have. The contemporaneous evidence shows that Mr Downs was occupied in emergency call handling throughout the night watch and Mr Gibson was juggling the roles of both SMC and call handler. Mr Downs said in his oral evidence that the trainee had received no training on how to use the mobile phone.⁶⁴ This is consistent with the general evidence that there was no training.

10.27 There were a number of problems relating to the use of the mobile phone during the night watch. Firstly, HM Coastguard missed the updated positions sent by those on board the small boat to the mobile phone at 02:20 and 02:21.⁶⁵ In oral evidence, Mr Gibson could not provide a specific reason as to why the co-ordinates were missed beyond that MRCC Dover was very busy.⁶⁶ This is consistent with the short staffing situation. The updated position information was important information for HM Coastguard, particularly in the absence of aerial surveillance or other means of obtaining location information. While this failure had the potential to be significantly relevant to the failure to find incident 'Charlie' on the night, as I explain more fully in Chapter 11, I agree with the MAIB that it was unlikely to have materially affected the outcome.⁶⁷ This was because the Valiant's course after arriving at the 02:01 Mayday relay position passed in the vicinity of the 02:20 and 02:21 positions.

10.28 A second problem relating to the use of the HM Coastguard mobile phone during the night watch was that four incoming calls from phone numbers associated with incident 'Charlie' – at 02:04, 02:10, 02:57 and 03:12 – were unanswered.⁶⁸ Although not answering the phone was in accordance with the oral briefing provided to staff at MRCC Dover, the calls could have provided important updating information. In the absence of aerial surveillance, the calls from incident 'Charlie' were an important source of information. If updated geolocation information had been requested from the callers at 02:57 or 03:12, this would have provided the Valiant with a more accurate location for incident 'Charlie' when it arrived on scene soon afterwards. Instead, the co-ordinates used by the Valiant in her search had been sent around an hour earlier, at 02:01.

64 INQ010720/125/ln21-23.

65 See INQ009434/13/par3.14.

66 INQ0101715/99/ln10-22.

67 INQ010445/86-87/par2.6.3.

68 See INQ009434/11-12/par3.10.

In a context where obtaining updated location information from incident 'Charlie' was essential in terms of the search and rescue mission, the absence of a system for answering calls to the mobile phone could therefore have impacted on the success of the operation.

- 10.29** Thirdly, contrary to what appears to be the oral briefing not to answer the mobile phone, it was nonetheless answered at 02:17. The call lasted three minutes and three seconds.⁶⁹ It is not known with certainty what was said on this call because it was not recorded. The call was answered by the non-operational trainee. In the MCA's interview notes with the trainee for the purposes of its internal review, the trainee accepted that she answered one call to the mobile phone but said that she was unable to understand what was being said.⁷⁰ She was not to know, but it was not appropriate for her to be answering what was effectively an emergency call with a small boat. She did not hold a communications qualification or indeed any HM Coastguard qualification. The situation resulted from the staffing situation at MRCC Dover which meant that Mr Gibson and Mr Downs were unable to monitor the mobile phone themselves or to provide full supervision.
- 10.30** Finally, despite having four numbers saved on the mobile phone associated with incident 'Charlie', HM Coastguard did not send the same messages uniformly to all the numbers it held. SMS messages were sent to three of the four numbers and WhatsApp messages were sent to two of the four.⁷¹ Similarly, when HM Coastguard tried to call the small boat associated with incident 'Charlie' at 04:16, seeking to understand whether it had been rescued, only one call was made to only one mobile phone number. The uneven practice is likely to have resulted from a combination of the short staffing situation and the absence of a standard operating procedure and training.
- 10.31** HM Coastguard was aware in November 2021 that MRCC Dover was operating a mobile telephone that was not integrated into the centralised systems. There is no evidence of any risk assessment being undertaken in respect of its use. There was no standard operating procedure in place or any training for its use. In his oral evidence, Mr Gibson accepted that there could have been more consideration relating to its use.⁷² However, devising HM Coastguard's policy on the use of the mobile phone was not a matter for him as an SMC.
- 10.32** In my view, the senior management of HM Coastguard were required to put in place a workable system involving clear instructions, which did not create risks for the prosecution of search and rescue operations. In oral evidence, the MCA's corporate witness said that the mobile phone was not integrated into HM Coastguard's systems in November 2021 because the small boat situation

69 INQ009434/11-12/par3.10.

70 INQ004737.

71 INQ009434/13-18/par3.13-3.14.

72 INQ010715/26/ln23-25.

was evolving at pace.⁷³ There is no doubt that in 2021, HM Coastguard was responding to an unprecedented situation in terms of numbers of small boat crossings. However, by November 2021, the mobile phone had been in use for over a year. It was foreseeable, as was recognised by Mr Gibson in his oral evidence, that once a mobile telephone number for HM Coastguard was distributed to people on board small boats, they would attempt to call it.⁷⁴ It seems to me that there was sufficient time to conduct a risk assessment and put in place a standard operating procedure for its use, even if this was a temporary instruction such as a 'call forward'. As the MCA's corporate witness confirmed to the Inquiry, the MCA did not consider the use of a call forwarding feature before November 2021.⁷⁵

Conclusion – was communication with incident 'Charlie' adequate?

- 10.33** There were clear inadequacies in HM Coastguard's communication with the small boat associated with incident 'Charlie'. In terms of call handling, the staff shortages at MRCC Dover meant that one staff member, who was not yet fully qualified as a Maritime Operations Officer, was answering calls throughout the shift, assisted by the SMC, who was spread thinly and distracted from his intended strategic role. Without the use of language interpretation, communication with small boats was limited and there was a high risk of misunderstandings. Basic and important information from callers from incident 'Charlie' was not obtained, despite calls often lasting several minutes. Standard practices had evolved at MRCC Dover, which were not contained in any HM Coastguard standard operating procedure. At least in some cases, these were based on incorrect assumptions and therefore provided incorrect instructions to callers from small boats. In the absence of aerial surveillance, calls with incident 'Charlie' were of increased importance. However, without appropriate staffing, the repeat calls from those on board were deemed a diversion, and the opportunity to obtain relevant information was missed.
- 10.34** Similarly, the use of the mobile phone on the night was also impacted by the staffing shortage. It was operated by a staff member who was supposedly non-operational and had only been employed by HM Coastguard for some 30 days. As with the treatment of calls from incident 'Charlie', relevant information sent to the HM Coastguard mobile phone was missed. While I acknowledge that the mobile phone was introduced at speed, there were obvious problems and risks associated with its use. HM Coastguard had not sought to address these by November 2021, despite it having been introduced for over a year.

73 INQ010746/151/ln11-13.

74 INQ010715/25/ln11-17.

75 INQ010786/2/par6. I note that a 'call forward' was introduced as an interim measure in early to mid-2022, in part as a result of HM Coastguard's investigation into incident 'Charlie', although this was only available for calls using the cellular mobile network and not for internet-based calls: INQ010786/2-3/par7.

Was the Mayday relay broadcast effective?

10.35 In the absence of effective communication with the small boat associated with incident ‘Charlie’, responses to the Mayday relay were the only other means available to HM Coastguard to obtain information about it before the arrival on scene of the Valiant and R163. The reasons for Mr Gibson’s decision to make the broadcast and its effectiveness are examined in the following paragraphs.

Why was the Mayday relay broadcast?

10.36 The Inquiry heard consistent evidence that the Mayday relay broadcast in respect of incident ‘Charlie’ was extremely rare in the context of small boat search and rescue.⁷⁶ Possibly, this was the first of its kind. None of the witnesses who were asked could recall a previous Mayday relay broadcast for small boat search and rescue.⁷⁷ The rarity of the use of the Mayday relay procedure for small boat search and rescue is consistent with the standard operating procedures specific to small boats which in November 2021 did not contain any reference to the Mayday procedure.⁷⁸

10.37 Mr Gibson decided to broadcast a Mayday relay in relation to incident ‘Charlie’ following his call with Mubin Rizghar Hussein at 01:48 and what he described in his witness statement as his gut feeling that there was real emergency.⁷⁹ In his oral evidence, he qualified this to an extent, stating that after the call at 01:48, he wanted visual confirmation of the level of distress of incident ‘Charlie’ given the lack of aerial surveillance.⁸⁰ In his oral evidence Mr Barnett, the SMC at the JRCC in Fareham who provided remote support on the night, confirmed that this was his understanding of why the Mayday relay was broadcast.⁸¹ He added that the use of the Mayday relay to obtain situational awareness in the circumstances was an accepted use of the procedure.⁸²

10.38 Mr Gibson’s consistent evidence was that he initially had what he described as “grave and imminent concern” about the safety of those onboard incident ‘Charlie’.⁸³ As I understand his evidence, he decided to broadcast a Mayday relay to indicate that there was an emergency and to seek information as to its exact nature. As Mr Barnett put it, its purpose was to highlight to passing vessels that HM Coastguard needed them to take action in relation to an emergency.⁸⁴ In my

76 INQ010746/163/ln1-11, INQ010740/72/ln1-4, INQ010715/103/ln5-7.

77 INQ010746/163/ln9-11, INQ010719/214/ln13-19, INQ010719/107/ln11-16, INQ010715/103/ln18-21.

78 INQ000449, INQ000428. By contrast, they referred to the use of broadcast action, as accepted by Mr Crane in his oral evidence: INQ010719/161/1-25, 162/1-4.

79 INQ010392/48/par90.

80 INQ010715/102/ln17-25.

81 INQ010719/108-109/ln14-25.

82 INQ010719/110-111/ln3-6.

83 INQ010715/102/ln21-22.

84 INQ010719/108/ln16-24.

view HM Coastguard used the Mayday relay to indicate that people were in distress in accordance with the applicable legal framework.⁸⁵

- 10.39** However, the contemporaneous calls disclose that there was a further factor influencing Mr Gibson’s decision to broadcast a Mayday relay, namely the presence of the Flamant, the French warship used by French Coastguard, close to the last known location of incident ‘Charlie’. Mr Gibson was aware of this from the Automatic Identification System information. As he put it in a call with Border Force MCC at 03:11, having been told that incident ‘Charlie’ was “full of water” Mr Gibson added: “[t]he reason I did the full Mayday broadcast was to get a certain vessel which is painted grey with a French flag... to attend...”.⁸⁶
- 10.40** Drawing together all of the evidence, the extremely rare Mayday relay was broadcast for incident ‘Charlie’ due to the combination of Mr Gibson’s 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 emergency. As the contemporaneous evidence makes clear, Mr Gibson’s plan was that the Flamant, as the closest government vessel to incident ‘Charlie’, would effect a rescue in UK waters. However, as he told Border Force on the call at 03:11, the Flamant “completely ignored a SOLAS Mayday distress call”.⁸⁷ A key plank of Mr Gibson’s strategy in relation to the Mayday relay was frustrated by the Flamant’s failure to respond.

Was co-operation with the French authorities effective?

- 10.41** Without access to the evidence in the ongoing French criminal investigation, the Inquiry is not able to determine the reasons that the Flamant did not respond to the Mayday relay. On 31 May 2023, the French police informed HM Coastguard that that the crew on board the Flamant on 24 November 2021 had denied receiving the Mayday relay broadcast.⁸⁸ In response, HM Coastguard pointed out that its voice recording system showed that at the time of the Mayday relay broadcasts, the Flamant was communicating with MRCC Gris-Nez on VHF Channel 16, which was the same channel used to broadcast the Mayday relay. HM Coastguard also pointed out that MRCC Gris-Nez was made aware of the Mayday relay by Mr Gibson on their call at 02:42, which was before the second Mayday relay broadcast.⁸⁹ It is for the French authorities to determine how the Flamant could not have been aware of the Mayday relay broadcast, if that was the case.

⁸⁵ See, in particular: SOLAS, Chapter V, Regulation 35.

⁸⁶ INQ007602/3.

⁸⁷ INQ007602/3.

⁸⁸ INQ007704.

⁸⁹ INQ007656/3. INQ004674/1.

- 10.42** There is an additional point. Mr Gibson accepted that he did not directly request that the French Coastguard task the Flamant to respond to the Mayday relay. Although in an email sent internally within the MCA on 29 November 2021, Mr Gibson said that he “called Griz [sic] Nez direct to ask if the Flamant could proceed”, he accepted in his statement to the Inquiry that he did not directly make this request.⁹⁰ He said that it was “heavily implied” in his call with French Coastguard at 02:42.⁹¹ I agree that he did make it clear on that call that the Flamant was the closest vessel to the Mayday relay position.⁹² In oral evidence, he said he did not think that he should request the French Coastguard to task the Flamant formally but he had since learnt that he could have done so.⁹³ The MCA’s corporate witness accepts that MRCC Dover could have requested MRCC Gris-Nez to task the Flamant.⁹⁴ This would be consistent with the Mancheplan.⁹⁵
- 10.43** Mr Gibson did not seek tactical support from the Maritime Tactical Commander, Mr Jones, in respect of the Flamant’s failure to respond to the Mayday relay.⁹⁶ Mr Jones’ oral evidence was that he was unaware that HM Coastguard could request the French Coastguard to task the Flamant.⁹⁷ Mr Jones added that, if he had been informed, he would have advised Mr Gibson to contact the French Coastguard to understand why the Flamant had not responded.⁹⁸ However, the French Coastguard had already told Mr Gibson at 02:42 that the Flamant could not attend.⁹⁹ The outcome is that it is unlikely that any tactical guidance from Mr Jones would have materially altered events on the night. The more general point is that it is surprising that staff with strategic and tactical roles within HM Coastguard were unaware in November 2021 of this key provision within the Mancheplan or, if they were aware of it, uncertain as to whether they should rely on it. This lack of knowledge would have inevitably resulted in an uneven application of important provisions of the plan. That would have impacted negatively on the effectiveness of co-operation with the French Coastguard.
- 10.44** It is impossible to know whether, if Mr Gibson had formally requested the French Coastguard to task the Flamant, it would have done so. While the Mancheplan provides for requests for the tasking of assets to be made between HM Coastguard and the French Coastguard, the final decision as to whether to task a French asset remained with the French Coastguard. Before November

90 INQ010358/1.

91 INQ010392/62/par118.

92 INQ007656.

93 INQ010715/125-126/ln6-9.

94 INQ010746/163-165/ln22-1.

95 INQ000095 Articles 35-37. See also paragraphs 2.17, and 7.63 to 7.67.

96 INQ010715/126-127/ln25-9.

97 INQ010719/217/ln3-8.

98 INQ010719/216-217/ln20-2.

99 INQ007656.

2021, requests for assistance of French assets had been made to the French Coastguard in relation to small boat incidents and equally, HM Coastguard had tasked UK assets following requests from the French Coastguard.¹⁰⁰ Indeed, a request was made by the French Coastguard to HM Coastguard later in the day of 24 November 2021, after incident ‘Charlie’ was discovered. HM Coastguard provided UK assets to assist in the search for survivors. These provisions of the Mancheplan were in use and demonstrated effective co-operation insofar as formal requests between the two national coastguards were made.

- 10.45** This was not the case on the night of 23 to 24 November 2021. While some questions remain unanswered, in particular due to the absence of information from the ongoing French investigation, there is sufficient evidence for me to conclude that there was a clear failure in the co-operation between HM Coastguard and the French Coastguard in respect of the Mayday relay broadcast. The Flamant’s failure to respond is a key factor. Equally, despite being made aware of the Mayday relay broadcast by Mr Gibson at 02:42, the French Coastguard at MRCC Gris-Nez did not task the Flamant to it. The ultimate question of whether the French Coastguard would have tasked the Flamant if a formal request had been made cannot conclusively be answered. The relevant point for the Inquiry’s purposes is that the processes in the Mancheplan were not followed. Overall, there was a failure in co-operation between the UK and French Coastguards on a number of levels.

Was the response from passing vessels effective?

- 10.46** A further important factor is the effectiveness of the Mayday relay broadcast in triggering a response from nearby vessels other than the Flamant. In this regard the Inquiry has drawn on the valuable work of the MAIB with the 17 vessels that passed within 6nm and 20 minutes of the Mayday relay position. Of the 13 vessels that replied to the MAIB’s investigation, six vessels replied that they had heard the Mayday relay but only three had responded to the broadcast. The MAIB report found that the low response rate appeared to be contrary to the obligations that the International Convention for the Safety of Life at Sea places on merchant vessels.¹⁰¹ I agree with this conclusion.
- 10.47** As indicated, three vessels responded to the Mayday relay broadcast. At 02:54, the Sixtine (a cargo ship) told MRCC Dover that it was within 4nm of the Mayday relay position and that it had had no sightings of a small boat.¹⁰² The second vessel was the KWK Excelsus (a crude oil tanker). The MCA has been unable to locate the calls between this vessel and MRCC Dover.¹⁰³ However, the tanker’s owners provided a copy of its log which records that at 03:30 the Mayday relay

100 INQ010098/72/par4.20.

101 INQ010445/77/par2.4.4.

102 INQ007772/2.

103 INQ001351/1.

was received and that it made no sightings, which was reported by the vessel's master to MRCC Dover on VHF Channel 11.¹⁰⁴

- 10.48** In respect of the third vessel to respond, the *Concerto* (a tanker), the MAIB report does not contain a complete record regarding the vessel's interaction with French and UK Coastguards. However, from the contemporaneous calls, the *Concerto* contacted MRCC Dover as well as the French Coastguard at CROSS Gris-Nez. There were a series of calls to MRCC Dover between 03:02 and 03:04. At around 03:03, MRCC Dover responded to tell *Concerto* to transfer to another VHF channel to await their call.¹⁰⁵ For unknown reasons HM Coastguard has no record of any further calls. It is clear that the *Concerto* tried repeatedly to contact MRCC Dover at this time. No evidence has been provided to the Inquiry that staff at the JRCC, who were operating Channel 16 on behalf of MRCC Dover during the night watch, attempted to follow up with the *Concerto*. This is surprising given that it was close to the Mayday relay location and was clearly seeking to make contact with HM Coastguard.
- 10.49** The entries in the *Concerto*'s log, provided to the MAIB investigators, record that it contacted CROSS Gris-Nez twice, first at 03:02 to report that it had not had any sightings and then again at 03:23 to report a small craft with people.¹⁰⁶ At 03:24 the log records that French Coastguard instructed it to resume passage on the basis that they would take over search and rescue.¹⁰⁷ The MAIB report observes that at 03:24, the *Concerto* was 2.2nm east of the Mayday relay position. It is not possible to draw definite conclusions whether or not the small boat seen by the *Concerto* at around 03:24 was the small boat associated with incident 'Charlie'. Le Monde newspaper has reported that, on a call between incident 'Charlie' and French Coastguard at 03:16, those on-board incident 'Charlie' said that they could see a big boat.¹⁰⁸ However, contrary to what was reportedly said to the *Concerto*, the French Coastguard seems not to have taken over search and rescue. The Inquiry has also seen no evidence that the French Coastguard passed the contents of its call with the *Concerto* to MRCC Dover. Again, in the absence of evidence from the French investigation, it is not possible to draw final conclusions on these various points.
- 10.50** The *Sixtine* and the *KW Excelsus* were both in the southwest-bound traffic lane of the Dover Strait at the time of the Mayday relay broadcast. The *Concerto* was in the opposite northeast bound lane. The MAIB report concluded that it was reasonable for MRCC Dover not to direct the *Sixtine* and *KW Excelsus* to assist. Neither vessel had reported that it had sighted a small boat. Given their large

104 INQ006224/1.

105 INQ010696/2.

106 INQ006210/2. However, the log does not record the attempted contact with MRCC Dover.

107 INQ006210/2.

108 The report refers to a call at 04:16, but this is understood to refer to Central European Time. INQ009690/2.

size, diverting them from their traffic lane was potentially dangerous. As for the Concerto, it reported sighting a small boat with people on board to CROSS Gris-Nez at 03:24 and the French Coastguard requested it to resume passage. At the very least, the reported sighting could have been relevant and passed to MRCC Dover. Equally, it is unfortunate that HM Coastguard did not follow up with the Concerto when it attempted contact. It was a missed opportunity to obtain relevant information. Given that Channel 16 was being operated remotely at the JRCC at Fareham, it is unclear whether MRCC Dover had any knowledge of, or input into, the Concerto's attempts to call HM Coastguard. The responses from passing vessels were not logged in the ViSION system. Therefore, Mr Gibson at MRCC Dover would not have known about these calls in the absence of contacting the JRCC or listening to Channel 16 himself. Given the level of activity on the night, it is most unlikely that he would have had time to do either. The failure to log the responses in the ViSION system hampered his awareness of the responses from passing vessels.

What was the impact of the incorrect digital selective calling alert?

- 10.51** Although Mr Gibson at MRCC Dover made the decision to broadcast the Mayday relay, the broadcast itself was undertaken by Mr Barnett at the JRCC.¹⁰⁹ Neither was able to recall who composed the text of the Mayday relay broadcast.¹¹⁰ Given that it was only Mr Gibson who had spoken to those on board the small boat associated with incident 'Charlie', it is likely that he provided the substantive content of the broadcast. The choice of the digital selective calling alert, which preceded the text of the broadcast, was made by the operator at the JRCC.¹¹¹ The first three broadcasts incorrectly used an 'urgency' digital selective calling alert rather than the correct designator of 'distress'.¹¹² Mr Barnett told the Inquiry that the reason for the incorrect classification could have been human error but he could not be certain.¹¹³ Mr Gibson agreed that it was likely to be operator error.¹¹⁴
- 10.52** The MCA's internal review concluded that the error made no difference to the responses of passing vessels as the content of the message would have still have been transmitted to every vessel.¹¹⁵ Mr Barnett explained that the error would have related to how the digital selective calling alert sounded on vessels' VHF sets, the purpose of the alarm being to draw attention to the broadcast that

109 INQ010140/16/par43.

110 INQ010715/105-106/ln25-13, INQ010719/112/ln9-10.

111 Mr Gibson's evidence was that he was unaware that the incorrect digital selective calling classification had been used since the Mayday relay was done remotely at the JRCC. INQ010392/55/par105.

112 Internal review: INQ008905/161/par8.3.23, 167/par8.3.50, 168/par8.3.56.

113 INQ010140/16/par44.

114 INQ010392/55/par105.

115 INQ008905/52/par4.12.4.

would follow.¹¹⁶ In oral evidence, he said that in each case a mariner would need to manually interact with the radio set to turn off the alert. Consequently an ‘urgency’ alert would have served the same purpose in alerting passing vessels.¹¹⁷ He also said that since the Mayday relay was broadcast verbally and not just by alert, there was no material difference to the actual content of the broadcast.¹¹⁸ Mr Gibson agreed that in his view the impact of the incorrect procedure having been used would not have been particularly significant since the alert still went to all vessels.¹¹⁹ In other words, the incorrect digital selective calling alert does not explain the failure of the Flamant and other passing vessels to respond to the Mayday relay.

Conclusion: was the Mayday relay broadcast effective?

- 10.53** The Mayday relay broadcast did not provide Mr Gibson with the assistance he sought. The closest government vessel, the Flamant, failed to respond. The response rate from passing vessels was very low. Of those few vessels that did respond, two saw nothing. The Concerto, which did see a small boat at 03:24, was unable – for unexplained reasons – to speak with HM Coastguard. Not only was there very low uptake, but the information from the most relevant responder, the Concerto, was not passed on to HM Coastguard.
- 10.54** Therefore the Mayday relay was ineffective. MRCC Dover did not obtain information on the nature of incident ‘Charlie’'s distress, nor did it receive any effective offers of assistance. Additionally, as explained in Chapter 11, the broadcast was terminated before any decision that incident ‘Charlie’ had been located. The reasons underlying the ineffectiveness of the Mayday relay were largely out of HM Coastguard’s hands. Ultimately, MRCC Dover had no control over the actions of passing vessels and final responsibility to task the Flamant lay with French Coastguard. There was failure in the co-operation between the two States.

Conclusion – was there adequate information gathering in respect of incident ‘Charlie’?

- 10.55** As the International Aeronautical and Maritime Search and Rescue (IAMSAR) Manual makes clear, to co-ordinate a response to a search and rescue incident most effectively, the SMC should have accurate, timely and complete information about the incident. In the absence of full information being initially provided, which is usually the case, the SMC should actively pursue

116 INQ010140/16-17/par45.

117 INQ010719/111/ln16-24.

118 INQ010140/16-17/par45.

119 INQ010392/55/par105.

an investigation so the information can be obtained.¹²⁰ In the case of incident 'Charlie', there was a lack of information from the outset: the absence of a surveillance flight and the absence 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 available sources of information for Mr Gibson were calls from the small boat itself.

- 10.56** The initial telephone call from incident 'Charlie' at 01:48 gave rise to an initial gut reaction from Mr Gibson, drawing on his training and experience, that there was an emergency situation. However, the language barrier complicated communication, there was a failure to follow standard operating procedures, mistakes were made, and opportunities were missed to gather further relevant information in subsequent communication between those on board incident 'Charlie' and HM Coastguard. HM Coastguard's call handling and the use of the mobile phone was ineffective in obtaining full information. The other strategy employed by Mr Gibson, the Mayday relay, also failed to provide relevant information for the reasons explained. As a result, Mr Gibson was unable to use any sightings from passing vessels to evaluate and analyse the information he had obtained from the telephone calls from incident 'Charlie'. Therefore, there was an overall failure in the information gathering stage of search and rescue in HM Coastguard's response to incident 'Charlie'. The reasons for this were largely systemic in nature.

120 International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 2', paragraph 3.8.2.

Chapter 11:

Search for incident ‘Charlie’

11.1 There were two assets tasked by MRCC Dover to zone 14 (the Dover Strait) on the night watch of 23 to 24 November 2021: the Border Force cutter, the Valiant, and the search and rescue helicopter R163. The Valiant was tasked to incident ‘Charlie’, but the time it was tasked actively to search for the small boat in distress was limited. R163 took over searching when it arrived on scene. However, R163 was neither tasked to incident ‘Charlie’ nor had any knowledge of it. The ineffectiveness of the search for incident ‘Charlie’ is examined in the following sections.

Did the meteorological conditions on the night impact on the search for incident ‘Charlie’?

Visibility and night-time illumination levels

11.2 It is important to acknowledge at the outset that the meteorological conditions for search and rescue were not favourable on the night of 23 to 24 November 2021. In its investigation, the MAIB engaged with the Met Office to understand and assess the visibility and potential performance of the search equipment used by the assets tasked by MRCC Dover on the night, primarily infrared and night vision equipment.¹ The Met Office’s report concluded that infrared visibility conditions were poor to moderate at best during the night of 23 to 24 November 2021, and that night-time illumination levels were likely to be below 10 millilux.² The Inquiry has not duplicated this work and has gratefully relied on it. On the basis of the Met Office’s findings, it is self-evident that the visibility conditions in an environment with little ambient light would have had an impact on the effectiveness of the search equipment on board the assets tasked.

The effectiveness of the equipment on board R163 and the Valiant

11.3 The two assets tasked by MRCC Dover on the night watch of 23 to 24 November 2021 had broadly similar search equipment, namely radar, night vision or thermal imaging equipment and search lights. Mr Graham Hamilton, the Director of UK Search and Rescue for Bristow Helicopters Limited and its corporate witness, and Christopher Trubshaw, the captain of R163, gave oral evidence to the Inquiry on the effectiveness of the equipment on board search and rescue helicopters for detecting small boats and people in the water. They both discounted radar

¹ INQ007211.

² INQ007211/3-4.

as an effective means of searching for small boats or people in the water (as opposed to larger objects like ships or aircraft).³ Captain Trubshaw said that using all the other equipment available (that is, night vision goggles, infrared and search lights) in conjunction provided the best chance of locating a search target.⁴ He added that the ability to distinguish objects in the water is vastly reduced at night.⁵

- 11.4** As regards the effectiveness of infrared search equipment, the MAIB report observed that a thermal contrast of at least 2°C between the sea and the target of a search is key to infrared effectiveness.⁶ The Met Office's analysis concluded that it was reasonable to assume that a loaded small boat would have a thermal contrast of 2°C, although it is possible that there was much less contrast, which would have reduced the efficacy of infrared.⁷ The Met Office's report did not assess the contrast for people in the water.⁸ However, the MAIB report concluded that it was probable that thermal contrast values would be below 2°C.⁹ As before, the Inquiry has not duplicated this work and has relied on it. The difference between likely thermal contrast values of small boats and people in the water demonstrates that whereas the infrared search equipment may have been effective in finding a small boat full of people, it would have been far less effective in locating people in the water. Further, Mr Hamilton's evidence was that the longer a person remains in the water, the thermal contrast further decreases due to the cooling effect of the water.¹⁰ He also made the point that people in the water could be masked by waves.¹¹
- 11.5** In terms of night vision equipment, Mr Hamilton acknowledged that it is limited by the need for ambient light, that is, moonlight or other lighting from vessels, in order for the equipment to function optimally.¹² The Met Office's report concluded that illuminances were likely lower than that of the generic 10 millilux threshold for effective night vision goggle use.¹³ However, the report accepts that it is not possible to infer from this generic threshold whether a target would or would not have been visible in these lighting conditions and from how far away it might have been visible.¹⁴ The conclusion is further caveated by the fact

3 INQ010716/76/ln13-23, INQ010716/99/ln14-25. See also statement of Commander Toy: INQ010136/6-7/par19.

4 INQ010716/96-97/ln22-3.

5 INQ010716/100/ln6-11.

6 INQ010445/62/par1.16.2.

7 INQ007211/11. The Met Office report refers to a thermal contrast of 2 Kelvin which is equal in magnitude to 2°C.

8 INQ007711/3.

9 INQ010445/62/par1.16.2.

10 INQ010716/75/ln2-10.

11 INQ010716/75/ln11-15.

12 INQ010716/72-73/ln21-7.

13 INQ007211/15.

14 INQ007211/15.

that verification of the 10 millilux threshold has been undertaken exclusively over land rather than sea.¹⁵ As regards the use of search lights, both Mr Hamilton and Mr Trubshaw agreed that while they are useful, they are not a complete solution since a search light creates a beam rather than a larger pool of ambient light as is necessary for night vision equipment.¹⁶ Mr Trubshaw added that search lights are adversely affected by fog which disperses the light.¹⁷ The same considerations applied to the similar equipment on board the Valiant in terms of its effectiveness on 23 to 24 November 2021. As Commander Toy told the Inquiry in his oral evidence, the Valiant was also equipped with a night vision camera that used thermal imaging and a large spotlight.¹⁸

Conclusion – the relevance of the meteorological conditions in the failure to locate incident ‘Charlie’

- 11.6** It is clear that the meteorological conditions on the night permitted the equipment on board the helicopter R163 and the Valiant to identify small boats with people on board. The Valiant identified two at a distance of around 0.7nm and embarked one of those, M957. Flying at an altitude of around 250 feet above average sea level and with a track spacing of 0.7nm, R163 provided multiple positions for small boats which enabled it to direct the Valiant to embark M958 and M959. The evidence speaks for itself that neither asset tasked by MRCC Dover on the night of 23 to 24 November 2021 had difficulty in locating small boats carrying people on board. Both assets identified small boats that were underway as well as those that had stopped in the water. The outcomes of the searches conducted by the Valiant and R163 are consistent with the findings of the Met Office’s report that the likely thermal contrast values between a small boat with people on board and the sea water would be sufficient for infrared search equipment to be effective.
- 11.7** The evidence is less conclusive in terms of the impact of the meteorological conditions in searching for a swamped small boat or people in the water. However, given the likely very low thermal contrasts for people in the water, I am in little doubt that meteorological conditions on the night contributed to the failure to locate those who had been on board incident ‘Charlie’. Equally, the low ambient light levels meant that the night vision equipment was at the lower end of effectiveness. I also have little doubt that this also contributed to the failure to find people in the water and the swamped small boat. It is unlikely that the ambient light levels were improved significantly by artificial means, given the limitations of search lights as described by Captain Trubshaw, the absence of other vessels in the immediate vicinity, and the likely fact that those in the water did not have any lights. This said, I am also in no doubt that the meteorological

15 INQ007211/14.

16 INQ010716/75/ln17-25, INQ010716/97-98/ln25-19.

17 INQ010716/99/ln9-13.

18 INQ010136/6-7/par19, INQ008330/27.

conditions on the night are not a complete answer to the question of why incident ‘Charlie’ was not located. There were additional factors that made the search ineffective.

Did the Valiant conduct an effective search?

- 11.8** The Valiant was the only asset specifically tasked to incident ‘Charlie’ on the night in question. The following sections address the effectiveness of its search including the appropriateness of tasking a Border Force cutter, the length of the Valiant’s journey to the scene, the time it spent searching, and the effectiveness of the information passed to its crew.

Was the Valiant an appropriate vessel to be tasked to incident ‘Charlie’?

- 11.9** The initial decision to task the Valiant to incident ‘Charlie’ was taken before MRCC Dover was on notice that there was an emergency situation. The Valiant was tasked simply because incident ‘Charlie’ had been identified as the first small boat that would cross the median line. Specifically, the Valiant was tasked because it had been identified as the primary responder on the night of 23 to 24 November 2021. In other words, when the Valiant was tasked, there was no consideration by HM Coastguard of whether it was an appropriate vessel to respond to a small boat in an emergency. At that point, HM Coastguard and Border Force believed they were responding to a small boat that was underway and did not necessarily require immediate assistance.
- 11.10** However, the situation changed from around 02:27, after the call between Mr Neal Gibson, the SMC at MRCC Dover, and Mubin Rizghar Hussein, the 16-year-old Iraqi Kurdish boy on board incident ‘Charlie’, and when the first Mayday relay was broadcast. In Mr Gibson’s oral evidence, he said that he had a gut feeling as a result of the call that there was a real emergency.¹⁹ No further assets were tasked at this point. Mr Gibson acknowledged that the Valiant was an ageing vessel and for safety and sustainability reasons it was slower than other responders.²⁰ However, he said that while he considered tasking RNLI, this would not have made a vessel arrive on scene more quickly in circumstances where the Valiant was already underway.²¹ There is no written record from the night in question showing these considerations, but I accept Mr Gibson’s evidence.
- 11.11** Mr Gibson also mentioned his concern about not exhausting or fatiguing resources, noting that there was no back up once RNLI had been exhausted.²² Therefore, in making tasking decisions on incident ‘Charlie’, Mr Gibson was

19 INQ010715/87/ln1-3.

20 INQ010715/129/ln1-6.

21 INQ010715/130/ln2-15.

22 INQ010715/131/ln5-12.

aware he had a limited pool of resources which he was concerned not to deplete. Mr Gibson's knowledge of the limited maritime assets in November 2021 was relevant to tasking decisions on the night in question.²³ His concern not to deplete the limited resources available to him was understandable given that the day watch of 24 November 2021 was forecast to be even busier.

- 11.12** The Valiant took approximately two hours from being first alerted about the tasking to arrive on scene. The Inquiry requested the RNLI's corporate witness and Head of Lifeboats, Mr Simon Ling, to provide an estimate of the length of time it would take an RNLI lifeboat to undertake the same journey. He provided an estimate of 73 minutes (or 1 hour and 13 minutes) for the Dover lifeboat from alert to arrival on the scene.²⁴ This was largely consistent with the estimate of 1 hour 12 minutes provided by the MCA's corporate witness.²⁵
- 11.13** Accordingly, by the time Mr Gibson considered that incident 'Charlie' required immediate assistance, at or shortly before 02:27, if an RNLI lifeboat had also been tasked at this point, it would have arrived on scene approximately 1 hour and 13 minutes later, at or around 03:40. This would have been after the Valiant which, at around 02:27, had already cleared the Port of Dover and had arrived on the scene at around 03:24 to 03:27. Therefore, tasking an RNLI lifeboat would not have provided an advantage in terms of speed.
- 11.14** However, there is a more important point. RNLI lifeboats are specialist search and rescue assets.²⁶ If an RNLI lifeboat had been tasked to incident 'Charlie', this would have enabled a specialist search and rescue asset to focus its efforts on the emergency situation of rescuing people from a sinking small boat or from the water. This would have freed up the Valiant to embark the other small boats. In the event, the Valiant's active search for incident 'Charlie' was highly restricted in time. It was actively searching between around 03:24, when Commander Toy called MRCC Dover to say that he was on scene for the Mayday relay position (the 02:01 geolocation position), and 03:34, when he called MRCC Dover again to inform them that the Valiant had identified two small boats some way off, one stationary and one underway. Shortly after the Valiant had intercepted the first small boat (M957) at around 03:48, the helicopter R163 came on scene, effectively taking over the search. From that point, the Valiant was guided by the helicopter to the co-ordinates it provided.
- 11.15** This leads to a further point. From around 03:15, when the updated French tracker was sent to HM Coastguard and Border Force, both organisations were on notice that there were four small boats reported by the French Coastguard (including incident 'Charlie') all located in a similar location near to the Sandettie

23 See paragraphs 9.27 to 9.29.

24 INQ010739/3/par9.

25 INQ010098/88/par5.44.

26 INQ010101/2-8/par7-20, INQ010741/54-55/ln13-8.

Light Vessel. Cumulatively, the numbers of people on board, as shown by the French tracker, exceeded the Valiant's survivor capacity. Indeed, on the night, Mr Gibson calculated this.²⁷ Despite this, in discussion with Mr Tom Willows of Border Force, he made a decision not to task any additional assets, but instead to wait to see if the Valiant could "deal with" the numbers.²⁸

- 11.16** Mr Gibson said in his statement that the use of one Border Force cutter and a search and rescue helicopter was "according to [his] experience of 'Amber' rated nights, normally a sufficient resource".²⁹ He said that, in his view, it was "not sensible to...assign more resources or further assets, especially as those resources may be needed later on, and crews needed time off to rest in between taskings".³⁰ This again shows that limited resources were at the forefront of Mr Gibson's mind when making tasking decisions. In his witness statement, Mr Gibson added that he did not task an RNLI asset or request further Border Force assets because he was "content with survivor capacity on Valiant".³¹ The reality on the night was expressed more starkly when he observed to Mr Willows of Border Force that the numbers were "pushing [their] luck for Valiant".³²
- 11.17** The MCA's corporate position was threefold. Firstly, the information about small boats received by HM Coastguard was not always reliable. Secondly, the survivor capacity of the Valiant could be exceeded and thirdly, additional assets could be requested if it was not possible to take all on board.³³ There are some problems with this reasoning. As to the reliability of the information, in this particular case, the information was provided by the French Coastguard whose tracker recorded the Flamant against all three small boats in the Sandettie area other than incident 'Charlie'. With a French asset having had sight of these three vessels, the information about them should therefore have been reliable. It is also noteworthy that the MCA's corporate position on the reliability of the information received by HM Coastguard appears contrary to its position that information was always taken at face value.³⁴
- 11.18** As to the MCA's suggestion that the Valiant's survivor capacity could be exceeded, this was at the discretion of its Commander, rather than a decision

27 INQ007602. It is noteworthy that the French tracker sent at 03:15 only contained information on the number of people on board for three of the four small boats identified as being in the same area: INQ007695. If the likely number of people on board the fourth vessel had been factored into Mr Gibson's calculation, he would have been aware that the Valiant's survivor capacity was further exceeded.

28 INQ007602/3.

29 INQ010392/70/par134.

30 INQ010392/70/par134.

31 INQ010392/70/par134.

32 INQ007602/4.

33 INQ010746/104-105/ln20-23.

34 See paragraph 12.15.

that could be taken by HM Coastguard.³⁵ In his oral evidence, Commander Toy observed that the figure of 100 in terms of survivor capacity for the Valiant was the number produced by the maritime safety team.³⁶ He said that if he had to go over the 100 limit to save lives, then evidently he would, but that he could not recall ever having had to do so. Rather, if the Valiant was at capacity, it would stand by a small boat until another asset arrived.³⁷ However, requesting more assets once the Valiant was on scene would have caused considerable further delay (at best, a delay of 1 hour and 13 minutes if the RNLI Dover lifeboat had been tasked), during which time the Valiant, loaded with casualties, would have also been required to remain on scene.

- 11.19** Given there was a Mayday relay broadcast indicating an emergency situation with incident ‘Charlie,’ Mr Gibson had been told by callers on board that the small boat was sinking, and the French tracker showed four small boats all in the same area with total numbers of people on board which exceeded the Valiant’s capacity. HM Coastguard should have been in a position to consider revisiting the decision not to task an additional maritime asset. The lack of human and maritime resources prevented this.

Did the Valiant take an unreasonably long time to arrive on scene?

- 11.20** The next question relevant to the effectiveness of the Valiant’s search was the time it took to arrive on scene. In his witness statement, Commander Toy said that the Valiant departed Dover within an expected timeframe of 30 minutes and then took around 20 minutes to clear the port of Dover, which he also said was normal.³⁸ Albeit not outside the expected timeframes, the length of time it took the Valiant from the initial alert to leave the port (a total of 52 minutes) is considerable.
- 11.21** Commander Toy said that the Valiant then went at best speed (16 knots). He explained in detail in his witness statement the reasons why he considered that 16 knots was the maximum safe speed, namely “the maximum speed which, taking into account the conditions in the Channel, would allow [him] to stop at a reasonable distance in accordance with Rule 6 of the International Collision Regulations”.³⁹ He compared what he called the “maximum safe speed”, taking account of the prevailing conditions, with the “maximum technical speed HMC Valiant could achieve”.⁴⁰ The Valiant arrived on scene around an hour after

35 INQ010717/26/16-20.

36 INQ010717/24-25/ln20-5.

37 INQ010717/25-27/ln13-16.

38 INQ010136/23/par64-65.

39 INQ010136/25/par69.

40 INQ010136/25/par69.

clearing the port of Dover. Commander Toy has observed in his statement that HM Coastguard did not request that he increase his speed at any point.⁴¹

- 11.22** The MCA's corporate witness provided an estimate of 1 hour and 22 minutes for the Valiant to arrive on scene from the point of being alerted, taking into account 30 minutes to assemble the crew and travelling at a speed of 20 knots.⁴² In his oral evidence, he accepted that this had failed to take into account the time to leave the port of Dover and accepted it should be 1 hour and 32 minutes. Even with this further time factored in, the time taken by the Valiant on the night in question was around 30 minutes longer than estimated by the MCA's corporate witness. This is likely to be explained by the different speeds used: the MCA's corporate witness based his calculation on the Valiant travelling at 20 knots, which was the same speed as an RNLI lifeboat, whereas Commander Toy makes clear that the Valiant's best speed was only 16 knots. The age of the Valiant may also have impacted its speed.⁴³ As Commander Toy made clear in his oral evidence, he travelled as quickly as was possible while maintaining a safe speed, taking account of the prevailing circumstances including the sea conditions, visibility and traffic.⁴⁴
- 11.23** While there is no formal target time in legislation or international law for responding to vessels in distress, in my view a two-hour journey from alert to arrival on scene is not appropriate in a search and rescue situation. Commander Toy accepted in his oral evidence that based on his experience, it was a "very long time" in a Mayday situation.⁴⁵ Given that HM Coastguard classed all small boats as being in the distress phase from the moment they passed the median line, there was a risk that a small boat would be in need of immediate assistance in that area. Moreover, given that small boat crossings had been identified as likely on the night of 23 to 24 November 2021, the Inquiry heard evidence on whether earlier notification by the French Coastguard of small boat activity would have made a difference to the tasking of Border Force assets. The MCA's corporate statement said that if the French Coastguard had notified HM Coastguard of the small boat activity in French waters sooner on the night of 23 to 24 November 2021, "HM Coastguard would have been able to task the ...[Valiant] sooner and it would have been positioned closer to the median line to rescue the small boats".⁴⁶ However, Mr Gibson regarded this as a theoretical possibility and concluded that earlier notification would not have had a significant impact on his actions during the night shift as he did not think that Border Force would have sent surface assets at an earlier

⁴¹ INQ010136/25/par69.

⁴² INQ010098/90/par5.52-5.53.

⁴³ INQ010715/129/ln1-6.

⁴⁴ INQ010717/105/ln10-20.

⁴⁵ INQ010717/87/ln3-6; 94/ln3-7.

⁴⁶ INQ010098/110-111/par6.48.

stage.⁴⁷ His view is reinforced by the evidence of Border Force Higher Officer, Ms Karen Whitehouse, who was also operational on the night. She explained in her witness statement the reasons why Border Force would not want to deploy an asset immediately on receiving French intelligence of small boat activity in French waters, since doing so “could be a complete waste of time and resources because the boat might not reach the median line”.⁴⁸

- 11.24** Therefore, it seems that the Valiant would not have been tasked sooner if the French tracker had been sent to HM Coastguard at an earlier stage. HM Coastguard was aware from the French tracker from around 00:56 that there were four small boats travelling towards the median line. An asset was not tasked at that point. The Valiant was only tasked once HM Coastguard had received further information from the French that incident ‘Charlie’ was about to cross into the UK search and rescue region (which it did at or around 01:28).⁴⁹

Was the Valiant provided with adequate information?

- 11.25** At the point at which the Valiant was tasked to incident ‘Charlie’ (at around 01:30), it was not provided with any information about the small boat except for the co-ordinates that had been provided to HM Coastguard by the French Coastguard. By contrast, MRCC Dover passed further information that it held to Border Force MCC, which related to the condition of the small boat, numbers of people on board and two telephone numbers.⁵⁰ This was relevant information which should have been provided to the Valiant. However, there is no contemporaneous evidence to show that it was passed by either Border Force MCC or MRCC Dover.
- 11.26** Further, the Valiant was not provided with any search parameters (including search patterns or track spacing) by MRCC Dover. Indeed, there is no evidence that any formal search planning was conducted. This is exemplified in a call at or around 01:38 when Border Force MCC queried with MRCC Dover how the Valiant would be able to locate and get locked on to incident ‘Charlie’ in the absence of aerial coverage and information as to the small boat’s course and speed.⁵¹
- 11.27** In the absence of search planning by MRCC Dover, once the Valiant arrived in the Mayday relay position and found nothing, its crew made their own determination as to where to travel to continue their search, rather than receiving instructions from the SMC at Dover. The contemporaneous evidence shows that the Valiant heard the Mayday relay and knew that it was attending an

⁴⁷ INQ010392/32/par66.

⁴⁸ INQ010135/16-17/par37.

⁴⁹ I note that MRCC Dover was aware of incident ‘Charlie’ by around 01:06, but that the Valiant was not tasked until 01:30. No explanation has been put forward for this delay.

⁵⁰ INQ007648.

⁵¹ INQ007652/3.

incident with a Mayday relay broadcast against it.⁵² This is supported by the entry in Commander Toy's daybook (at 02:34) which references that he was proceeding to Mayday.⁵³ It is also consistent with the Home Office's corporate statement from Mr Stephen Whitton, which observes that Border Force vessels would always be aware of Mayday transmissions as they would monitor VHF emergency channels.⁵⁴ Commander Toy said in his witness statement that at or around 02:30 (shortly after the Valiant had left the port of Dover), HM Coastguard informed him that a small boat was taking water.⁵⁵ However, he said that while taking water was serious, it did not necessarily mean that a small boat was sinking as "[i]t was common for migrant vessels to take on water, given that they were wholly unsuitable for Channel crossings and, in particular, had a very shallow freeboard".⁵⁶ There is no evidence that the Valiant was informed that there were people in the water or the small boat to which it was tasked was sinking.

- 11.28** Equally, there is no contemporaneous evidence that Border Force MCC was informed that small boat 'Charlie' was sinking or that there were potentially people in the water, although it had been made aware of the Mayday relay.⁵⁷ In her witness statement, Ms Whitehouse confirms that she does not recall being made aware of this. If she been told, she would have recorded it in her daybook.⁵⁸ However, her evidence is that having information that incident 'Charlie' was sinking would have had no impact on the search and rescue response as HM Coastguard "retained ownership of decision-making around available assets to render the fastest possible support to a vessel in distress" and she "simply could not make BFM [Border Force Maritime] vessels go any faster than they safely could".⁵⁹
- 11.29** In my view, the Valiant was not provided with sufficient information to enable it to conduct an effective search. Commander Toy gave evidence that it might not have affected his search if he had been told that there were people in the water because he was "on high alert in any case".⁶⁰ However, it was important for the Valiant to have information about the condition of the small boat known as incident 'Charlie', beyond that it was taking on water, which, as Commander Toy observed, was common with many small boats. By failing to pass relevant information to the Valiant, HM Coastguard's standard operating procedures were not followed.⁶¹ Moreover, in the absence of information about the condition of

52 INQ007613/2.

53 INQ002051/3.

54 INQ010137/26-27/par67.

55 INQ010136/23-24/par66.

56 INQ010136/23-24/par66.

57 INQ000565, INQ010135/23-24/par57.

58 INQ010135/24-25/par59.

59 INQ010135/24-25/par59.

60 INQ010717/113/ln17-21.

61 For example, see the standard operating procedure entitled 'Instructions to SRUs': INQ003795.

incident 'Charlie', the crew of the Valiant were unable to form their own views as to whether incident 'Charlie' had been identified, rather than some other small boat. The failure to pass relevant information to the surface asset on scene hampered its ability to search effectively.

- 11.30** Further, there is no contemporaneous evidence that the Valiant was provided with the last known geolocation positions sent at 02:20 and 02:21 by those on board incident 'Charlie'. Whereas MRCC Dover missed those messages at the time they were sent, Mr Gibson was aware of them from around 03:30, when the Valiant was arriving in the location of the 02:01 Mayday relay position. Mr Gibson said that he would have informed the Valiant with updated positions as a matter of course, once it was closing in, but he fairly accepted that he did not know whether this happened on the night in question.⁶² Mr Gibson accepted that it was potentially right that the Valiant should have been provided with updated co-ordinates.⁶³ It is obvious that it should have been. However, even the updated co-ordinates were over an hour out of date by the time that the Valiant was on scene. In fact, they were in the same north-easterly direction of the drift as the Valiant travelled between around 0324 and 0334 when it saw two small boats.⁶⁴ Therefore, it is unlikely that having the updated co-ordinates would have materially changed the outcome.

Should the Mayday relay have been terminated before incident 'Charlie' was located?

- 11.31** The question of whether the Mayday relay should have been terminated before incident 'Charlie' was located is related to the Valiant's search. The Mayday relay was terminated before the Valiant was alongside any small boat, and therefore before any small boat had been identified as incident 'Charlie'. Mr Gibson's oral evidence was that the rationale for the Mayday relay had been for vessels to assist, so that once the Valiant was on scene, there was no further benefit.⁶⁵ In oral evidence, the Small Boat Tactical Commander, George Papadopoulos, expressed some surprise that the Mayday relay had been terminated before the Valiant was alongside any small boat. He said that he would have expected the Mayday relay to have ended when the SMC had sufficient information to conclude that one of the small boats recovered was incident 'Charlie'.⁶⁶ However, he added that another factor for ending it could be that there were sufficient resources on scene and help was no longer needed from passing vessels.⁶⁷ Given the absence of an up-to-date position for incident 'Charlie', coupled with the flaws identified with the Valiant's search, it seems to me to have been premature

62 INQ010715/100/ln2-11.

63 INQ010715/100/ln19-22.

64 See paragraph 8.101.

65 INQ010715/109-110/ln13-25.

66 INQ010740/79/ln2-19.

67 INQ010740/79/ln20-25, 80/ln1-5.

to terminate the Mayday relay before there was sufficient information to indicate that it had been located or that further assistance was no longer required.⁶⁸

Conclusion: was the Valiant's search for incident 'Charlie' effective?

- 11.32** Viewed as a whole, the evidence is that the Valiant's search for incident 'Charlie' was ineffective. This was not the fault of the Valiant's Commander or crew. The Valiant was tasked around 20 minutes after HM Coastguard was aware of incident 'Charlie' and then took two hours to arrive on scene. Its crew were not provided with any search parameters, nor were they given relevant information. Because of this, the information contained in the Mayday relay was not understood by Commander Toy to be a real emergency. The information that Commander Toy did have, namely the 02:01 Mayday relay co-ordinates, was out of date. Having identified two small boats in its short period of active search, and later embarking one of them, the Valiant was then guided by R163's search. The ViSION log for incident 'Charlie' shows that the Valiant was cleared from that incident at 06:46.⁶⁹ From that point, it was no longer actively searching for, and no longer tasked to, incident 'Charlie'.

Did R163 conduct an effective search?

- 11.33** R163's search is of central importance given that the Valiant's search was so circumscribed. At the outset, I accept that it is likely that the area covered by R163's expanding square search covered the range of the potential drift of incident 'Charlie'. The Inquiry has not sought to duplicate the drift analyses undertaken by the MAIB and the MCA and I accept the conclusions of both organisations. However, as recognised by the IAMSAR Manual, even if a search object is present in the area searched, if the probability of detection is low due to other factors, such as flaws in the search method or environmental factors, a search of that area will be unlikely to succeed.⁷⁰ The fact that the area covered by R163 likely contained the swamped small boat cannot be a definitive answer to the question of whether its search was effective.

68 The IAMSAR Manual guidance is that cancellation of a distress message should occur "as soon as the distressed craft has been recovered or when the assistance of SAR facilities is no longer required". See: International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 3, section 2-9.

69 INQ000237/13.

70 International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 2', paragraph 4.6.15: "...a very normal search of an area (probability of detection = 0%) that almost certainly contains the search object (probability of containment = 100%) has almost no chance of succeeding".

Was R163 provided with adequate information?

- 11.34** When R163 was initially tasked at around 02:51, the tasking was for a patrol.⁷¹ As the pilot of R163, Captain Trubshaw, explained in his oral evidence, “patrolling” is the term for when an asset is asked to “fly up and down and see what you can find”, whereas “searching” is when an asset is looking for something specific within a certain area.⁷² Consistent with Mr Trubshaw’s evidence, the ViSION log entitled ‘Aerial SAR’ recorded the mission as being to “identify/localise positions of migrant vessels”. Therefore, R163 was essentially given a surveillance tasking to identify small boats.
- 11.35** Despite the Mayday relay for incident ‘Charlie’ having been broadcast before the time of the tasking of R163, the intention in tasking the helicopter for a patrol flight was to provide domain awareness and thereby to mitigate HM Coastguard’s lack of situational awareness due to the absence of the fixed-wing surveillance flight. In his oral evidence, Dominic Golden, the Aviation Tactical Commander, said that he was unaware of the Mayday relay.⁷³ He said that the ARCC was never told about people in the water, a boat taking on water, or even incident ‘Charlie’.⁷⁴ This information was relevant to the tasking decisions made by the ARCC. Mr Golden’s oral evidence was that if he had known that a small boat was taking on water or there were people in the water, he would have explored the possibility of tasking an additional search and rescue helicopter from Lee-on-Solent or Humberside.⁷⁵ The mutual incompatibility that had existed since May 2019 between the ViSION systems of the ARCC and HM Coastguard’s maritime teams meant that the Aviation Tactical Commander was unable to obtain information about the circumstances surrounding incident ‘Charlie’ by reviewing the maritime ViSION logs.⁷⁶ Mr Golden accepted in oral evidence that during the short period of his employment with HM Coastguard before the incompatibility was introduced, he would open and review the maritime incident logs.⁷⁷
- 11.36** The initial instructions given by Mr Gibson were also for R163 to complete a patrol. He gave a patrol area to cover: a rectangular box between the MPC Buoy up to the Sandettie Light Vessel. He explained that the small boats were “somewhere between [those] two search markers” and referred to the Valiant attending one small boat in the context of many others.⁷⁸ In oral evidence,

71 The ViSION log entitled ‘Aerial SAR’ records the tasking of R163 at 02:51 (INQ000226/3-4). The migrant administration ViSION log has an entry at 02:47 that R163 has been tasked (INQ000235/6). INQ010716/112/ln24-25.

72 INQ010716/109/ln1-4.

73 INQ010718/169/ln3-6.

74 INQ010718/169/ln7-10.

75 INQ010718/170/ln13-25.

76 See paragraph 6.52.

77 INQ010718/111/ln5-16.

78 INQ008823/4.

Mr Gibson explained that it was not a search area that he was setting: he was not searching for a specific incident but rather gathering an aerial picture of the state of small boat activity.⁷⁹ In giving initial instructions to R163, at around 02:50, it is surprising that there was no mention of the Mayday relay and that ‘Charlie’ had been reported to be sinking with potentially people in the water. Just 10 minutes previously, the French Coastguard had told Mr Gibson that those on board incident ‘Charlie’ had asked for help and said that they were in the water, and some 25 minutes earlier, Mr Gibson had identified a call from incident ‘Charlie’ during which the caller had said that they were sinking.⁸⁰ In his oral evidence, Mr Gibson said that did not tell R163 this because he was still unaware of the nature of the distress of incident ‘Charlie’ and he was unclear whether it was “just full of water” or whether it had sunk.⁸¹ The point is that at no time during the night was this vital information passed to R163.

Was search planning conducted for R163?

- 11.37** As is clear, the initial instructions to R163 were for a patrol and no search planning was conducted. Maritime search planning is the process by which a search plan is calculated in respect of a target which is not underway, but drifting. In the most general terms, it firstly requires the calculation of an area to be searched, which includes estimating the most probable location of survivors and the uncertainty about that location (search area determination). This, in turn, requires calculation of the likely drift of a search object, taking into account environmental and meteorological factors as well as its physical characteristics. After the search area has been identified, the search planner is required to determine the best way to search that area using the available search facilities so that the chances of finding survivors are maximised. This includes decisions on search patterns, sweep width and track spacing (search area coverage).⁸² The role of the search planner is to adjust the variables, such as the relationship between sweep width and track spacing, the number of available assets and the time available to search, in order to obtain a desired probability of detection.⁸³

79 INQ010715/138-139/ln20-7.

80 INQ007656/3-4, INQ007654 as recorded in the incident ‘Charlie’ ViSION log INQ000237/9.

81 INQ010715/147/ln16-19.

82 International Maritime Organization and International Civil Aviation Organization (2019), ‘IAMSAR Manual Volume 2’, paragraph 4.1.2. See also INQ006710. The coverage of a search area is determined by sweep width and track spacing. Sweep width refers to the sum of the distance effectively searched each side of a search asset. Track spacing refers to the distance between adjacent search tracks. The relationship between the track spacing, sweep width and search area size will determine how well an area is covered and, therefore, how effective a search will be. If the sweep width and track spacing are equal, theoretically all of a given area is searched and the coverage factor is 1 (100% coverage). If the track spacing is greater than the sweep width, an area can only be partially searched and the coverage factor is less than 1. Alternatively, if the track spacing is less than the sweep width, some of an area is covered twice and the coverage factor will be greater than 1 (INQ003781/12-13).

83 HM Coastguard’s training slides entitled ‘Maritime search planning part 1’ indicate that 79% is the probability of detection aimed for as a minimum: INQ006710/37.

- 11.38** Once R163 was airborne, by around 03:48, around an hour after the initial instruction providing a patrol area, Mr Gibson spoke again to the helicopter's crew.⁸⁴ He requested that R163 search around the Sandettie Light Vessel with either an expanding square search or a parallel track as the crew saw fit to search for vessels in the area.⁸⁵ As he accepted in his oral evidence, these are internationally recognised IAMSAR Manual search tracks, but he had not modelled for drift.⁸⁶ There is no evidence that formal search planning was undertaken. Consequently, the search pattern was not based on IAMSAR Manual search planning techniques.
- 11.39** There is a conflict in the evidence as to the reasons for the search pattern. In oral evidence, Mr Gibson said that his decision was based on his opinion that "if anything had broken down from their initial positions, the drift would be to the north-east".⁸⁷ However, he recorded in the contemporaneous migrant administration ViSION log at 03:54 that an expanding square around Sandettie was recommended "as craft positions [have been] reported in the vicinity".⁸⁸ These are likely to be the four small boats identified as in the Sandettie area by the French tracker sent at 03:15 (French small boats '3', '7', '10' and '11', which corresponded to HM Coastguard incidents 'Delta', which was a repeat of 'November', 'Charlie', 'Lima', and 'Mike'). The reasoning in the migrant administration ViSION log is consistent with Mr Gibson's evidence that search planning relates to a target that is drifting, whereas small boats which are often underway and making way cannot be mathematically modelled for search.⁸⁹ The absence of any formal search planning for drift is also consistent with the evidence of Richard Cockerill, who joined the watch at Dover at around 05:00, after R163 had been airborne for approximately one hour. Richard Cockerill recalled in his oral evidence that R163 was carrying out an observational sweep and was not involved in active rescues at the time.⁹⁰ Therefore, it is likely that Mr Gibson requested R163 to fly an expanding square search or a parallel track search using the Sandettie Light Vessel as a datum point because this would have covered the area in which four small boats had been reported by the French Coastguard.

84 'Aerial SAR' ViSION log (INQ000226/5). The migrant administration ViSION log contains an entry at 03:54 that R163 lifted from Lydd (INQ000235/8).

85 INQ008825/2.

86 INQ010715/144/ln5.

87 INQ010715/144/ln5-11.

88 INQ000235/8.

89 INQ010715/141/ln3-6.

90 INQ010720/198/ln9-14.

Was R163 tasked to incident ‘Charlie’?

11.40 The MCA’s internal review states that at around the time of the call between Mr Gibson and R163 shortly after 03:48, R163 was tasked to incident ‘Charlie’.⁹¹ There is no contemporaneous evidence to support this. The content of the call between Mr Gibson and R163 does not refer specifically to incident ‘Charlie’.⁹² Moreover, the actions of R163 are recorded in the migrant administration ViSION log because, as Mr Gibson accepted in oral evidence, it had been tasked to a patrol, not to a specific incident.⁹³ That log has an entry at 02:47 from Mr Barnett recording that R163 was tasked (without mention of incident ‘Charlie’). The ‘Charlie’ incident log does not contain reference to R163 being tasked in relation to it. In the ‘Charlie’ log, the only two references to R163 are made within the context of the Valiant’s movements (namely that it was proceeding to positions provided by R163).⁹⁴ Accordingly, the evidence as a whole leads to the conclusion that R163 was never tasked to incident ‘Charlie’.

Who determined R163’s track spacing?

11.41 There is no contemporaneous evidence that Mr Gibson provided information on track spacing and sweep width to R163 on the night in question. The evidence of Captain Trubshaw (the captain of R163) is that the required track spacing is passed to the helicopter crew from the controlling authority (which, on the night in question, was the SMC at Dover).⁹⁵ However, he accepted in oral evidence that if no track spacing had been set by the SMC, the crew of R163 would adopt what it considered to be a sensible track spacing.⁹⁶ He also noted the dangers associated with a search unit itself determining search parameters. A decision taken by the crew of the aircraft might not fit with the overall co-ordinator’s mission plan and could therefore be counter-productive.⁹⁷ In his interview with the MAIB, Captain Trubshaw noted that the calculation of track spacing was a scientific enterprise and could not be guessed.⁹⁸

11.42 Mr Gibson accepted in oral evidence that generally it would be the SMC to set search parameters including track spacing and sweep width. He added that this tasking was different from a traditional maritime search because R163 was looking for multiple small boats, rather than one specific target. He said that he was “trying to cover all [his] bases with the one aerial asset [he had]”.⁹⁹ This

91 INQ008905/175/par8.3.87.

92 INQ008825.

93 INQ010715/142/ln2-15.

94 INQ000237/12.

95 INQ009651/12-13/par4.3.4, INQ010716/103/ln16-18.

96 INQ010716/138/ln17-23.

97 INQ010716/103-104/ln16-6.

98 INQ006321/28: “...it is scientific. It’s not just, all right, I’ll put half a mile on that one”.

99 INQ010715/146/ln7-9.

again supports the conclusion that R163 was never tasked to search specifically for incident 'Charlie' and was engaged in essentially a surveillance tasking.

- 11.43** Based on the contemporaneous evidence as well as the oral evidence of Mr Gibson and Captain Trubshaw, Mr Gibson did not provide track spacing to R163 and the decision to set track spacing of 0.7nm was made by the crew of R163. This was problematic in circumstances where, as on the night on question, R163 did not have relevant information about incident 'Charlie'. For a sensible and appropriate track spacing to be set, it is necessary to have such information. This is because track spacing and sweep widths are computed by reference to the properties of the search target. In his oral evidence, Captain Trubshaw confirmed that the crew of R163 could decide a parameter through knowledge of the search target. However, they could not calculate within the aircraft whether the track spacing chosen by reference to the target was the correct or most desired parameter, which could only be determined by the controlling authority.¹⁰⁰

Was R163's track spacing relevant to the failure to locate incident 'Charlie'?

- 11.44** On the night in question, R163 was tasked to look for multiple small boats believed to be in the Sandettie area, but was not told to search for a sinking small boat or people in the water. Without knowledge of the specific search target, the crew of R163 were not in a position to decide an appropriate track spacing. Given that they had been told to locate small boats, R163's crew made the decision on track spacing appropriate to search for small boats, rather than people in the water. The track spacing set by R163 (0.7nm) accords with the IAMSAR Manual's recommendation for small boats of 6 metres to 10 metres in size. The IAMSAR Manual recommended that the track spacing to search for a person in the water, adjusted to take account of the conditions on the night, was 0.0nm.
- 11.45** There was conflicting evidence on how a helicopter could fly with track spacing set at 0.0nm. The MCA's corporate witness said that 0.0nm would not be an appropriate track spacing as the aircraft would not be able to move and would have stayed static, hovering.¹⁰¹ However, Captain Trubshaw gave two alternatives in his oral evidence. He said that track spacing of 0.0nm meant that the helicopter would fly over the same piece of ocean or be in the hover, looking directly below.¹⁰² Given Captain Trubshaw has the relevant qualifications and expertise to fly the helicopter, I prefer his evidence. In a further witness statement following his oral evidence, Captain Trubshaw said that the lowest track spacing that R163 could be programmed to fly all search patterns was 0.2nm.¹⁰³ He said that track spacing of 0.2nm made the search pattern incredibly

100 INQ010716/105/ln4-7.

101 INQ010746/173/ln14-21, 175/ln7-11.

102 INQ010716/145/ln3-8.

103 INQ010744/1/par2.2.

intensive, particularly in the initial legs of a search, but allowed for saturation of an area.¹⁰⁴ The IAMSAR Manual recognises that optimal track spacing from a theoretical perspective may require some adjusting in circumstances where it is too small for the search facility to follow.¹⁰⁵

- 11.46** In oral evidence, Mr Gibson said that the downside of flying a very narrow track spacing is that a smaller area is covered, and this was inappropriate because he knew there were other small boats for which he wanted to obtain positions.¹⁰⁶ However, increasing the track spacing increases the area which can be searched but reduces the coverage factor and the probability of detection.¹⁰⁷ Mr Gibson told the Inquiry that it was a balance of knowing that there were multiple incidents and he was trying to cover all bases.¹⁰⁸ His priority in tasking R163 was a surveillance flight to obtain domain awareness, rather than using it to search for a sinking small boat or people in the water. As before, the limited pool of assets available was relevant to tasking decisions. This was a problem that was systemic in nature and Mr Gibson had no choice but to work with the limitations confronting him.
- 11.47** The question of whether the effectiveness of R163's search was impacted by the adoption of track spacing recommended by the IAMSAR Manual for searching for small boats rather than people in the water is contentious. The MAIB report found that this was relevant to the effectiveness of the search.¹⁰⁹ By contrast, the MCA's position, as its corporate witness's oral evidence made clear, is that the track spacing used by R163 (0.7nm) was an appropriate track spacing to search for a swamped small boat and/or people in the water. In oral submissions, the MCA's corporate witness provided two reasons for this view.
- 11.48** Firstly, he did not accept that a track spacing of 0.2nm would be more effective for finding people in the water or a sinking small boat. The reason he gave was that a track spacing of 0.2nm would have meant that the aircraft would not have covered as large a search area as it did.¹¹⁰ However, the problem with this approach is that it fails to take account of the absence of search planning undertaken by MRCC Dover. The oral evidence from Mr Gibson was clear that the large size of the area to be covered by R163 was relevant because he wanted information on the multiple small boats that had been reported in the Sandettie

104 INQ010744/1/par2.2.

105 International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 2', paragraph 5.10.5.

106 INQ010715/149/ln5-8.

107 Likewise, decreasing the track spacing has the opposite effects. It decreases the area and increases the coverage factor and the probability of detection. See: International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 2', paragraph 5.10.5.

108 INQ010715/149/ln13-15.

109 INQ010445/92/par3.2.9.

110 INQ010746/175-176/ln21-4.

area. The concern to cover a large area was based on the surveillance tasking that R163 had been set: to find multiple small boats around the Sandettie Light Vessel. If R163 had been tasked to search for incident 'Charlie' alone, with search planning based on the last known position and likely drift, rather than searching for multiple small boats within a wider area, the concern to cover a large area to find multiple small boats would have fallen away. As the IAMSAR Manual makes clear, one of the objectives of search planning is to decide "whether to search a small area with a high coverage factor or a larger area with a lower coverage factor", noting that the best choice is usually one which maximises the probability of success.¹¹¹

- 11.49** Secondly, various witnesses gave evidence that the track spacing for multiple people in the water is higher than for one person in the water.¹¹² It would appear self-evident that locating a number of people in the water grouped together is less difficult than locating a single person in the water, since the target size is larger with a group of people. However, when applied to the events in question, the relevance of this point is less clear. This is because the same limitations relating to the infrared and night vision equipment apply to numerous people in the water, as the ambient light levels and thermal contrast are unchanged. Additionally, there is limited evidence relating to the numbers of people who remained afloat at the time of R163's search and even less evidence as to how those who remained afloat were positioned.
- 11.50** Accordingly, the reasons provided by the MCA do not convince me that 0.7nm was an appropriate track spacing to search for people in the water on the night of 23 to 24 November 2021. If search planning based on the likely drift of incident 'Charlie' had been conducted, it may have been apparent that a far smaller area of search coverage was appropriate to maximise the probability of detection and success. However, I am unable to conclude this with certainty given that search planning for incident 'Charlie' was never undertaken.
- 11.51** It is noteworthy that the evidence of the survivor, Mr Issa Mohamed Omar, is that a helicopter did not fly overhead and he refers only to seeing an aircraft far away in the distance.¹¹³ I attach significant weight to his evidence as the only eyewitness to give oral evidence to the Inquiry. While he accepts that the physically and mentally traumatic nature of the events he experienced have caused some problems with his memory, I consider the question of whether or not a helicopter flew overhead or nearby is likely to be something he would be able to recall, given that he – and others who had been on board incident 'Charlie' who remained alive during the night – were desperately seeking rescue.

111 International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 2', paragraph 4.7.2.

112 INQ010716/147/ln1-5, INQ010715/148-149/ln12-3, INQ010746/171/ln4-10.

113 INQ010388/19/par108.

Mr Omar's evidence suggests that R163 did not fly overhead or close by the location of where he and the others who had been on board incident 'Charlie' had entered the water.

- 11.52** The IAMSAR Manual guidance recommended a sweep width (and track spacing) of 0.0nm to search for people in the water given the visibility on the night. As the MAIB report recognised, this meant that the chance of detecting the people in the water who had been on board incident 'Charlie' was negligible unless the helicopter flew directly overhead. Mr Omar's evidence, which I have accepted, is that R163 did not fly directly overhead. The likelihood of flying directly overhead reduced as the track spacing and search area increased. Accordingly, while some questions remain unanswered, there is sufficient evidence for me to conclude that the choice of track spacing and sweep width was relevant and may have contributed to the failure to find the people in the water on the night.

Conclusion – did R163 conduct an effective search?

- 11.53** The evidence leaves me in no doubt that R163's search was not effective for the purposes of searching for people in the water. This was not the fault of R163's captain or crew. Of primary relevance is the fact that they were never tasked to incident 'Charlie' and never told that they were searching for a sinking or swamped small boat or that there were potentially people in the water. On any reasonable view, it is difficult to see how R163 could have carried out an effective search for a sinking small boat or people in the water without being told that this was the target of its search. Captain Trubshaw said in evidence that if he had been told there were people in the water, "that does change things".¹¹⁴ In his interview with the MAIB, he observed that detecting people in the water was "a lot, lot, lot harder...exponentially harder" than detecting vessels.¹¹⁵ In his oral evidence to the Inquiry, he said that, if he had been told that there were people in the water, he would have searched and saturated that point, initially on top of the datum and then whatever search pattern was provided.¹¹⁶
- 11.54** Secondly and relatedly, R163's flight was primarily a surveillance patrol. Mr Gibson's oral evidence was that he was trying to cover all bases with limited resources. The absence of the fixed-wing flight meant that the search and rescue helicopter was not used for its primary purpose of search and rescue. Full search parameters were not provided to R163, which meant that Captain Trubshaw and his crew were forced to make their own decisions about track spacing and sweep width. The crew could not do this effectively in the absence of information about the search target.

¹¹⁴ INQ010716/131/ln19-22.

¹¹⁵ INQ006321/29.

¹¹⁶ INQ010716/146/ln1-14, 148/ln6-17.

- 11.55** Thirdly, the absence of search planning meant that there was no meaningful calculation of the search area to be covered and how that area was to be searched, including determining the appropriate track spacing and sweep width, as well as the consideration of variables to attain the desired probability of detection. Poor visibility meant that, applying the IAMSAR Manual recommendations for track spacing and sweep width (0.0nm), R163 would have been unlikely to locate people in the water unless it flew directly over them. Self-evidently, the larger area covered by the wider track spacing used by R163 (0.7nm) made it less likely that R163 would fly directly overhead. If formal search planning had been undertaken, this could have been mitigated by altering other variables, including the use of a narrower track spacing, but also increasing the number of search and rescue units on scene and increasing the duration of the search. However, the failure to conduct search planning meant that these factors could not properly have been considered and R163's search ultimately had no quantifiable value. Given the ad hoc nature of the search, conducted without any recognised search and rescue modelling or calculation, there was no way of confidently or credibly assessing the quality of the search or of knowing whether or not R163 had been successful.
- 11.56** These difficulties were compounded by the failure to debrief search personnel, and in particular, Captain Trubshaw, regarding the quality of R163's search.¹¹⁷ The importance of debriefing search personnel was highlighted by the Small Boat Tactical Commander, Mr Papadopoulos, in his oral evidence. When asked whether R163's failure to find a sinking small boat was reliable information that would permit search and rescue to be terminated on incident 'Charlie', he said:
- "It depends on the quality of the aerial search, what kind of search [R163] have effected, what their belief on the quality of their search was. So what does the captain of R163 think the quality of the search was? Could they see, for example, seagulls sitting on the surface of the water? Because that indicates to me that they could have easily picked up people in the water or debris. So again, it depends on the quality of the search and the quality and the confidence of the asset."¹¹⁸
- 11.57** Mr Gibson did not request this information of Captain Trubshaw or Commander Toy. It was the end of the night watch and I have accepted Mr Gibson's evidence that he was overwhelmed and fatigued by this point due to the inability to take a break.¹¹⁹ The absence of information about the quality of the searches

¹¹⁷ The IAMSAR Manual guidance observes that: "[A] timely and comprehensive debriefing of search crews is as important as the briefing. A careful debriefing and evaluation of the reports of search crews is necessary for an accurate evaluation of the search activities. This evaluation in turn will determine if and where further searching should be done." See: International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 2', paragraph 5.19.1.

¹¹⁸ INQ010740/81-82/In19-2.

¹¹⁹ See paragraph 9.3.

undertaken is an additional reason that Mr Gibson could not be confident about their effectiveness. Even without the benefit of hindsight, the failures to conduct search planning and to debrief search personnel had an adverse impact on MRCC Dover's ability to determine reliably whether incident 'Charlie' had been located.

Conclusion – was the search for incident 'Charlie' effective?

- 11.58** The meteorological conditions on the night are not a complete answer to the question of why those who had been on board incident 'Charlie' were not located given the weaknesses in the searches by the Valiant and R163. In particular, neither the Commander of the Valiant nor the captain of R163 were informed that they were searching for a sinking or swamped small boat or that there were potentially people in the water. No formal search planning was undertaken, with the result that full search parameters were not provided. Search personnel were not debriefed, and the searches had no quantifiable value in terms of determining the probability of detection and, ultimately, the probability of success. For the reasons explored in this chapter, it was not safe 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'.

Chapter 12:

Reconciliation, termination of search and rescue, and closure of incident ‘Charlie’

- 12.1** Two important issues for the Inquiry are when and why HM Coastguard decided that incident ‘Charlie’ had been resolved. In considering them I have kept at the forefront of my mind that those on duty on 23 to 24 November 2021 were overwhelmed by the combination of the volume of small boat activity and short staffing. I have also kept in mind the need to avoid judging actions taken on that night with the benefit of hindsight. I have examined these actions taking into account the conditions and perspectives at the time.

Did HM Coastguard conclude that incident ‘Charlie’ had been resolved on the night watch?

- 12.2** Central to the issue of whether HM Coastguard had decided that incident ‘Charlie’ had been resolved on the night watch are the reconciliation decisions of the SMC at Dover, Mr Neal Gibson. He accepted in oral evidence that he failed to record in writing any decision identifying one of the three small boats recovered by the Valiant as incident ‘Charlie’.¹ However, he said that consciously or unconsciously, he must have assumed that the second small boat embarked by the Valiant, M958, was incident ‘Charlie’.² In oral evidence, he explained that by this he meant that he had arrived either at a definite or probable conclusion.³ While, as I have acknowledged, he did not make any contemporaneous record in the ViSION logs or tracker of his decision that M958 was incident ‘Charlie’, there is circumstantial evidence that supports what he says and which, on balance, convinces me that his evidence is correct.
- 12.3** Firstly, the two other small boats embarked by the Valiant, M957 and M959, were – in contrast to incident ‘Charlie’ – identified in the ViSION logs and contemporaneous calls as corresponding to HM Coastguard references ‘Lima’ and ‘November’, respectively. Therefore, M958 was the only small boat of the three embarked by the Valiant which had not been identified and assigned a

1 INQ010715/164-165/ln17-4.

2 INQ010392/98/par195.

3 INQ010715/164/ln15-23.

HM Coastguard reference in the ViSION logs by the end of the night watch. The contemporaneous calls show that while Mr Gibson had initially assumed that M957 was incident 'Charlie', by 04:21 on the night, he had rejected his initial assumption. That was because, by this time, he had obtained information from the Valiant about the position of M957, its colour, the number of people on board and whether any calls had been made to HM Coastguard. This information was consistent with the records he held for incident 'Lima'. Therefore, at 04:21, Mr Gibson told the Valiant that they would "work with [M957] potentially being Lima and obviously carry [their] search on for Charlie and vessels that have been reported in the area".⁴ It is clear that at this point, Mr Gibson believed that incident 'Charlie' remained outstanding. Around an hour later, at 05:27, he recorded his view by making an entry in the ViSION log for incident 'Lima' that he "believe[d] this vessel was picked up by Valiant at 0423UTC".⁵ Equally, M959, the third small boat embarked by the Valiant, was later recorded in the ViSION logs as corresponding to incident 'November'.⁶

- 12.4** The second reason for concluding that Mr Gibson believed M958 was incident 'Charlie' is that after embarking M958, at 06:46, the ViSION logs show that the Valiant was cleared from her tasking to incident 'Charlie' and assigned to incident 'November' (M959) located in the vicinity of Southwest Goodwin, which is a different area of the Dover Strait to where incident 'Charlie' was considered to be.⁷ Therefore, after M958 was embarked, no asset was assigned specifically to search for incident 'Charlie' by HM Coastguard. This is also consistent with Mr Gibson's stated belief that he considered that M958 was incident 'Charlie'.
- 12.5** However, the unfortunate failure to record the decision that M958 was incident 'Charlie' in writing had the inevitable consequence that this would not be apparent to others working during the night shift, unless Mr Gibson informed them verbally. There is no evidence that he did so. By contrast, there is evidence that those providing remote support to MRCC Dover from the JRCC believed that incident 'Charlie' had been identified as the first small boat embarked by the Valiant, M957. At 03:57, when the Valiant had recently arrived alongside M957 and Mr Gibson had not yet identified it as likely to be incident 'Lima', Mr Barnett, the SMC at the JRCC, recorded M957 as incident 'Charlie' in the HM Coastguard tracker.⁸ Although there remain some unanswered questions, the evidence, and in particular the contemporaneous calls, leave me in no doubt that this was entered in error. Mr Barnett's evidence was that the source for the information that he entered at 03:57 would have been the 'Charlie' incident log at 03:56

4 INQ007578/2.

5 INQ000246/4.

6 INQ000252/7, INQ000237/13.

7 INQ000237/13.

8 INQ006802.

where Mr Downs had entered the ‘M’ number M957.⁹ He added that the original source of the information would have been Border Force, passed to MRCC Dover, and that he “would have then simply updated the tracker to match the information on ViSION to ensure the tracker was as up to date as possible”.¹⁰ In oral evidence, he said that he was not aware that Mr Gibson had later identified M957 as incident ‘Lima’.¹¹

- 12.6** Mr Barnett bears no responsibility for the mistaken entry. As he explained in his oral evidence, he was not involved in the detail of incident ‘Charlie’ or engaged in scrutinising the ViSION logs.¹² Both Mr Gibson and Mr Downs told the Inquiry that the ViSION system automatically entered all information about small boats encountered by the Valiant on the log for incident ‘Charlie’ because the Valiant was tasked to incident ‘Charlie’.¹³ Accordingly, all the information about the small boats embarked by the Valiant was included in the ‘Charlie’ ViSION log without any of them in fact being attributed to incident ‘Charlie’. This included Mr Downs’ entry in the ‘Charlie’ log at 03:56 providing an ‘M’ number, which did not relate to the small boat associated with incident ‘Charlie’. This was self-evidently liable to cause confusion for someone who was involved remotely in MRCC Dover’s work, such as Mr Barnett.
- 12.7** The MCA’s corporate witness said that the ViSION system had a process to override the automatic population of all entries about an asset in the incident log to which it is tasked.¹⁴ However, neither Mr Gibson nor Mr Downs were aware of this process in November 2021. While Mr Downs had left HM Coastguard in 2022, Mr Gibson’s oral evidence suggested that he remained unaware of the process explained by the MCA’s corporate witness at the time of the Inquiry’s hearings in March 2025.
- 12.8** Mr Barnett’s mistaken entry in the tracker also demonstrates the risks of the model of remote cover used by HM Coastguard. Staff at the JRCC were updating the tracker without the full, relevant operational information and situational awareness known to MRCC Dover. Moreover, the error was not corrected by anyone at MRCC Dover during the night watch. In particular, Mr Gibson did not correct Mr Barnett’s error when, at 05:30, he entered information in the tracker confirming that incident ‘Lima’ had been embarked by the Valiant.¹⁵ Given the overall knowledge that he held as SMC, if Mr Gibson had seen the entry of ‘M957’ in the ‘Charlie’ row of the shared UK tracker, he should have realised that there was an error. In his witness statement, Mr Barnett said

9 INQ010140/15/par38.

10 INQ010140/15-16/par40.

11 INQ010719/98/ln2-7.

12 INQ010719/94/ln19-22, 98/ln12-16.

13 INQ010715/68-69/ln21-15, INQ010720/162/ln13-24.

14 INQ010746/183/ln3-20.

15 INQ006808.

that Mr Gibson would have had overall responsibility for ensuring the tracker was correct.¹⁶ In his oral evidence he added that Mr Gibson would have had sufficient time and resource on the night to have oversight of the tracker, although he noted that he was not aware at the time that Mr Gibson was undertaking significant call handling that night.¹⁷

- 12.9** I am very aware of the difficulties for Mr Gibson that night due to the short staffing and volume of work. As he explained in his evidence – and it is entirely unsurprising – by this point of the night watch he was feeling tired and overwhelmed.¹⁸ He had worked through the night without having had any break. The volume of work and the lack of adequate support at MRCC Dover meant that he was overwhelmed and unable to meaningfully review the tracker. I have no doubt that when Mr Barnett made the entry at 03:57, his intentions were to assist Mr Gibson. In turn, Mr Gibson was doing his best in an impossible situation. The problems which led to the errors in the HM Coastguard tracker on the night were systemic in nature.
- 12.10** The contemporaneous evidence also leaves me in no doubt that staff at Border Force MCC believed, erroneously, that M957 was incident ‘Charlie’. The daybook of Karen Whitehouse, Higher Officer at Border Force MCC, attributed M957 to incident ‘C’ (‘Charlie’) at 03:48.¹⁹ The Border Force tracker at 04:50 included the same error as contained in the HM Coastguard tracker from 03:57, namely attributing M957 to incident ‘Charlie’.²⁰ Further, in a call at or around 05:04 between Border Force MCC and the Valiant, the Border Force speaker incorrectly identified the first small boat embarked by the Valiant (M957) as incident ‘Charlie’. That error was not corrected by the Valiant speaker.²¹ Ms Whitehouse said in her first witness statement that the reason why Border Force MCC believed that M957 was incident ‘Charlie’ was because that was what HM Coastguard believed.²² She is correct to the extent that the HM Coastguard tracker from 03:57 identified M957 as incident ‘Charlie’. However, as is clear from the earlier discussion, this is not what Mr Gibson, as SMC, believed. This erroneous belief held by Border Force, including the entries on the Border Force tracker, had no material effect on HM Coastguard’s decisions on reconciliation in relation to incident ‘Charlie’.²³

16 INQ010140/14-15/par36.

17 INQ010719/70/1-16.

18 INQ010715/49/ln3-6.

19 INQ000565.

20 INQ001215.

21 INQ007627, INQ007817. This can only refer to the first small boat (M957) due to the timing of the call (at or around 05:04). The second boat was not located by Valiant until around 05:21 and not embarked until around 05:55.

22 INQ010135/26/par64.

23 See paragraph 12.32.

- 12.11** Accordingly, the evidence leaves me 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. However, due to the failures in record keeping, there was a mismatch between the information contained in the documentary records and the SMC’s conclusions. The latter were unrecorded and not shared with others who were operationally involved on the night.

Why did Mr Gibson decide that M958 was incident ‘Charlie’?

- 12.12** Although I have accepted Mr Gibson’s evidence that he believed that M958 was incident ‘Charlie’, it is important to recognise that the information obtained by MRCC Dover about M958 was inconsistent with what HM Coastguard knew about incident ‘Charlie’. As Mr Gibson accepted in his oral evidence, the information was “obviously conflicting”.²⁴ It was inconsistent in a number of ways. Firstly, in relation to the condition of the small boat, M958 was underway and not in distress or in need of immediate assistance, whereas incident ‘Charlie’ had stopped and a Mayday relay had been broadcast because it was taking on water and in need of immediate assistance. Secondly, in respect of the demographics of those on board, M958 contained only adult men whereas all reports of the small boat associated with incident ‘Charlie’ were that it had women and children on board. Thirdly, in relation to whether calls to HM Coastguard had been made by those on board M958, it was reported that one person had seen someone make a single call, whereas MRCC Dover was aware that a very large number of calls had been made by different people on board incident ‘Charlie’. In this regard Mr Gibson had told Mr Willows of Border Force MCC at around 03:11 on 24 November 2021 that MRCC Dover had been receiving multiple calls from the same boat.²⁵
- 12.13** In other words, none of the details matched except that firstly, M958 was found in the vicinity of the Sandettie Light Vessel, which was a similar location to the last known position for incident ‘Charlie’, and secondly, there were a similar number of people on board M958 (31) and in some of the reports from incident ‘Charlie’ (which ranged between 33 and 43). However, the location of M958 was not capable of providing a positive identification of incident ‘Charlie’. The French intelligence had reported that there were four vessels – namely incidents ‘Charlie’, ‘Lima’, ‘Mike’ and ‘Delta’ – all located in a similar area close to the Sandettie Light Vessel, and incidents ‘Mike’ and ‘Delta’ remained outstanding along with incident ‘Charlie’.²⁶ Equally, the existence of broadly similar numbers of people on board M958 and incident ‘Charlie’ was not capable of giving a

²⁴ INQ010715/161/ln11-16.

²⁵ INQ007602/2.

²⁶ Incident ‘Delta’ was identified by HM Coastguard as a repeat of incident ‘November’.

positive identification because in November 2021, most small boats carried between 30 to 40 people and the numbers provided by the French Coastguard for the other three small boats reported to be in the Sandettie area were all within that range.²⁷ Based on these two factors, either alone or in combination, there was nothing to distinguish incident ‘Charlie,’ from incidents ‘Delta’ and ‘Mike’. The central and obvious factor distinguishing incident ‘Charlie’ was that it was the subject of a Mayday relay as it was taking on water and in need of immediate assistance.

- 12.14** Therefore, a central question is how Mr Gibson could have concluded that M958 was incident ‘Charlie’ when the information held on both small boats was obviously conflicting and crucially, that a small boat taking on water and in need of immediate assistance had not been found by the Valiant or R163. Mr Gibson provided the answer in his oral evidence. He said that after an initial gut feeling that there was a real emergency, which caused him to broadcast a Mayday relay, as the night progressed and the Valiant and R163 did not find a swamped small boat, but rather found small boats that were underway and in good condition, he began to consider that the information received from incident ‘Charlie’ had been exaggerated and to doubt whether the emergency was real.²⁸ His explanation to the Inquiry is consistent with the interview notes produced as part of the MCA’s internal review into the events in question where Mr Gibson is recorded as saying that by 04:30 he “was getting tired, [and the] initial thought of sinking small boat [was] gone”.²⁹
- 12.15** Mr Gibson’s evidence that he started to doubt whether he had correctly estimated the level of distress conflicts with that of the MCA’s corporate witness, who told the Inquiry that the information HM Coastguard received from incident ‘Charlie’ was taken at face value.³⁰ I prefer Mr Gibson’s evidence on this point. As the SMC in charge of incident ‘Charlie’, he is best placed to explain his own decisions. As indicated, I found him to be a candid witness. His evidence is also consistent with that of the Aviation Tactical Commander, Mr Dominic Golden, who accepted that the thought that callers may have exaggerated the level of their distress may have had some impact on his decision-making.³¹ As Mr Gibson said in oral evidence, at no point during the night did he consider that he had reliable information about the condition of incident ‘Charlie’.³² He said that he

27 The MCA’s closing submissions identify the average number of people on board a small boat in November 2021 as 33.

28 INQ010715/86-87/ln20-15, 163/ln1-15, 178/ln17-24.

29 INQ004724/3.

30 INQ010746/153/ln19, 21-23, 154/13-14: “We will take, at face value, what is said... Everything should be taken at face value... I can wholeheartedly say that every call was treated on face value and appropriate response given.”

31 INQ010718/101-102/ln2-8.

32 INQ010715/181-182/ln24-12.

never had any information that the small boat associated with incident ‘Charlie’ was sinking or that there were people in the water.³³

12.16 However, it is important to recognise that callers from those who Mr Gibson identified at the time as being on board incident ‘Charlie’ did in fact tell him this. After the initial call at 01:48 with Mubin Rizghar Hussein which led Mr Gibson to believe there was a real emergency, at 02:25, MRCC Dover was told that those on board incident ‘Charlie’ were “sinking” or “almost sink[ing]” and that they had “lost [their] engine”.³⁴ At 02:31, another caller from incident ‘Charlie’ told him that the boat was “broken” and “finish[ed]” and that those on board were “dying”.³⁵ At 02:42, the French Coastguard informed Mr Gibson that those on board incident ‘Charlie’ had said: “help me, help me, help me. We are in the water”.³⁶ In his oral evidence, Mr Gibson said that he was unsure, due to the language barrier, whether the information from the French Coastguard meant that the people on board incident ‘Charlie’ had entered the water or whether it meant they were on a craft in the sea.³⁷ However, the guidance in the IAMSAR Manual is that even if the information is uncertain or doubtful, it should be acted on where confirmation cannot be obtained without undue delay.³⁸ Taken at face value and considered cumulatively, the information provided in these telephone calls was information known to Mr Gibson that the small boat associated with incident ‘Charlie’ was sinking and that there was, at the very least, a possibility that people were in the water. However, as the events show, this evidence was not taken at face value.

12.17 The MCA’s internal review said that the absence of further calls from those on board incident ‘Charlie’ after the Valiant was on scene reasonably supported Mr Gibson’s belief that the incident had been resolved and those on board had been rescued.³⁹ However, the assumption that the distress calls stopped because incident ‘Charlie’ had been rescued is also explicable because of the belief that those on board incident ‘Charlie’ had exaggerated their level of distress. By the time the Valiant was on scene, Mr Gibson did not believe that incident ‘Charlie’ was in any real danger. Therefore, it is likely that he did not give serious consideration to the alternative – and likely correct – reason why the calls had stopped: the people on board incident ‘Charlie’ had fully entered the water. In his oral evidence, Mr Downs said that this possibility did not cross his mind.⁴⁰ The communications expert instructed by the Inquiry, Iain Ivory, concluded that the

33 INQ010715/147-148/ln16-5.

34 INQ007654/2-3.

35 INQ007655/3-4, 7.

36 INQ007656/2.

37 INQ010715/122-123/ln5-19.

38 International Maritime Organization and International Civil Aviation Organization (2019), ‘IAMSAR Manual Volume 2’, paragraph 3.4.2.

39 INQ008905/102/par6.1.12.

40 INQ010720/159/ln21-25.

undelivered status of the WhatsApp message sent at 03:33 by HM Coastguard to a number associated with incident ‘Charlie’ and the failure of a call made at 04:16 are consistent with the mobile telephones of those on board incident ‘Charlie’ being submerged in the water and no longer functioning.⁴¹ The belief that those on board had likely exaggerated their situation meant that Mr Gibson and Mr Downs did not appreciate that calls stopping was a cause for concern.

- 12.18** In other words, an important reason why Mr Gibson decided that a small boat that did not match the information he held on incident ‘Charlie’ was, nonetheless, incident ‘Charlie’ was because by the time M958 was located, he did not believe that the information he had received about incident ‘Charlie’ was true. This reflects the perceptions and understandings in HM Coastguard at the time. The Inquiry received evidence from various sources that in November 2021, there was a widely held belief within HM Coastguard that callers from small boats regularly exaggerated their level of distress.⁴² Some HM Coastguard staff, who were operationally involved with small boats in November 2021, went as far as to suggest that the majority of calls from small boats exaggerated the level of distress, that it happened “nine times out of ten”, and that the calls appeared scripted.⁴³
- 12.19** There is insufficient evidence to determine conclusively whether callers from small boats exaggerated their level of distress, and if so, how often. The Inquiry is not aware of any research, data or statistics on the point. The Inquiry has seen a ViSION log from 20 November 2021 which records that a caller on board a small boat provided potentially inaccurate information about the level of distress of those on board.⁴⁴ However, the only documentary evidence advanced by MCA witnesses that callers from small boats were coached to exaggerate did not, on further investigation, support this claim. In particular, it was said that there was a website and leaflets which told callers from small boats to exaggerate.⁴⁵ When the Inquiry requested these resources, there was no evidence that exaggeration was encouraged. The leaflets, which were disclosed to the Inquiry subsequent to oral evidence about exaggeration, provided emergency telephone numbers and encouraged those on small boats to call the UK or French authorities if they were

⁴¹ INQ010133/par5.2.

⁴² INQ010715/83-86/ln19-15, INQ010716/115/ln7-23, INQ010718/99/ln1-24, INQ010719/58-59/ln1-6, INQ010719/125/ln1-13, INQ010720/102-104/ln17-17, 105/ln11-17, INQ010720/204-205/ln16-6, INQ010740/50-51/ln24-13, INQ010746/153/ln4-11.

⁴³ INQ010719/58/ln1-25, 59/ln1-6, INQ010720/105/ln11-15, 106/1-21, INQ010719/125/ln1-13.

⁴⁴ INQ010269/23. Although it is noteworthy that the final substantive entry in the log, at 13:52, suggests that there was uncertainty about the reconciliation of that incident: “Are we able to clarify that this is the same vessel that has made all the calls to the ambulance and CG [Coastguard] and there are NO children or adults... in danger or have been in the water?” There is no answer to this question recorded in the log.

⁴⁵ INQ010715/82-83/ln17-10.

in distress.⁴⁶ Similarly, when the Inquiry asked for the website which was said to encourage callers to exaggerate, this was the website of the non-governmental organisation Alarm Phone, which contained information about the safety of life at sea but did not encourage exaggeration.⁴⁷

- 12.20** While some of the HM Coastguard witnesses said that they had first-hand experience of exaggeration by callers from small boats, others, such as the Aviation Tactical Commander, said that he had heard about it from colleagues.⁴⁸ Even where witnesses did say that they had experienced exaggeration first hand, it was unclear whether assumptions had been tested and alternative explanations for apparent exaggeration had been explored, such as the language barrier and miscommunication, as well as the difficulty for HM Coastguard of knowing with any certainty which calls had been made from any given small boat that had been located.
- 12.21** Some witnesses accepted that the genuine subjective distress of callers from small boats could be misinterpreted. The MCA's corporate witness said in his oral evidence that he considered the perception of exaggeration may occur "because one person's view of distress is very different to another's".⁴⁹ The Small Boat Tactical Commander, Mr George Papadopoulos, also recognised that the perception of danger is subjective and observed that waves splashing over and water coming into a small boat, which happened frequently, might cause someone who was not a mariner to believe they were sinking.⁵⁰ There is also the point that those at HM Coastguard were speaking, without interpreters, to those whose first language was not English, and who would likely be genuinely terrified by the situation in which they found themselves. There is self-evidently a wide scope for miscommunication and misconception in this context.
- 12.22** There is no need for me to determine whether callers from small boats did exaggerate. The relevant point is that it was a widely held belief shared among HM Coastguard staff who worked on small boats and was discussed between colleagues, sometimes in terms which were inappropriate.⁵¹ This could lead to contrasting a legal classification of the 'distress' phase, which applied to all small boats in accordance with HM Coastguard's policy, with what was said to be a true search and rescue incident.⁵² The Inquiry was also told by Mr Downs that new recruits at MRCC Dover were informed as part of their training that callers from small boats would overstate the level of distress.⁵³

46 INQ010753, INQ010754, INQ010755, INQ010756.

47 INQ010784.

48 INQ010718/99/ln14-24.

49 INQ010746/153/ln13-14.

50 INQ010740/53/ln10-14.

51 See paragraphs 8.60 and 8.73.

52 INQ007389/4.

53 INQ10720/103-104/ln14-7.

- 12.23** Notwithstanding this widely held belief, Mr Gibson did not dismiss the information he initially received from those on board the small boat associated with incident ‘Charlie’. His initial gut reaction to the call at 01:48 led to the Mayday relay broadcast. In his oral evidence he explained that as the night went on, and the Valiant and R163 did not find a sinking small boat, the possibility that those on board incident ‘Charlie’ had exaggerated their plight became dominant in his mind.⁵⁴ However, for the reasons discussed in Chapter 11 concerning the nature of the searches of the Valiant and R163, it was unsafe to conclude that the failure to find a sinking small boat meant that there was no such boat.
- 12.24** The widely held perception that callers from small boats regularly exaggerated their level of distress created the risk that callers from a small boat facing a real emergency might not be believed when giving information about their situation, which might possibly lead to loss of life. This was not recognised by HM Coastguard before 23 to 24 November 2021. The corporate view was that staff would take all information received from small boats at face value, and that in accordance with general training they would not take decisions based on personal beliefs, including that the majority of callers from small boats exaggerated their level of distress. Reliance on general training to manage the specific situation in which operational staff believed that information received from small boats was regularly exaggerated was insufficient. There was an obvious risk that this situation could give rise to the risk of errors. In his oral evidence, Mr Papadopoulos, HM Coastguard’s designated lead in relation to small boat search and rescue, accepted that there was a risk that the widely held belief about exaggeration could cause staff to jump to premature conclusions or be biased in certain directions.⁵⁵ It was a systemic failing that in 2021, HM Coastguard did not challenge this prevalent belief and did not recognise that it created a risk that information received from small boats might not always be treated at face value.
- 12.25** In their reports, both the MAIB and the US Coastguard concluded that a habituation or normalcy bias had developed in HM Coastguard operational staff. The US Coastguard recommended that “[w]atch officers must treat every distress alert as genuine until they determine otherwise. Supervisors must be alert to normalcy bias and take actions including regular training to counter the detrimental effects”. The MCA’s response to the review accepted the recommendation made by the US Coastguard and stated that updates had been made to standard operating procedures to reinforce this requirement throughout the national network.⁵⁶ I was surprised with the MCA’s corporate

⁵⁴ See references at footnote 28 of Chapter 12.

⁵⁵ INQ010740/57-58/ln25-6.

⁵⁶ INQ004342/5. I note that HM Coastguard’s response did not refer to the US Coastguard’s recommendation about providing “regular training to counter the detrimental effects [of normalcy bias]”.

witness' evidence to the Inquiry that information was taken at face value on 23 to 24 November 2021, and with the MCA's internal review which concluded that there was no evidence of normalcy bias in response to incident 'Charlie'.⁵⁷ HM Coastguard's ongoing failure to recognise any role played by habituation or normalcy bias on 23 to 24 November 2021 at a corporate level casts doubt on the extent to which the US Coastguard's recommendation has been implemented.

What did the incoming day watch understand about incident 'Charlie' and why was the incident closed?

- 12.26** At the outset of the day watch, at around 07:30, incident 'Charlie' was still showing as an ongoing incident in the ViSION system and HM Coastguard tracker. However, there was no active search and rescue undertaken in relation to incident 'Charlie' at any point during the day watch. It was considered to be resolved from the outset of the watch. Why did the oncoming day watch believe this to be the case?
- 12.27** The first documentary record that incident 'Charlie' was resolved was made on the HM Coastguard tracker relatively early in the morning shift. The incoming SMC at MRCC Dover, Mr James Crane, marked incident 'Charlie' as resolved on that tracker at around 09:11, shortly after Mr Papadopoulos had marked incidents 'Lima' and 'November' as resolved. In the absence of a written record from the night watch, it is most likely that Mr Crane relied on what he was told during the oral handover from the outgoing SMC, Mr Gibson, in order to record incident 'Charlie' as resolved on the tracker. The written handover documents from 23 to 24 November 2021 no longer exist since the template was a live document which has since been overwritten.⁵⁸ However, the Inquiry has received oral evidence on the content of the briefing. While not recollecting its full details, Mr Crane's evidence was that Mr Gibson mentioned the Mayday relay and that Mr Gibson would have shown him on ViSION to which incident the Mayday broadcast related.⁵⁹ Mr Crane said that he recalled Mr Gibson telling him that as a result of the Mayday relay broadcast, "assets from both France and the UK had been dispatched to attempt to locate a small boat...and that some boats had been picked up in that area by HMC Valiant".⁶⁰ Mr Crane said that the bare minimum information was given as an overview of the resolved incidents.⁶¹
- 12.28** In his oral evidence, Mr Gibson said that he would have gone through the tracker with Mr Crane and would have talked at length about ongoing incidents

57 INQ008905/104/par6.1.18.

58 INQ009632/16/par36.

59 INQ010142/16/par43.

60 INQ010142/16/par44.

61 INQ010719/137/ln11-25.

and given an overview of what had been resolved.⁶² He said that he raised no concerns about incident 'Charlie' as he believed it had been recovered.⁶³ Mr Papadopoulos also said that his understanding from the handover was that there was nothing outstanding from incident 'Charlie'.⁶⁴ The evidence of Mr Richard Cockerill, the only person whose shift overlapped the two watches at MRCC Dover, was that he did not believe that there were any incidents from the night watch that were outstanding.⁶⁵ Mr Cockerill did not have any first-hand operational knowledge of incident 'Charlie' since he was not present at MRCC Dover before 05:00 and had not received a handover when he started his shift.⁶⁶

- 12.29** The evidence about the contents of the handover was broadly consistent. All witnesses were consistent that incident 'Charlie' was not handed over as an ongoing incident that required further search and rescue action. The oncoming day watch understood from Mr Gibson's handover that incident 'Charlie' had been resolved. Given the evidence that the bare minimum information was given in the overview of resolved incidents, it seems unlikely that Mr Gibson would have provided any reasoning for his decision that incident 'Charlie' was resolved. It also seems unlikely that the oncoming day watch would have expected it.
- 12.30** In addition to relying on the handover from Mr Gibson, there is a further possibility that Mr Crane had regard to the 'M' numbers recorded in the HM Coastguard tracker when he recorded incident 'Charlie' as resolved at 09:11. At that time, the HM Coastguard tracker still showed Mr Barnett's incorrect entry from 03:57 recording M957 against incident 'Charlie'. M959 had been added against incident 'November' at 08:28 by the day watch trainee at MRCC Dover.⁶⁷ Additionally, at 08:35 on 24 November 2021, another erroneous entry had been made on the HM Coastguard tracker when a Divisional Commander, who was working from MRCC Humber, entered M958 against incident 'Lima'.⁶⁸ The error is understandable given that the Divisional Commander had no operational knowledge of events during the night watch and, at the time the entry was made, the information on the face of tracker showed that incident 'Lima' had been embarked by the Valiant. However, self-evidently, the entry of M958 in the tracker should have been undertaken during the night watch by staff who were operationally involved with that incident. This failure in record keeping, along with the SMC's failure to update the ViSION logs, led to a situation in which staff who had not been operationally involved were required to second guess decisions on reconciliation that had been made during the previous shift.

62 INQ010715/166/ln2-6.

63 INQ010715/179/ln12-16.

64 INQ010740/76/ln8-12.

65 INQ010720/197/ln11-15, 203/ln20-23.

66 INQ010720/196/ln6-12, 199/ln15-25, 200/ln1-4.

67 INQ006830.

68 INQ006835.

- 12.31** It is possible that the entries on HM Coastguard's tracker in the morning of 24 November 2021 provided further reassurance to the day watch that there was nothing outstanding from the Valiant's tasking during the night watch. Therefore, on the face of the tracker all appeared to be in order as the three small boats rescued by the Valiant had been reconciled by HM Coastguard. The problem, as before, was systemic. MRCC Dover did not have the resources to provide proper oversight of the tracker which meant that there were gaps following the night shift which others, including non-operational staff, were left to fill without having access to sufficient information. Equally, HM Coastguard had not put in place a policy whereby HM Coastguard staff knew their roles and responsibilities in relation to the tracker and there was a reliable mechanism for identifying errors within it.
- 12.32** For completeness, I do not consider that the Border Force tracker played any role in Mr Crane's recording of incident 'Charlie' as resolved. I have no reason to doubt the evidence of Mr Crane and Mr Papadopoulos that they were unaware of the Border Force tracker.⁶⁹ However, I note that the Border Force tracker contained the same errors as the HM Coastguard tracker, as well as additional errors. One of these was the identification of M958 as incident 'E' ('Echo') on the 07:00 version, which had no basis in the HM Coastguard records.⁷⁰ This casts significant doubt on evidence that Border Force only updated their tracker using the information on HM Coastguard's tracker.⁷¹
- 12.33** While Mr Crane marked incident 'Charlie' as resolved in the HM Coastguard tracker, he did not make a corresponding entry in the ViSION log. Around an hour later, at 10:08, the ViSION log was updated by George Close, one of the Maritime Tactical Commanders at the JRCC in Fareham. In his evidence, Mr Close said that his action was based on the HM Coastguard tracker, most likely a reference to Mr Crane's action at 09:11. In his witness statement, Mr Close said that he also consulted the ViSION logs, which is the likely source of the additional information he recorded at 10:08.⁷² Therefore, it appears that Mr Close mistakenly believed that at least some of the information recorded on the 'Charlie' log had been positively identified as incident 'Charlie'. It was understandable that Mr Close reached an incorrect conclusion. As I have already explained, the inclusion of information about all three small boats embarked by the Valiant on the 'Charlie' log was, self-evidently, confusing.
- 12.34** Although not treated as an ongoing incident at any point during the day watch on 24 November 2021, incident 'Charlie' was not formally closed until 15:21. That was done by the day watch trainee under the supervision of Mr Crane. In his oral

69 INQ010142/10/par24, INQ009632/26/par67.

70 INQ001231.

71 See evidence of Ms Whitehouse: INQ010135/8-9/par20.

72 INQ010212/21/par56.

evidence, Mr Crane said that the incident was closed as a result of Mr Close's record in the ViSION log at 10:08, stating that the tracker showed that incident 'Charlie' was resolved. Mr Crane said that the Maritime Tactical Commander was a senior officer and so the entry was determinative.⁷³ Therefore, it is more likely than not that incident 'Charlie' was closed because Mr Gibson had informed Mr Crane that it was resolved during the handover, which was consistent with the incorrect information on the face of the HM Coastguard tracker. Mr Crane then relied on this information to record the incident as resolved in the HM Coastguard tracker, which in turn, was relied on by Mr Close to update the ViSION log. The actual closure of incident 'Charlie' at 15:21 was a clerical exercise relying on these earlier entries. No new information was entered by the trainee when closing the incident.

Were the information management failures that occurred on the night foreseeable and systemic in nature?

- 12.35** There were significant failings in information management on 23 to 24 November 2021. The ViSION logs could not be the single source of truth, as required by HM Coastguard policy, when relevant information was not recorded within them.⁷⁴ Moreover, the ViSION logs were a source of confusion: the inclusion of all three small boats embarked by the Valiant within the incident 'Charlie' log, without positively attributing any of them to incident 'Charlie', was obviously confusing and led to a misunderstanding by the Maritime Tactical Commander on the day watch. In the absence of a reliable record in the ViSION system, the oncoming day watch relied on short verbal overviews given by way of handover and on the HM Coastguard tracker, which contained significant errors.
- 12.36** The failures in information recording which took place on the night of 23 to 24 November 2021 were not isolated incidents. HM Coastguard was aware of them before November 2021. Two witnesses who were operational at MRCC Dover in November 2021 gave evidence that the volume of work meant that standard operating procedures on the recording of information in the ViSION system were not followed. Mr Downs said in oral evidence that it was quite common for mission statements to be completed after an incident had been resolved because there was no time to do this at the point at which assets were tasked.⁷⁵ Additionally, Mr Crane's evidence was that quite often shifts were so busy that there was insufficient time to record the reasons for closing an incident.⁷⁶ Mr Crane also observed in oral evidence that the volume of incoming calls meant that it was very difficult for him, as an SMC, to manage his team

73 INQ010719/152-153/ln16-16.

74 INQ010715/154/ln15, INQ010746/179/ln11-14.

75 INQ010720/117-118/ln20-17, 123/ln5-15.

76 INQ010719/155/ln20-25, 156/ln1-12.

successfully.⁷⁷ The failure to record mission statements while a search and rescue operation was ongoing meant that the reasoning and considerations taken into account by the SMC in prosecuting an operation could not be reviewed by other HM Coastguard staff, including the Maritime Tactical Commanders who were intended to conduct RAG reviews of these statements.

- 12.37** From at least August 2021, HM Coastguard was aware that MRCC Dover faced being overwhelmed due to the volume of small boat activity. One of the reports from August 2021 noted that the Maritime Operations Officers at MRCC Dover were observed to be “struggling with the amount of information coming in, the logging of that information, the analysis of this data and communication with the remote SMC”.⁷⁸ In his email to the Chief Coastguard and Assistant Chief Coastguard on 17 August 2021, Divisional Commander Bill noted the difficulties in correlating duplicate incidents due to the number of open incidents.⁷⁹ Mr Bill’s email shows that the failure to update the ViSION logs properly was particularly detrimental when an SMC was working remotely from another station since, in the absence of a physical presence in the operations room, the remote SMC relied on the ViSION logs for situational awareness. This also highlighted the limitations of having a remote SMC since, as was recognised, “much of the information the SMC requires is not available in ViSION and the migrant tracker”.⁸⁰
- 12.38** In his oral evidence, the MCA’s corporate witness accepted that HM Coastguard was aware, at the time of the incident in November 2021, that concerns had been expressed about the way records were kept.⁸¹ When asked what, if anything, had been done to address those concerns before 23 to 24 November 2021, the MCA’s corporate witness responded that staff had been sent a reminder of the importance of logging appropriate information within the ViSION system through HM Coastguard’s intranet, the Coastguard Information Portal.⁸² In my view, this reminder of the rules was not capable of addressing the reasons for the record-keeping failures, which were linked to overload and the volume of calls from small boats.
- 12.39** In his oral evidence, the MCA’s corporate witness discussed the tension between record keeping and taking action in a timely manner, stating that his preference would always be to rescue a person over record keeping.⁸³ Clearly, saving lives must always be the priority of any search and rescue organisation. However, in my view, it is important to recognise the value of information management

77 INQ010719/124/ln14-23.

78 INQ007279/4.

79 INQ003322/1.

80 INQ003322/2.

81 INQ010746/179/ln15-25.

82 INQ010746/180-181/ln17-1.

83 INQ010746/180/ln1-9.

and record keeping as instruments in assisting the success of search and rescue missions. They are not in conflict with it. As recognised in the IAMSAR Manual guidance, sound processes are instrumental to obtaining desired results.⁸⁴ Indeed, as was clear from the August 2021 emails, information in the ViSION system was mission-critical for a remote SMC, who would be unable to maintain situational awareness without proper record keeping. Equally, a Maritime Tactical Commander's RAG review depended on sufficient information being entered within the ViSION logs so that a meaningful review of an SMC's thought process could take place. HM Coastguard's search and rescue missions depended on full and accurate record keeping. In November 2021, HM Coastguard had not taken sufficient action to resolve the serious information management problems that had previously been identified.

Conclusion – was decision-making on the reconciliation, termination of search and rescue, and closure of incident 'Charlie' effective?

- 12.40** The problems identified in Chapter 11 with the search for incident 'Charlie' affected decisions on reconciliation. Mr Gibson identified the second small boat embarked by the Valiant (M958) as incident 'Charlie', despite there being, as he accepted, an "obvious conflict" between the information held on incident 'Charlie' and the small boat identified as M958. He did not record his decision in writing, nor did he share it with colleagues during the night watch. The only reasonable explanation for his decision was given in his oral evidence. After initially believing that there could be a real emergency, the failure of the Valiant and R163 to find a sinking small boat coupled with the phone calls stopping from incident 'Charlie' led him wrongly to conclude that the callers had exaggerated the level of their distress. Given the failings in the searches of the Valiant and R163, this conclusion was unsafe.⁸⁵
- 12.41** The prevalence of the belief within HM Coastguard that callers from small boats regularly exaggerated their level of distress was a far broader problem within HM Coastguard in and before November 2021. Irrespective of the truth or otherwise of the belief, it created the obvious risk that callers from a small boat facing a real emergency may not be believed when giving information about their situation, which might possibly lead to a loss of life. It relied on generic training that information should be taken at face value which, in all the circumstances prevailing at the time, was plainly inadequate. It was a systemic failing that

⁸⁴ International Maritime Organization and International Civil Aviation Organization (2019), 'IAMSAR Manual Volume 1', paragraph 6.1.7(a): "Processes more than results. Mission statements, goals and objectives are important to any organization, but if sound processes are used the desired results are more naturally identified and achieved."

⁸⁵ See paragraph 11.58.

HM Coastguard did not consider and act on the risks of this belief before 23 to 24 November 2021.

- 12.42** Finally, there were failures in record keeping on 23 to 24 November 2021. Of particular relevance was the mismatch between the SMC at Dover's (unrecorded and uncommunicated) decision that the small boat identified as M958 was incident 'Charlie' and the HM Coastguard tracker, which recorded in writing that the small boat identified as M957 was incident 'Charlie'. This was an error that originated with the JRCC. It is more likely than not that the error resulted from a combination of the JRCC's reduced situational awareness as a result of working remotely, coupled with the misleading and incomplete record keeping at MRCC Dover and, in particular, the inclusion of information about all three small boats embarked by the Valiant on the ViSION log for incident 'Charlie'.
- 12.43** In practice, search and rescue was terminated on incident 'Charlie' after the Valiant embarked the second small boat (M958). There was no active search and rescue undertaken in relation to incident 'Charlie' at any point during the day watch of 24 November 2021 because it was considered to be resolved from the outset of the watch. It is likely that the oncoming day watch believed this to be the case as a result of what was said in the handover between watches, combined with the error recorded in the HM Coastguard tracker which showed that incident 'Charlie' was M957. This had not been corrected during the night watch and persisted into the day watch. An additional error was added into the HM Coastguard tracker early during the day watch when the reference M958, which Mr Gibson had decided was incident 'Charlie', was incorrectly attributed to incident 'Lima'. Given that Mr Gibson had never recorded his decision-making about incident 'Charlie', these errors in the tracker would have contributed to the impression that all appeared to be in order.
- 12.44** Accordingly, on the morning of 24 November 2021, the day watch SMC marked incident 'Charlie' as resolved in the HM Coastguard tracker and this was then relied on by the day watch Maritime Tactical Commander to record it as resolved in the ViSION logs. Incident 'Charlie' was later formally closed, in the afternoon of 24 November 2021, with no further analysis or investigation. It was reasonable for HM Coastguard staff working on the day watch to rely on information received from the outgoing night watch SMC and the documentary records (in this case the HM Coastguard tracker given the gaps within the ViSION logs). They could not be expected to check and second guess the decisions of colleagues taken during the previous shift, nor did they have the operational knowledge to do so. The result was that the mistakes made during the night watch were insulated from effective review. This was another serious failing in HM Coastguard's systems.

PART 4:

People in the small boat

This part of the report addresses the first aspect of the Terms of Reference and ascertains the identities of those who died in the mass casualty event of 23 to 24 November 2021 while attempting to cross the English Channel in a small boat.

Chapter 13:

Those who died and the missing

13.1 In reporting on the events of 23 to 24 November 2021 when people died attempting to cross the Channel in a small boat, my Terms of Reference require me, firstly, to ascertain the identities of those who died. This chapter explains how the Inquiry went about that task, identifying those who died in the tragedy, including those who are missing, as well as the two survivors. Chapter 14 then explains in summary who they were and the impact of the tragedy on their families. The loss of life that day has been at the centre of the Inquiry's work.

The deceased

- 13.2** The Inquiry was aware from publicly available information that following the tragedy, 27 bodies were recovered by the French authorities, and that a formal identification process was undertaken.
- 13.3** On 25 June 2024, the Inquiry team wrote to the French Public Prosecutor to obtain details of the identities established by the French authorities. The French Public Prosecutor confirmed, by letter dated 21 August 2024, that 27 bodies were recovered following the shipwreck, and that an identification process, primarily based on genetic and fingerprints analysis, was undertaken. As a result of that process, the identities of 26 of the 27 bodies were ascertained. The French Public Prosecutor provided the names of the 26 individuals, together with their date of birth, sex and nationality. For the reason stated below, the identity of the 27th body could not be ascertained.
- 13.4** The families of 21 of the 26 individuals whose identities were ascertained in the French process are represented by Duncan Lewis Solicitors. They provided the death certificates of 17 of those individuals to the Inquiry. The Inquiry obtained the death certificates of the remaining nine individuals from the City of Lille, France. Each death certificate recorded that the deceased died 'at sea' or 'offshore' on 24 November 2021. Duncan Lewis Solicitors also provided copies of identity documents (such as passports and national ID cards) for the deceased whose families they represent.

13.5 Accordingly, the identities of the following 26 men, women and children have been established to the satisfaction of the Inquiry:¹

- Bryar Hamad Abdulrahman (born 11 November 1998 in Iraq), aged 23 years
- Mhabad Ali Ahmed (born 21 November 1989 in Iraq), aged 32 years
- Hasan Mohamed Ali (born 15 September 1984 in Iraq), aged 37 years
- Kazhal Ahmed Khidir Al-Jamoor (born 1 January 1975 in Iraq), aged 46 years
- Hadiya Rizghar Hussein (born 6 April 1999 in Iraq) aged 22 years
- Mubin Rizghar Hussein (born 27 May 2005 in Iraq), aged 16 years
- Hasti Rizghar Hussein (born 27 February 2014 in Iraq), aged 7 years
- Mohammed Qader Awla (born in 2000 in Iraq), aged about 21 years
- Bilind Shakir Baker (born 1 January 2001 in Iraq), aged 20 years
- Muslim Ismael Hamad (born 14 January 2002 in Iraq), aged 19 years
- Afrasia Ahmed Mohamed Akoi (born 11 April 1994 in Iraq), aged 27 years
- Maryam Noori Mohammedameen (born 21 March 1997 in Iraq), aged 24 years²
- Serkawt Pirot Mohammed (born 18 March 1993 in Iraq), aged 28 years³
- Mohammed Hussein Mohammedie (born 1 January 2002 in Iraq), aged 19 years⁴
- Shakar Ali Pirot (born 29 August 1991 in Iraq), aged 30 years
- Rezhwan Yassin Hassan (born 23 June 2002 in Iraq), aged 19 years
- Sirwan Alipour (born 22 October 1998 in Iran), aged 23 years
- Niyat Ferede Yeshiwendim (born 14 June 1999 in Ethiopia), aged 22 years
- Meron Hailu Gebrehiwet (born 31 May 1996 in Ethiopia), aged 25 years
- Fikiru Shiferaw Tekalegn (born 5 June 1978 in Ethiopia), aged 43 years⁵
- Halima Mohammed Shikh (born 1 January 1988 in Somalia), aged 33 years
- Didar Ahmad (born 15 May 1994 in Afghanistan), aged 27 years
- Shahwali Kochy (born 1 January 1995 in Afghanistan), aged 26 years

1 The ages of the deceased are provided as at the date of death. The dates of birth stated in this paragraph and in paragraph 13.8 are taken from identity documents, death certificates or from information provided by families. In some cases, '1 January' is given as the day and month of birth where this information is not known.

2 Spelt 'Maryam Nouri Mohammedameen' on the death certificate.

3 Spelt 'Serkaut Perot Muhammad' on the death certificate.

4 Spelt 'Mohammed Hussein Mohammed' on the death certificate.

5 INQ009639/2/par6. Fikiru's wife, Emebet Kefyalew, states that his birthday is incorrectly recorded on his death certificate as 5 June 1975.

- Mohammed Naeem Mayar (born 1 January 1975 in Afghanistan), aged 46 years
 - Husain Tanha (born 1 March 1997 in Afghanistan), aged 24 years
 - Mohamed Ali Mohamed Hassan Elsaey (born 20 May 2001 in Egypt), aged 20 years.
- 13.6** The 27th body recovered is believed by the French authorities to be that of Le Van Hau, a Vietnamese male born on 18 February 1992 (aged 29 years at the time of the incident). However, the French Public Prosecutor informed the Inquiry that the 27th body remains unidentified because the Vietnamese authorities did not recognise the identity document which was provided to them. The death certificate, which the Inquiry obtained from the City of Lille, records the 27th deceased as being Le Van Hau, the husband of Thi Phuong Thao Nguyen.
- 13.7** The Inquiry further notes that the death of a Le Van Hau in the English Channel on 24 November 2021 was reported in the Vietnamese press on 18 December 2021, and that reporters appear to have spoken to his wife and other family members.⁶ Without the confirmation by the Vietnamese authorities, the identity of the 27th person who died cannot be conclusively ascertained. However, the Inquiry suggests that the 27th deceased was Le Van Hau.

The missing

- 13.8** The Inquiry believes that there were at least a further four people on the boat whose bodies have not been found. These are:
- Pshtiwan Rasul Farkha Hussein (born 1 January 2003 in Iraq), aged 18 years
 - Twana Mamand Mohammed (born 30 March 2003 in Iraq), aged 18 years
 - Zanyar Mustafa Mina (born 12 January 2001 in Iraq), aged 20 years
 - Gomaa Gaber Mohamed Ahmed Nada (born 29 May 1979 in Egypt), aged 42 years.
- 13.9** The father of Pshtiwan Rasul Farkha Hussein, the brother of Twana Mamand Mohammed and the father of Zanyar Mustafa Mina provided witness statements to the Inquiry.⁷ Pshtiwan's father recounts that his son spoke to him on 23 November 2021 from the boat via video call.
- 13.10** Twana's brother similarly gave evidence that he was in contact with Twana during the night of 23 November 2021 by Facebook message, with Twana confirming that he had boarded the boat. Twana's brother was also in contact with other

⁶ VN Express International (2021), "I'm going now": final message of Vietnamese worker drowned in Channel'. Available at: <https://e.vnexpress.net/news/news/i-m-going-now-final-message-of-vietnamese-worker-drowned-in-channel-4405082.html> (accessed 15 October 2025).

⁷ INQ010092, INQ010210, INQ009472.

people on the boat during the course of the journey, including Bryar Hamad Abdulrahman, who is confirmed as deceased.

- 13.11 Zanyar's father's evidence was that Zanyar texted him on the night of 23 November 2021 that "I am leaving now". He further confirmed that Zanyar was travelling with Rezhwan Yassin Hassan, another of the deceased.
- 13.12 In their correspondence with the Inquiry, the French Public Prosecutor noted Pshtiwan Rasul Farkha Hussein, Twana Mamand Mohammed, Zanyar Mustafa Mina and Gomaa Gaber Mohamed Ahmed Nada as people who could have been on board the small boat on 23 November 2021.
- 13.13 The Inquiry therefore concludes, with reasonable confidence, that Pshtiwan Rasul Farkha Hussein, Twana Mamand Mohammed, Zanyar Mustafa Mina and Gomaa Gaber Mohamed Ahmed Nada were on board the boat on 23 November 2021.

The survivors

- 13.14 The Inquiry is satisfied that there were two survivors: Issa Mohamed Omar and Mohammed Shekha Ahmad.
- 13.15 Issa Mohamed Omar participated in the Inquiry. In particular, he gave very helpful oral and written evidence, including a detailed account of what occurred on the small boat on the night of 23 to 24 November 2021, leading to it being swamped and capsizing.
- 13.16 The second survivor, Mohammed Shekha Ahmad, did not participate in the Inquiry. The Inquiry made efforts to contact him to invite him to participate, but was unsuccessful in its attempts.
- 13.17 In his evidence to the Inquiry, the first survivor, Mr Issa Mohamed Omar, recounted seeing Mohammed Shekha Ahmad in the water after the small boat capsized on 24 November 2021. He also recounted his interactions with Mohammed Shekha Ahmad after they were rescued.

The number of people in the small boat

- 13.18 The Inquiry is satisfied that at least 33 men, women and children boarded the small boat on the evening of 23 November 2021, on a beach near Dunkirk.

13.19 However, the Inquiry has received evidence indicating that there were more than 33 people on board the small boat. On the night of the incident, HM Coastguard was told in two separate calls that there were 40 people on board.⁸ Further, the evidence of Mr Omar was that “whilst I am certain that the smugglers told us that there were 33 of us, I do not believe that is the true number of people on board the boat that night”.⁹ The basis of Mr Omar’s belief includes that:

- there were already three people on board the boat (including the driver) when the smugglers undertook the count on the beach
- he does not believe that the smugglers included children in their count, and he believes that there were at least two other young children on board, in addition to Hasti Rizghar Hussein
- his recollection is that the smugglers brought an additional two or three people on board the boat after the count.

13.20 The Inquiry has no reason to doubt the evidence of Mr Omar. However, it has not been possible to determine with sufficient certainty that there were more than 33 people on board the boat.

8 INQ008929/6, INQ007655/2.

9 INQ010388/9/par46.

Chapter 14:

Remembering those in the small boat

- 14.1** The people in the small boat came from a number of countries. The majority were from the Kurdistan region of Iraq. There were also Somalis, Ethiopians, Afghans, Egyptians and one Iranian. As indicated in Chapter 13, there was also someone believed to be a Vietnamese national.
- 14.2** The occupants of the boat were united in their aim to reach the UK, albeit for different reasons. Some were seeking to move in search of a better life and opportunities. Others were seeking to join family who had settled in the UK. Some of the occupants of the boat were trying to escape political violence. In particular, many of the family members of the Ethiopian people on the boat told the Inquiry that their loved ones were fleeing war in the Tigray region of Ethiopia, as well as targeted political violence. If it was not for this, they believe that their family members would not have been on the small boat on 23 November 2021. The wife of Fikiru Shiferaw Tekalegn told the Inquiry that “he would never have left us if he had not felt threatened in Ethiopia”.¹ The father of Meron Hailu Gebrehiwet similarly observed that “she had no desire to leave Ethiopia and our home in Tigray before the war started. She had a good life, and she was happy here. She had big ambitions”.²
- 14.3** During the hearings, there was oral evidence from family members who had provided written statements to the Inquiry dealing with, among other things, the impact of the loss of their loved ones on their lives. This evidence, provided by way of recordings (with translated versions read by members of the Inquiry legal team at the public hearings), showed the individuals to be much valued and loved members of their families. Family members spoke of their devastation, including in particular, the emotional pain caused by the loss of their parent, child or spouse.
- 14.4** For example, of her own loss, the mother of Mhabad Ali Ahmed told the Inquiry that “I feel as if a part of myself has been ripped out, and as if the wound will never heal”, and of her grandchildren’s loss, that “it breaks my heart that her children will grow up without their mother, and that they have lost the opportunity to experience her love and her care”.³ There was also the loss of friendship and companionship. The father of Muslim Ismael Hamad spoke of the loss of “my best friend, and the only person with whom I could share my troubles

1 INQ009639/10/par53.

2 INQ010391/2/par 8.

3 INQ010211/6/par22.

and my burdens”.⁴ Mhabad’s mother similarly referred to her as her “best friend” and “closest companion”.⁵

- 14.5** In some cases, the emotional pain is compounded by the loss of financial support, where the person on the boat was the breadwinner of the family or provided financial support to extended family members. For example, the wife of Fikiru Shiferaw Tekalegn told the Inquiry that: “Fikiru’s death changed all of our lives forever. We have all had to adapt to living life without him and finding ways to support ourselves given that so many of us in the family were dependent on him.”⁶ Fikiru’s brother described the financial consequences of his death as “catastrophic”.⁷
- 14.6** For those whose loved ones were still missing, there is the pain caused by the continued uncertainty and lack of finality. In the case of the father of Pshtiwan Rasul Farkha Hussein, he has clung on to the hope that his son is alive, however unlikely this may be. He told the Inquiry that: “Pshtiwan’s body has never been found and it is the only thing I can think about. I am certain he is alive. I believe that he will be found and brought back to me. I have to have hope or else I will not survive.”⁸
- 14.7** The remainder of this chapter summarises the evidence given by family members as to who those who died were and how they lived. This summary cannot do justice to the detailed evidence provided by family members. Instead, the aim is to capture something of who each individual was as a person and what they meant to their families. There is also a summary for one survivor, Issa Mohamed Omar, based on his evidence to the Inquiry. For individuals where a statement was not provided to the Inquiry, the limited biographical information known to the Inquiry has been included. How the deceased died is dealt with in Chapter 15.

4 INQ009668/7/par28.

5 INQ010211/3/par9.

6 INQ009639/10/par51.

7 INQ009640/6/par28.

8 INQ010092/5/par30.

The deceased

Afrasia Ahmed Mohamed Akoi

14.8 Afrasia was born on 11 April 1994 and was 27 years old at the time of the incident. He was one of nine children. He lived in the Azadi neighbourhood in Rania with his family, until he left Iraq on 26 October 2021.⁹

14.9 His father remembers Afrasia as very smart. He graduated from high school in 2015. He applied to university, but he did not get accepted so he tried to find work instead. He worked as a tiler but struggled to find a permanent job.¹⁰

14.10 Afrasia's family were living in poverty and could not afford the very basics. Although Afrasia did not discuss his reasons for wanting to leave Iraq in detail, his father believes he wanted a better life for himself and his family.¹¹



Bilind Shakir Baker

14.11 Bilind was born on 1 January 2001. He was one of 13 siblings and half-siblings.

14.12 His father explains that Bilind had a strong relationship with his siblings and that he was always very good with them. He was especially loving and caring towards his siblings in the years after his mother passed away, in 2005. Despite being young, he was always there for them.¹²

14.13 His father recounts that Bilind did not like school very much and so he only went to elementary school. He left education around Grade 6 when he was 11 years old.¹³

14.14 Bilind, his father says, loved to swim. There is a river that goes through Zakho, and a famous bridge that crosses it. Bilind would go there every day to swim with his friends during summer and spent as much time in the water as possible.¹⁴



9 INQ009018/2/par11.

10 INQ009018/2/par13.

11 INQ009018/2/par14.

12 INQ010387/2/par7.

13 INQ010387/2/par 8.

14 INQ010387/2-3/par 10.

Bryar Hamad Abdulrahman

14.15 Bryar was born on 11 November 1998, and he was 22 years old at the time of the incident.

14.16 Bryar was one of eight siblings: six brothers and two sisters. He was the second eldest. His brother describes Bryar as a very kind and happy person, who got along well with his family.¹⁵

14.17 Bryar attended school until he was 14 years old. His brother explains that he really enjoyed school, but he was not able to continue because of financial difficulties. He stopped attending school and started working with his brother and father as a labourer. The pay was low and not enough to make a living.¹⁶

14.18 Bryar got engaged around 2019, but due to his financial circumstances, the marriage was called off. According to his brother, this was part of the reason why Bryar decided to leave Iraq. He hoped to improve his circumstances to be able to have a family in the future. Bryar wanted a better life. He was living in poverty and was searching for better opportunities.¹⁷



Didar Ahmad

14.19 Didar was a male from Afghanistan, who was born on 15 May 1994.

15 INQ009758/1-2/par8, 2-3/par15.

16 INQ009758/2/par12-13.

17 INQ009758/2/par 14.

Fikiru Shiferaw Tekalegn

14.20 Fikiru was born on 5 June 1978 and was 43 years old at the time of the incident.¹⁸ He was the third of eight children.

14.21 Fikiru was married and had two children (born in 2017 and 2021). Before leaving Ethiopia, he lived with his family in Addis Ababa.

14.22 His family remember him as a very content family man, who mostly spent time at home or working for his businesses. His hobbies included cooking (he was the best cook his wife knew) and reading books.¹⁹

14.23 Fikiru's wife remembers him as kind and humble. He was successful in business and financially supported his extended family, including his parents. He was particularly close to his mother, who was his best friend and advisor.²⁰

14.24 While Fikiru was not Tigrayan, in the year before his departure, he believed he was being targeted and feared for his life. His brother believed he was targeted because he was successful and had many business connections across the country, including in Tigray.²¹



Halima Mohammed Shikh

14.25 Halima was born on 1 January 1988 and was 33 at the time of the incident.²² She has three children, who are now 13, 11 and 9.²³

14.26 Halima's cousin describes her as a good person, with a good character. She was loved by those around her and kind to everyone.²⁴



18 INQ009639/2/par6. Fikiru's wife, Emebet Kefyalew, states that his birthday is incorrectly recorded on his death certificate as 5 June 1975.

19 INQ009639/10-11/par54.

20 INQ009639/10/par 50, 10-11/par54.

21 INQ009640/2/par11, INQ009639/3/par14.

22 INQ009748/1/par7.

23 INQ010091/2/par13.

24 INQ010091/5/par30.

- 14.27** Halima left Somalia because of the political instability and violence. She wanted a better life for herself and her children and sought to travel to Europe to make this possible.²⁵

Hasan Mohamed Ali

- 14.28** Hasan was born on 15 September 1984, and was 37 years old when he left Kurdistan, Iraq. He was one of 13 children.

- 14.29** Hasan's father describes his son as a lovely man. He was very gentle and kind-spirited. He had a strong bond with his siblings and his mother. His siblings thought he was very brave and strong. He was always respectful towards other people and wanted to help people where he could.²⁶



- 14.30** His father explains that Hasan was not married and did not have any children. Before he left Iraq, he was working in the Peshmerga (the security forces). He had been in the military for 20 years. In his spare time, Hasan spent time with his family at home or with friends. His father explains that he had a lot of people who loved him and liked spending time with him.²⁷

Husain Tanha

- 14.31** Husain was a male from Afghanistan, who was born on 1 March 1997.

25 INQ009748/2/par11.

26 INQ009750/2/par9.

27 INQ009750/2/par8.

Kazhal Ahmed Khidir Al-Jamoor

14.32 Kazhal was 46 years old at the time of the incident. She was from Darabandikhan, a town in Kurdistan, Iraq.

14.33 She lived there with her husband, Rizghar, and her three children – Hadiya, Mubin and Hasti, who all died in the incident. She left Iraq in August 2021, along with her three children.²⁸

14.34 Kazhal was a housewife before she left to make the journey to Europe. Her husband describes that she and her children had dreams of leaving Kurdistan and having a better life in the UK. According to her husband, this is a dream that many people in Kurdistan have. People want to leave to get away from the corruption, escape the lack of opportunity and live a better life.²⁹



Hadiya Rizghar Hussein

14.35 Hadiya was 22 years old at the time of the incident. She was the eldest daughter of Kazhal and Rizghar. Hadiya lived together with her parents and two siblings in Darabandikhan.

14.36 She left Iraq in August 2021 with her mother and two siblings. Her father says that Hadiya spoke perfect English and dreamt of continuing her studies in the UK. She dreamt of becoming a doctor. Like her mother and siblings, she had dreams of leaving Kurdistan and having a better life in the UK.³⁰

Hasti Rizghar Hussein

14.37 Hasti was seven years old at the time of the incident. She was the youngest child of Kazhal and Rizghar. Hasti lived together with her parents and two siblings, Hadiya and Mubin, in Darabandikhan.

14.38 Hasti left Iraq in August 2021 with her mother and two siblings, with a dream of living a better life in the UK.³¹

Mubin Rizghar Hussein

14.39 Mubin was 16 years old at the time of the incident. He was the son of Kazhal and Rizghar. Mubin lived together with his parents and two siblings in Darabandikhan.

14.40 Mubin left Iraq in August 2021 with his mother and two siblings, with a dream of living a better life in the UK.³²

28 INQ009642/1/par6.

29 INQ009642/2/par9.

30 INQ009642/2/par 8.

31 INQ009642/2/par 8.

32 INQ009642/2/par 8.

Maryam Noori Mohammedameen

14.41 Maryam was born on 21 March 1997 and was 24 years old at the time of the incident. She was one of six children. She lived in Kurdistan.

14.42 Her father describes Maryam as incredibly kind and that she used to take care of everyone. She was remarkably caring towards her mother and looked after her in any way that she could. Maryam also had a great relationship with her siblings and was loved by the whole family.³³



14.43 Her father recalls that Maryam was smart. She completed her high school education. After this, Maryam applied for a place at university but unfortunately was unsuccessful. She wanted to study engineering. In the years after this, Maryam started to feel like she had no opportunities in Kurdistan.³⁴

14.44 In 2021, Maryam met and then got engaged to her fiancé. After their engagement, Maryam planned to travel to the UK so she could live with him. Her father believes that after an initial attempt to obtain a visa was unsuccessful, Maryam decided to leave Kurdistan on her own and attempt to travel to the UK, where she wanted to build a life with him.³⁵

Meron Hailu Gebrehiwet

14.45 Meron was born in Adigrat in Tigray on 31 May 1996 and was 25 years old at the time of the incident. She was the youngest of seven siblings.

14.46 Before the war in Tigray breaking out in November 2020, Meron ran a successful juice bar with her sister, serving fresh fruit juice and milkshakes.³⁶

14.47 Meron's father describes her as kind and humble. She cared for her parents and siblings and financially supported her parents with the money she earned from the juice bar.³⁷



33 INQ010339/2/par8.

34 INQ010339/2/par9.

35 INQ010339/2/par11-12.

36 INQ009759/2/par8.

37 INQ010391/2/par8.

- 14.48** After the Tigrayan war started, she initially fled to Addis Ababa in February 2021. However, as a Tigrayan, she felt unsafe and was also unable to work. She left Addis Ababa for Europe in October 2021 to find safety.³⁸

Mhabad Ali Ahmed

- 14.49** Mhabad was born on 21 November 1989, was the second youngest of eight children. She lived in Erbil, Iraq her whole life until she left in 2021.

- 14.50** Her mother describes Mhabad as warm and open-hearted, who cared deeply about everyone around her. She was a wonderful person – kind, patient, loving, and extremely beautiful. People who met her would always comment on her calm, serene presence.³⁹



- 14.51** Mhabad was married to her husband, who lived in the UK, and had two children. Her mother says that Mhabad was a wonderful mother and was attentive to her children's every need. Her children adored her and could not bear to spend a moment away from her.⁴⁰

Mohamed Ali Mohamed Hassan Elsaey

- 14.52** Mohamed was a male from Egypt, who was born on 20 May 2001.

Mohammed Hussein Mohammedie

- 14.53** Mohammed was born on 1 January 2002 and was 19 years old at the time of the incident. Mohammed was the middle child of three, living with his family in Kurdistan, Iraq.

- 14.54** Mohammed's father described him as a special child. He was a very good son and was very good to his parents. He also said that Mohammed was very close with his siblings and was always helping them out. At school he was loved by everyone, especially the teachers. Mohammed would also help his father on their family farm.⁴¹



38 INQ009757/3/par14, INQ009759/4/par20.

39 INQ010211/2/par6.

40 INQ010211/2/par7, 3/par9.

41 INQ009641/2/par12.

- 14.55** As Mohammed's father was a refugee from Iran, Mohammed and his siblings had no legal status in Iraq. Although he completed his Grade 12 education with flying colours, Mohammed was unable to go to university as he did not have the right to study. He did not have any options or ways to build a life for himself in Kurdistan.⁴²

Mohammed Naeem Mayar

- 14.56** Mohammed was a male from Afghanistan, who was born on 1 January 1975.

Mohammed Qader Awla

- 14.57** Mohammed was 18 years old when he left Kurdistan. He lived in the village of Qadrawa, with his parents and four brothers. Mohammed was the second youngest.



- 14.58** Mohammed had lots of friends, and his father describes him as popular. People liked to be around him. He wanted a good future, and he wanted to look after his family. He was a very kind person.⁴³

- 14.59** Mohammed worked as well as attending school up until the final year of high school. His father recalls how he loved school and was a good student. However, he left school because he wanted to be independent, recognising the financial difficulties his family were facing.⁴⁴

- 14.60** Mohammed told his father that he did not have any hope of a good life in Kurdistan, and he was scared about his future there. He wanted to go to the UK to build a life for himself – he believed the UK was a good country where he could have rights and protections which he did not have in Kurdistan.⁴⁵

⁴² INQ009641/2/par13.

⁴³ INQ009752/2/par11.

⁴⁴ INQ009752/2/par13-15.

⁴⁵ INQ009752/3/par16-17.

Muslim Ismael Hamad

14.61 Muslim was born on 14 January 2002 and was 19 years old at the time of the incident. He was the second oldest of seven children. He grew up in Soran in Iraqi Kurdistan, with his parents and siblings.⁴⁶



14.62 As a child, his father recalls, Muslim was energetic and full of dreams. He loved school. He would tell his father that he wished to be a doctor or an engineer. He was extremely studious. His father described him as a remarkably kind and caring boy, who from a young age was protective of his younger siblings.⁴⁷

14.63 As he grew older, recognising the financial problems that his family struggled with, Muslim dropped out of school at around 17 years old. He started working with his father, trading ceramic tiles in the market. His aim was to help provide for his family, and in particular for his siblings. Despite this, Muslim's family struggled to make ends meet.⁴⁸

14.64 After much thought, his father says, Muslim decided to travel to the UK, where there were more opportunities. He wished to be able to send money home to take care of his family and ensure that his younger siblings were able to complete school.⁴⁹

Niyat Ferede Yeshiwendim

14.65 Niyat was born in Mekelle, in the Tigray region of Ethiopia on 14 June 1999. She was 22 years old at the time of the incident. She was the third of four children.

14.66 After Niyat finished high school in 2018, she began studying pharmacy at the Sheba University College in Mekelle. She wanted to set up her own pharmacy in Mekelle. The war between the Ethiopian government and the Tigray People's Liberation Front broke out two years into her studies.⁵⁰



⁴⁶ INQ009668/2/par6.

⁴⁷ INQ009668/2/par7.

⁴⁸ INQ009668/2/par8.

⁴⁹ INQ009668/3/par11.

⁵⁰ INQ009756/2/par11-12.

- 14.67** Niyat's parents describe her as a kind and generous person. She often helped neighbours, especially the elderly, and her greatest dream was to one day build a shelter where they could be cared for and feel safe. She was also a deeply spiritual person, spending much time in prayer at churches and monasteries.⁵¹
- 14.68** Niyat's family explained that, as a result of the war, Mekelle was unsafe. As a young woman, Niyat faced a particular risk of rape and sexual violence. Tigrayans were also targeted throughout the country. When Niyat left Mekelle in January 2021, she initially went to Addis Ababa. She was subsequently arrested and detained. After her release, she sought to travel to Europe for her safety. She would never have left if the war had not started.⁵²

Rezhwan Yassin Hassan

- 14.69** Rezhwan was born on 23 June 2002 and was 19 years old at the time of the incident. He had four siblings and lived with his family in Sangasar, Iraqi Kurdistan.
- 14.70** Rezhwan's father describes him as a kind and clever young man. He loved spending time with people, and he was always respectful. Rezhwan was a top student and wanted to carry on learning anything he could. He was hoping to go to university.⁵³
- 14.71** In the afternoons after school or at the weekend, he would work as a carpenter or help with roofing for houses. This work was infrequent, and he did not have a stable job. With the lack of opportunities in Kurdistan, Rezhwan's father believes that he left because he hoped for a better future.⁵⁴



51 INQ009756/2/par13-14.
 52 INQ009756/3/par21, INQ009751/2/par11.
 53 INQ009643/2/par10-11.
 54 INQ009643/2/par11.

Serkawt Pirot Mohammed

14.72 Serkawt, nicknamed ‘Harem’ by his family, was born on 18 March 1993 and was 28 years old at the time of the incident. Harem was the third oldest child, living in Ranya in Kurdistan, Iraq with his family.⁵⁵

14.73 Harem’s brother explains that Harem had very good relationships with his parents and his siblings. His brother described him as friend to them all. Harem was very kind and helped his parents a lot. He always supported his family – whether emotionally, financially or with any other favour.⁵⁶



14.74 Harem’s brother also tells how Harem had many interests and was intelligent. He was very sporty and played a lot of football with his friends. Harem studied in school until he was 17 years old, when he left and began working as a labourer. Harem worked at a company in Ranya, loading and unloading goods from lorries. Before he left Ranya, he had lost his job as a labourer and was struggling to support himself.⁵⁷ Harem had struggled with the lack of opportunities and hardships he faced in Kurdistan. He had explained to his family that he hoped to find a better life in another country.⁵⁸

Shahwali Kochy

14.75 Shahwali was a male from Afghanistan, who was born on 1 January 1995.

Shakar Ali Pirot

14.76 Shakar was born on 29 August 1991 and was 30 years old at the time of the incident. He lived in Kurdistan with his parents and siblings.

14.77 His brother describes Shakar as very calm. He was a good listener and a good person. He had a very good relationship with his siblings, and he always listened to his parents. Shakar spent most of his time at home with his family and would also spend time with other relatives such as his cousins. He was not an extroverted person.⁵⁹



55 INQ009754/2/par7.

56 INQ009754/2/par8.

57 INQ009754/2/par8-9.

58 INQ009754/2/par10.

59 INQ009755/1-2/par7-8.

- 14.78** Shakar was a good student, attending the University of Sulaimani where he studied geology. He graduated in 2014. After graduating, his brother recounts that Shakar spent four or five years trying to find a job in his field. After several years of being unable to find a job that would draw on his skills and knowledge, Shakar started working as a labourer. The work was not full-time and did not pay enough to support him. To find better opportunities, Shakar decided to travel to the UK.⁶⁰

Sirwan Alipour

- 14.79** Sirwan was born on 22 October 1998 and was 23 years old at the time of the incident. He was from Sardasht in Iran, where he grew up with his older brother and parents.

- 14.80** Sirwan studied until he was 17 years old and started working in a bakery. After a year, he then started working as a mechanic. He did this for around four years, and then in early 2021, he joined his father in his bed and mattress business.⁶¹



- 14.81** Sirwan's brother remembers him as very easy-going. Through his job as a mechanic, he made connections with many people in his town. Everyone in the town knew him. His brother recalls how he was very funny, always making jokes, and that he had a lot of friends. He often played football with friends after work.⁶²
- 14.82** Sirwan wanted to be a mechanic in the UK. He could not earn a lot of money in Iran with the salary he was being paid. Like many young people in Iran, Sirwan wanted to travel abroad, to have a future and to follow his dreams of a better life.⁶³

Le Van Hau

- 14.83** As I have noted in Chapter 13, the Inquiry believes that the 27th person whose body was found is Le Van Hau, a male from Vietnam, who was born on 18 February 1992.

60 INQ009755/2/par11-12, 2-3/par14.

61 INQ009753/2/par10.

62 INQ009753/2/par13.

63 INQ009753/3/par15, 17.

The missing

Gomaa Gaber Mohamed Ahmed Nada

14.84 Gomaa was a male from Egypt, who was born on 29 May 1979.

Pshtiwan Rasul Farkha Hussein

14.85 Pshtiwan was born on 1 January 2003 and was 18 years old at the time of the incident. He was one of nine children and was the eldest son. He lived with his parents and siblings in Hajiawa, a town in the Sulaymaniyah Governorate in Iraq.



14.86 Pshtiwan's father explains that Pshtiwan's sister was born with a heart defect which requires expensive surgery to treat. Pshtiwan wanted to settle in the UK, and eventually to bring over his sister for treatment.⁶⁴

14.87 Pshtiwan went to school from the age of six to nine years old, leaving school to find work to support his family and sister. He started working as an assistant in a vegetable shop. He had several jobs like this from the ages of nine to 15. Eventually, when he was 15, he started a small vegetable-selling business by himself.⁶⁵

14.88 His father describes how Pshtiwan liked helping others too, which he did quietly and without wanting praise. If a young family was struggling, he would bring them milk or fruit to help them. It was this attitude that made him want to leave Kurdistan for the UK, to make a better life for his family, and for his sister to get the medical treatment she needs.⁶⁶

Twana Mamand Mohammed

14.89 Twana was born on 30 March 2003. He was 18 years and 7 months old at the time of the incident. He is one of seven siblings. He lived in Hajiawa in Kurdistan, Iraq with his family.

14.90 His brother described Twana as very energetic and that he spent most of his time exercising. He loved playing football, going to the gym and practising



⁶⁴ INQ010092/2/par10, 12.

⁶⁵ INQ010092/2/par13, 14.

⁶⁶ INQ010092/3/par15.

Taekwondo. He was a black belt in Taekwondo and his brother described him as the best performer in Hajiawa.⁶⁷

- 14.91** Twana was still going to school before he left Kurdistan on 10 August 2021. He had just completed 10th Grade and would have been starting 11th Grade in September 2021. His brother describes Twana as very intelligent. However, his focus was on sports as he wanted to become a football player or Taekwondo practitioner. He felt that he would never be able to achieve this in Kurdistan. Twana wanted to go to the UK to find somewhere with real opportunities.⁶⁸

Zanyar Mustafa Mina

- 14.92** Zanyar Mustafa Mina was born on 12 January 2001 and was 20 years old at the time of the incident. He was the second eldest of five children.

- 14.93** Zanyar's father remembers him as active and healthy. He often played football and went swimming in the local lake with his friends. His father describes him as very energetic and smart, loved by his family and friends. He was a very kind person, and he always wanted to help people.⁶⁹



- 14.94** Zanyar wanted to avoid conflict with the Iraqi government and seek a better life. His father describes an unsafe and unstable environment in Kurdistan, which he believes motivated Zanyar to leave. Zanyar attempted to leave Iraq and reach the UK three times.⁷⁰

The survivors

Issa Mohamed Omar

- 14.95** Issa was born on 27 June 1993 in Somalia. He is one of five siblings.
- 14.96** In his evidence to the Inquiry, Issa describes how, along with his mother and siblings, he fled Somalia for Yemen in 2006 after his father was killed. He lived in Yemen until 2014, when war broke out. He was arrested and imprisoned. Following an attack on the prison in January 2015, Issa told the Inquiry that he was transferred to hospital in Iran for treatment. Following his discharge from hospital, he escaped to Turkey. In the years that followed, he informed the

67 INQ010210/2/par10.

68 INQ010210/2-3/par11, 3/par13.

69 INQ009472/1-2/par7.

70 INQ009472/2/par8.

Inquiry how he travelled across Europe until he reached Northern France in November 2021.⁷¹

14.97 On 24 November 2021, Issa was rescued from the Channel, after having spent around 10 hours in the water. He has suffered both physically (particularly loss of skin on his lower limbs) and mentally as a result of the events on 23 to 24 November 2021.⁷²

Mohammed Shekha Ahmad

14.98 The second survivor, Mohammed Shekha Ahmad, is a male from Iraq.

71 INQ010388/2-5/par6-27 .

72 INQ010388/20/par114, 21/par118.

PART 5:

Conclusions and recommendations

This part of the report in Chapter 15 draws together the conclusions relating to the second aspect of the Terms of Reference, about when, where and in what circumstances those who died in the small boat tragedy of 23 to 24 November 2021 came by their deaths. It then deals with the third aspect of the Terms of Reference, namely to identify what further lessons can be learnt from the events of 24 November 2021 and, if appropriate, to make recommendations to reduce the risk of a similar event occurring. Chapter 16 describes the three investigations which have already been undertaken into the events of that night, and the extent to which the recommendations made as a result have been accepted and implemented. Chapter 17 then turns to the Inquiry's own recommendations.

Chapter 15:

Conclusions: an avoidable loss of life

Introduction

- 15.1** This chapter draws together the key conclusions from Parts 2 and 3 of the report regarding the loss of life on 24 November 2021. It does this in the context of the views expressed by the Inquiry's expert on survivability. In particular, it considers the extent to which the loss of life was avoidable.

The people smugglers

- 15.2** In its report, the Marine Accident Investigation Branch (MAIB) stated that: "By providing an unsuitable craft and inadequate safety equipment for the crossing, and by crowding thirty-three people onto the boat, the people who facilitated the attempted crossing put the occupants of the boat at high risk of coming to harm."¹ It is difficult to disagree with that conclusion.
- 15.3** The precise cause of the boat's failure has not been ascertained. It is held by the French authorities and no investigation by this Inquiry has been possible. That it failed is beyond doubt. Approximately four hours into the journey, the boat began to take on a significant amount of water. Approximately six hours into the journey, the boat was swamped. Efforts by those on board to bail out the water were unsuccessful. No assistance was provided by the people smugglers who facilitated the attempted crossing. Their actions are subject to ongoing investigations in France. The Inquiry has not had access to the material gathered in the course of those investigations. Responsibility for the condition of the boat and how it was equipped and loaded lies with the smugglers.

Survivability

- 15.4** At a point between 03:17 (when what is likely to be the last call from incident 'Charlie' ended) and 03:33 (the time a WhatsApp message was sent by HM Coastguard to incident 'Charlie', never to be delivered), all of those on board the sinking small boat fully entered the water. To assist its understanding of what happened after this point, the Inquiry instructed Professor Michael Tipton MBE to provide his opinion on survivability. Professor Tipton is Professor of Human and Applied Physiology at the University of Portsmouth. He is an expert in cold

1 INQ010445/91/3.1(1).

water survival. He has specialised in research into thermal physiology for over four decades and is widely published in this field. His current roles include Chair of the National Water Safety Forum, council member of the Royal National Lifeboat Institution (RNLI), and consultant advisor to the Medical Director of the RNLI.

- 15.5** Professor Tipton gave oral evidence to the Inquiry, consistent with his written report.² He concluded that most of those on board drowned when they could no longer hold on to the buoyant remains of the small boat. That was 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.
- 15.6** 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. That was because they would have been pre-cooled by exposure to an air temperature of between 2°C and 5°C, and by the cold seawater that had been filling the boat for some time. Therefore, it is likely that the remainder died over a longer period. It is also likely that they were still alive when, at around 03:24, 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 on 24 November 2021, and others between sunrise and the time rescue was taking place 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, and a smaller number were still alive until the early afternoon.
- 15.7** The probable survival times set out in Professor Tipton's report are based on predictive modelling. Those predictive models are used by search and rescue authorities to assist in setting time limits for search and rescue missions. Professor Tipton has explained that "the prediction of survival time remains an inexact science due to the large number of environmental and personal variables that can influence this time". The variation between individuals and incidents is a key complicating factor.

2 INQ010740. See also: INQ010283, 'Expert witness report on the survivability of those involved in the events of 23-24 November 2021'.

- 15.8** The direct experience and observations of Mr Issa Mohamed Omar, one of the two survivors of the incident, and a witness at the Inquiry, are in keeping with Professor Tipton's model. In his written statement of 3 January 2025, he says that he saw Halima Mohammed Shikh struggling as soon as the boat capsized, and that he believed she was one of the first people to drown.³ He went on:

"When the sun came up, I remember seeing that around 15 or less of us were still holding on to the boat. I am not sure that all of those people were still alive. I believe it was only men but I would not be able to identify who was still holding on to the boat. No one was communicating with each other. I do not recall speaking with anyone in the water. Those who were alive were half-dead. There was nothing we could do anymore. I could see bodies floating all around us in the water. I presume most people were either already dead or were unconscious. ...

I remember that Mohammed Shekha Ahmad ... the other survivor was also hanging on to the boat ...

I can recall that for some time there was a Kurdish woman swimming near me. I had not seen her holding on to the boat but she suddenly appeared near me in the water. I do not know her name and I did not recognise her from any of the photos of the victims that I have seen. The Kurdish woman was looking for her children."⁴

- 15.9** 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.⁵ In his statement for the Inquiry, the father of Mohammed Hussein Mohammedie says that he was told by the second survivor, Mohammed Shekha Ahmad, that his son was alive until around 30 minutes before Mohammed Shekha Ahmad was finally rescued.⁶
- 15.10** Aside from the circumstances of Halima Mohammed Shikh and Mohammed Hussein Mohammedie, there is no evidence which safely indicates the order in which those who died lost their lives. Certainly two, and probably three, people were still alive at about midday on 24 November 2021.
- 15.11** Professor Tipton was asked to consider the likelihood of survival of any person who had been on board the boat and whose body has not been recovered. This is an important question for the families of the four people who were on the boat and who remain missing. Professor Tipton's opinion is set out in paragraph 4.9 of his report:

3 INQ010388/18/par102.

4 INQ010388/19-20/par109-112.

5 INQ010714/46/ln8-9.

6 INQ009641/7/par37.

“Given the ages of the missing individuals (18–20 years), and looking at the predicted functional and survival times ... I think it unlikely that these individuals survived more than 4–5 hours after entering the water [applying the predictive modelling referred to above]. Given that two of the missing individuals were considered ‘good swimmers’ (no relevant information on the other two), and one had said that he thought he could ‘swim the distance’, it is possible that these individuals attempted to swim to the nearest shore. This would have increased their rate of cooling, reducing predicted survival time, and move them away for [sic] the scene.”

- 15.12** In light of Professor Tipton’s opinion, I think it unlikely that any one of the missing individuals survived as long as Mr Omar, Mr Ahmad or Mr Mohammedie. Each of the missing individuals probably died sometime between 07:00 and 12:30 on 24 November 2021.

UK Search and rescue effort

- 15.13** The search and rescue effort on the night of 23 to 24 November 2021 was affected by a number of factors.

Resources: staffing

- 15.14** The sharp increase in small boat crossings in 2021, in particular in November that year, exacerbated a long-standing problem of short staffing at the Maritime Rescue Coordination Centre (MRCC) at Dover. By November 2021, efforts to increase staff numbers had been only partially successful. A number of newer recruits had not completed their training by then. MRCC Dover had become heavily reliant on remote cover and on new, partially trained recruits to respond to small boat crossings.
- 15.15** While remote cover from the Joint Rescue Coordination Centre (JRCC) at Fareham or other stations within HM Coastguard’s national network, which was known as ‘zone flexing’ or ‘network flexing’, did and could provide support to MRCC Dover, it had been recognised before November 2021 that the remote involvement of staff from other geographical locations created problems for situational awareness. In November 2021, zone flexing or network flexing was not an adequate solution to HM Coastguard’s problems with the sufficiency of staff in respect of small boat search and rescue.
- 15.16** On the night watch of 23 to 24 November 2021, there were insufficient operational staff members at MRCC Dover. The recommended staffing level was three qualified search and rescue operative staff in MRCC Dover. The Search and Rescue Mission Co-ordinator (SMC) was the only fully qualified staff member on search and rescue duty. In addition, there was short staffing at the level above MRCC Dover. There was a single Maritime Tactical Commander on duty covering HM Coastguard’s national network, instead of the recommended

complement of two. The single Maritime Tactical Commander who was on duty was unable to review small boat distress incidents proactively while he was managing the whole of the national network.

- 15.17** The staffing situation had a direct impact on the events of the night.
- a.** The SMC at Dover was diverted from his strategic role by call handling work that should have been undertaken by Maritime Operations Officers. During part of the night, he was also required to cover for the Vessel Traffic Service team, which is responsible for ensuring vessels travel safely through the English Channel. As a result, he was unable to take a break during his 12-hour shift. Unsurprisingly, this left him feeling exhausted and overwhelmed and clearly affected his operational performance. Standard operating procedures were not followed and critically, he was not able to record his decision-making and relevant information in relation to incident 'Charlie'. He was placed in an intolerable position.
 - b.** Because of staff shortages at MRCC Dover, remotely based staff at the JRCC were involved in MRCC Dover's work for most of the night. Their situational awareness was inadequate. That was partly a result of incomplete record keeping at MRCC Dover. As a result, mistakes were made in the recording of information by the JRCC.
 - c.** There was inadequate oversight of decision-making and inadequate supervision of non-operational staff at MRCC Dover.
- 15.18** The problems of staffing at MRCC Dover had been repeatedly identified within HM Coastguard and they had been expressly related to risks. These risks included the loss of life through ineffective preparation and/or response, the loss of situational awareness, and the adverse impact on staff wellbeing and morale. HM Coastguard was aware of the issues and risks. The Inquiry received little evidence explaining how, if at all, these issues had been practically addressed by November 2021.
- 15.19** For reasons given elsewhere in the report, the oversight of the Marine and Coastguard Agency (MCA) by the Department for Transport (DfT) and, in turn, the MCA's oversight of HM Coastguard was not as effective as it should have been before and following 24 November 2021. Without effective oversight, the extent of the need for change was not adequately identified or addressed.⁷ The risk of overwhelm was not recorded in the MCA corporate risk register until sometime in November 2021. There is no record that any discussion of this risk had occurred at the relevant meeting of the MCA's Sponsorship Board or, if it had, it had not been minuted and had not resulted in any effective plan for its resolution.

7 See paragraphs 7.9 to 7.18 and 17.36.

- 15.20** The staffing of MRCC Dover on the night of 23 to 24 November 2021, both on site and through remote working, was inadequate. The result was that staff were overwhelmed. This was a risk which had been expressly foreseen. It is the lens through which the acts, omissions, errors and failures of HM Coastguard personnel on the night are to be viewed.

Resources: maritime and aerial assets

- 15.21** HM Coastguard has no maritime search and rescue assets itself. In relation to small boats, for maritime assets it relies primarily on Border Force and RNLI. In respect of these assets, it had been recognised well before November 2021 that the volume of small boat arrivals was placing critical and unsustainable pressure on both Border Force and the RNLI.
- 15.22** This pressure impacted on the tasking decisions made on the night of 23 to 24 November 2021. HM Coastguard and Border Force were reluctant to use more than one maritime asset that night in the knowledge that what they deployed would further reduce the assets available for the following day watch, which was forecast to be even busier. The Border Force's vessel the Valiant was the only maritime asset tasked by HM Coastguard on the night watch. That was despite MRCC Dover's knowledge firstly that people on board incident 'Charlie' had said that they were sinking and were in the water, and secondly that the information from the French Coastguard indicated that there were at least four small boats in the same area, close to the Sandettie Light Vessel, including incident 'Charlie'. Consequently, there was a real risk that the Valiant's capacity to embark all of those on board four small boats, including incident 'Charlie', which was sinking, would be exceeded and yet there was no reconsideration of the possible tasking of the RNLI.
- 15.23** There was also pressure before November 2021 on the operators of aerial assets contracted by HM Coastguard as a result of the increase in small boat activity. By October 2021 there had been discussion of procuring additional assets for situational awareness. The increase in aerial resources did not take effect until March 2022. On the night of 23 to 24 November, the 2Excel surveillance flight could not be undertaken. This was a foreseeable occurrence and one which had been foreseen before November 2021. The risks associated with the absence of a surveillance flight were well known and clearly identified. Yet there was no predetermined contingency plan to respond to the absence at short notice of a surveillance flight and the consequent loss of situational awareness. Time was lost on the night in ad hoc planning to compensate for this restriction in situational awareness. The decision to deploy the search and rescue helicopter, R163, to carry out surveillance meant, in turn, that the flying hours of that helicopter available for search and rescue were reduced. This impacted on its availability during the day watch of 24 November 2021.

The Mayday relay broadcast

- 15.24** HM Coastguard decided to broadcast a Mayday relay at 02:27 on 24 November 2021 in response to incident 'Charlie'. This indicated that those involved in incident 'Charlie' were in distress and mandated a response from all vessels in the area. Through this process, HM Coastguard hoped to obtain information about incident 'Charlie' and assistance from other vessels, if assistance was available.
- 15.25** The closest vessel to incident 'Charlie' at the time of the Mayday relay was the French warship the *Flamant* used by the French Coastguard. According to evidence provided to the Inquiry by HM Coastguard, the *Flamant* was approximately 3 nautical miles (nm) – about 15 minutes – away from the co-ordinates that were broadcast in the Mayday relay. By contrast, the *Valiant* was about 9nm and 60 minutes away. The *Flamant* did not respond. Its silence is striking. As explained earlier, HM Coastguard did not ask the French Coastguard directly to request its tasking, a course which was open to it.⁸ The French Coastguard was aware of the respective travel distances of the *Flamant* and the *Valiant*. The *Flamant* was said to be with another small boat. It moved away from the median line towards the French coast.
- 15.26** The acts and omissions of the *Flamant* remain subject to investigation by the French authorities, 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 of those on board would have been saved.
- 15.27** The response rate to the Mayday relay from passing vessels was very low. HM Coastguard had no control over the actions of passing vessels. Of the few vessels which did respond, two saw nothing. Despite attempting to do so, the *Concerto*, which did see a small boat, was unable – for unexplained reasons – to speak with HM Coastguard about it and consequently no information was passed on from the *Concerto* to HM Coastguard. On the evidence before the Inquiry, no effective offers of assistance were made to HM Coastguard by the *Concerto* or any other vessel. The *Concerto* did communicate twice with the French Coastguard. In the latter conversation it reported that it had sight of a small boat. However, the French Coastguard instructed it to resume passage. This information was not passed by the French Coastguard to HM Coastguard. Ultimately, no assistance was provided to incident 'Charlie' as a result of the Mayday relay. No information on the nature of distress relating to incident 'Charlie' was obtained through the Mayday relay.

8 See paragraph 10.42.

- 15.28** There are both evidential and practical barriers to enforcing the obligation under the International Convention for the Safety of Life at Sea (SOLAS) to render assistance to a vessel in distress. No prosecution for non-compliance with the obligation to render assistance has been brought by the MCA and no referrals have been made by HM Coastguard to the MCA for potential non-compliance for at least five years. It is possible that the effective absence of consequences for a failure to meet this SOLAS obligation may have impacted on the extent to which passing vessels did not respond to the Mayday relay, which HM Coastguard broadcast on the night of 23 to 24 November 2021.

Information gathering

- 15.29** HM Coastguard was well aware before November 2021 that there were unique challenges associated with securing robust and reliable information about small boats attempting to cross the Channel. These included:
- the likelihood of receiving multiple mobile telephone calls from the same boat
 - communications difficulties including gaps in mobile network coverage and language problems
 - the provision of inaccurate information, deliberately or otherwise
 - difficulties with locating such boats in the Channel
 - challenges with safely establishing which boats had been located.
- 15.30** From the start of the night shift on 23 November 2021, HM Coastguard was hampered by a lack of real-time information about the small boats crossing the Dover Strait that night. For the reasons explained earlier, no surveillance flight was undertaken.⁹ The French Coastguard provided no information about incident ‘Charlie’ until the call taken by the non-operational trainee at about 01:06. Information was not proactively sought from the French authorities, despite delays in the French authorities emailing their spreadsheet being a recognised and long-standing problem. The Mayday relay resulted in no further information. Therefore, before the arrival of maritime and then aerial assets on scene, the only sources of information for HM Coastguard about the condition of incident ‘Charlie’ were calls from the small boat itself.
- 15.31** The HM Coastguard operational staff who gave evidence to the Inquiry had received no specific training on small boat search and rescue and were provided with limited written guidance for responding to small boats. No training or guidance had been given about when or how Mayday relays should be used for small boat search and rescue.

⁹ See paragraph 9.35.

- 15.32** As a result of the first call he took from incident ‘Charlie’ at 01:48, the SMC at Dover believed that this was potentially an emergency situation. Despite this assessment and contrary to standard operating procedures, some later calls were treated as a distraction, key information from subsequent callers from the small boat was not obtained, and the information that was obtained was not treated at face value.
- 15.33** The language barrier complicated communication. HM Coastguard was well aware of this difficulty before November 2021. It was also aware of practical difficulties in using the interpretation service it had available to communicate with small boats. No alternative means of resolving these issues had been considered by November 2021.
- 15.34** The standalone mobile phone at MRCC Dover had been employed by HM Coastguard since late October 2020, with the specific purpose of receiving location information from small boats. It was not linked to other existing systems, including the ViSION information management system. There was no system for recording calls or messages to or from this mobile phone. There was no system for sharing information received via the mobile phone with other staff members. There was no system for monitoring the mobile phone, and no written guidance given to staff as to whether it could or should be used to make calls.
- 15.35** As explained earlier, HM Coastguard missed opportunities to gather updated geolocation information about incident ‘Charlie’. It initially missed the updated geolocation positions sent via WhatsApp by those on board the small boat to HM Coastguard’s mobile phone at 02:20 and 02:21, and it did not ask for updated geolocation information during the many calls made by those on board incident ‘Charlie’ to HM Coastguard following the call at 01:48.¹⁰ These lost opportunities to gather and correlate information from incident ‘Charlie’ were coupled with the lack of real-time information from any surveillance flight, the limited and late information provided by the French authorities, which was then inaccurately reflected on the ViSION log, and the lack of meaningful response to the Mayday relay. All this shaped and limited the UK search and rescue response to incident ‘Charlie’.

The search

- 15.36** No one who had been on board incident ‘Charlie’ was located as a result of the search carried out under the direction of HM Coastguard by the Valiant or by the helicopter R163 between 03:24 and 06:46 on 24 November 2021. The meteorological conditions on the night provide only a partial answer to the question of why those on board were not located. Opportunities were lost in the searches which were carried out by both the Valiant and the helicopter R163. This was attributable not to their captain or crew but to HM Coastguard.

¹⁰ For example, see paragraph 10.15.

- 15.37** As to the Valiant, it was tasked around 20 minutes after HM Coastguard was made aware of incident 'Charlie'. It took two hours to arrive on the scene. The Valiant was not given any search parameters or relevant information to enable it to identify incident 'Charlie'. In particular, the Valiant's Commander and crew were not told of the possibility that incident 'Charlie' was swamped or of people in the water. Because of this, its Commander did not understand the information contained in the Mayday relay to be a real emergency. The information that the Valiant's Commander did have, namely the Mayday relay co-ordinates gathered at 02:01, was out of date by the time the Valiant arrived at that location. Having initially identified two small boats, and having then embarked one of them, the Valiant was thereafter guided by R163 to the locations of two more small boats. This meant that it was only actively searching from its initial arrival on scene until it was alongside the first small boat it embarked. It was then directed to two other small boats and after the third was cleared from incident 'Charlie' at 06:46, which meant that it was no longer actively looking for it.
- 15.38** With respect to aerial assets, helicopter R163 carried out aerial surveillance from 04:02, approximately 29 to 45 minutes after all people aboard incident 'Charlie' had fully entered the water. The captain and crew of R163 were never tasked specifically to incident 'Charlie'. They were never provided with any co-ordinates specific to incident 'Charlie'. They were never told that they were searching for a sinking or swamped small boat and that there were potentially people in the water – information which HM Coastguard had received from the callers on board incident 'Charlie' and from the French Coastguard at 02:42.
- 15.39** Without knowing what to look for, the effectiveness of the helicopter R163's work in respect of incident 'Charlie' was frustrated from the outset. The captain and crew of R163 could not make informed and appropriate decisions on track spacing for a search in the absence of information about a search target. Contrary to standard operating procedures, HM Coastguard did not provide full search parameters (which would have included track spacing and sweep width) to R163. The track spacing selected by the captain of 0.7nm was appropriate and effective to locate an intact small boat, but not to locate people in the water given the conditions of the night. This track spacing meant that R163 covered a larger area but would be less likely to fly directly overhead incident 'Charlie'. No search planning had been undertaken by HM Coastguard. Therefore, HM Coastguard did not know that R163 was unlikely to have located people in the water unless it flew directly over them, particularly given the poor visibility that night, and it had no way of knowing whether R163's search had been successful in locating incident 'Charlie'. Inaccurate tasking of R163, by geolocation and by search object, may have contributed to the failure to find the people in the water on the night.

Resolution, record keeping and reconciliation

- 15.40** The SMC at MRCC Dover identified the second small boat embarked by the Valiant (M958) as incident ‘Charlie’, despite there being an obvious conflict between the information held on incident ‘Charlie’ and the small boat identified as M958.¹¹ He did not record his decision in writing, nor did he share it with colleagues during the night watch. The only reasonable explanation for his decision to reconcile the incidents in this way was that given in his oral evidence. After initially believing that there could be a real emergency, the failure of the Valiant and R163 to find a sinking small boat, coupled with phone calls stopping from incident ‘Charlie’, led him to conclude that the callers had exaggerated the level of their distress and had been rescued, rather than that they had fully entered the water. Given the failings in the searches conducted by the Valiant and R163, for reasons just explained, this conclusion was unsafe.
- 15.41** 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 may not be believed when giving information about their situation, which might possibly lead to a loss of life. HM Coastguard relied on generic training that information given by callers should be taken at face value. In the circumstances at the time, generic training was inadequate to displace the widely held belief about the regular exaggeration of distress levels in calls from small boats. It was a systemic failing that HM Coastguard did not consider and act on the risks posed by this belief before 23 to 24 November 2021.
- 15.42** The belief of exaggeration, when coupled with the extreme pressure on HM Coastguard staff handling small boat search and rescue, an over-reliance on inexperienced personnel, the shortcomings in remote working, and an absence of effective supervision, explains why it was possible for HM Coastguard to believe that incident ‘Charlie’ had been resolved when it had not. These issues were systemic in nature and should have been recognised by HM Coastguard before November 2021. They crystallised in the events of 23 to 24 November 2021.
- 15.43** HM Coastguard’s nightshift ended at 07:30 on 24 November 2021. All those involved operationally during the night watch believed that incident ‘Charlie’ had been resolved. This incorrect belief was transmitted to and acted on by the incoming day watch. It is likely that the day watch accepted this incorrect assessment as a result of what was said in the handover between watches, combined with errors recorded in HM Coastguard’s operational support spreadsheet, known as the tracker. These errors included the following.

¹¹ See paragraphs 12.12 to 12.25.

- a. There was an incorrect entry showing that incident 'Charlie' was M957, therefore suggesting that it was the first small boat embarked by the Valiant that night, whereas the SMC at Dover had in fact decided that M957 was incident 'Lima'. This error in the tracker had not been corrected during the night watch and persisted into the day watch. This was an error that originated with the JRCC. It resulted from a combination of the JRCC's reduced situational awareness because of working remotely coupled with the misleading and incomplete record keeping at MRCC Dover, in particular the inclusion on the ViSION log for incident 'Charlie' of information about all three small boats embarked by the Valiant.
- b. There was an incorrect attribution, early in the day watch, of the nominal M958 to incident 'Lima', whereas the Dover SMC had in fact decided (but not recorded in writing) that M958 was incident 'Charlie'.

In the absence of any recorded decision-making by the Dover SMC about incident 'Charlie', these errors in the tracker contributed to the impression that all appeared to be in order.

- 15.44 Accordingly, on the morning of 24 November 2021, the day watch SMC marked incident 'Charlie' as resolved in the HM Coastguard tracker. This entry was in turn relied on by the day watch Maritime Tactical Commander to record incident 'Charlie' as resolved in the ViSION logs. Incident 'Charlie' was formally closed during the afternoon of 24 November 2021, in reliance on this entry in the ViSION logs, without further investigation or analysis.
- 15.45 It was reasonable for HM Coastguard staff working on the day watch to rely on information received from the outgoing SMC and the information available via the HM Coastguard tracker. Day watch staff could not be expected to check and second guess the decisions of colleagues taken in the previous shift, nor did they have the operational knowledge to do so. However, the result was that the mistakes made during the night watch were insulated from any effective review.
- 15.46 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 the people who were still alive and in the water, between 06:46, when the Valiant was cleared from its tasking to incident 'Charlie', and 12:57 on 24 November 2021, when HM Coastguard was first notified by the French Coastguard that bodies had been discovered by a French fishing vessel. Otherwise, the search would have continued until the expiry of the upper limit for survivability as calculated under HM Coastguard procedures, and therefore at least throughout 24 November 2021. This period self-evidently incorporated all daylight hours on 24 November 2021. 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 undertaken adequately during 24 November 2021, including during daylight hours, more lives would have been saved.

Chapter 16:

Reports into the incident and changes since November 2021

- 16.1** There have been three substantive investigations or reviews of the events of 23 to 24 November 2021. First, the MAIB carried out an investigation and set out its findings in a report which was published on 9 November 2023 (the MAIB report).¹ Secondly, the US Coastguard was commissioned to conduct a peer review of HM Coastguard's search and rescue response on 23 to 24 November 2021. The US Coastguard produced a report which it submitted on 14 July 2023.² Thirdly, HM Coastguard conducted an internal review into the incident and produced a draft report in May 2024 (the internal review).³ That report has not been finalised, since it awaits the outcome of the inquiries by the French authorities. This chapter considers each of these in turn.

MAIB investigation

The MAIB and the status of the MAIB report in the Inquiry

- 16.2** The MAIB is an independent unit within the DfT. It is well respected internationally for its record of investigating marine accidents. It investigates marine accidents involving all vessels in UK territorial waters, as well as marine accidents involving UK vessels worldwide.⁴ The MAIB is empowered by the Merchant Shipping Act 1995 and carries out its work pursuant to regulations made under that Act, namely the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 (SI 2012/1743) (the Regulations).
- 16.3** The MAIB obtained important evidence as part of its investigation. For example, it commissioned expert reports on drift analysis from three forensic oceanography specialists. It also engaged with the Met Office to understand and assess the visibility and potential performance of infrared and night vision equipment, and it used specialist equipment to extract data from the HM Coastguard mobile phone at MRCC Dover. As evident from previous chapters, the Inquiry has been able to draw on this work and has benefitted greatly from it.

1 INQ010445.

2 INQ008904.

3 INQ008905.

4 Merchant Shipping Act 1995, section 267. Available at: www.legislation.gov.uk/ukpga/1995/21/contents (accessed 10 November 2025).

- 16.4** As noted in Chapter 2, the Regulations limit the purpose of an investigation by MAIB to a sole objective: the prevention of future accidents through ascertaining a marine accident's causes and circumstances.⁵ Given this statutory mandate, the MAIB report is more limited in scope and approach than the Inquiry. The Inquiry has placed those who were on board the small boat and their families at the heart of its work, including by receiving evidence from survivors and the families of the deceased and missing. The MAIB was not required to do this given its statutory mandate. A further result of the nature of the MAIB's remit meant that the Inquiry received significantly more documentary and oral evidence, including an expert report on survivability.
- 16.5** Early on, the Inquiry considered the status to be attributed to the MAIB report. There were three possible approaches available. The first, to adopt the MAIB report wholesale, was inconsistent with the Terms of Reference (which required me, in conducting the Inquiry, to consider the MAIB's investigation). The second, to conduct a full re-examination of the issues, would attract the justified criticism of unnecessary duplication. Accordingly, I decided that the Inquiry should take a third, middle course, mindful of the need to avoid duplication in investigations and seeking by way of the Inquiry's investigation to enhance and build on the existing MAIB report. In other words, the Inquiry has taken the MAIB report into account as part of the investigation, without supplanting it.
- 16.6** Due to the statutory scheme under which the MAIB report was produced, it does not contain any information about the investigation itself, including the identity of the investigator(s), the steps taken as part of the investigation, the evidence received, or the dates when the investigation took place.
- 16.7** The MAIB did provide to the Inquiry some of the material obtained by it or generated during its investigation. However, the MAIB did not provide to the Inquiry all the relevant information in its possession on the basis that the Regulations imposed restrictions on its ability to disclose records. In particular, the MAIB took the view that certain records, including statements taken by the MAIB or supplied to the MAIB during the investigation, together with correspondence received from parties involved in the investigation, could not be disclosed unless a court ordered otherwise (although in the case of statements, the maker of the statement could disclose the statement directly to the Inquiry).⁶ Further, while the MAIB has a discretion under the Regulations to disclose certain documents to official authorities (such as the Inquiry) without a court order, it considered that documents disclosed pursuant to such discretion could not be disclosed to third parties.⁷

5 Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, Regulation 5. Available at: www.legislation.gov.uk/uksi/2012/1743/contents (accessed 10 November 2025).

6 Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, Regulation 13. Available at: www.legislation.gov.uk/uksi/2012/1743/contents (accessed 21 November 2025).

7 Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, Regulation 13(7). Available at: www.legislation.gov.uk/uksi/2012/1743/contents (accessed 21 November 2025).

Key conclusions and recommendations in the MAIB report

- 16.8** The MAIB report contains a narrative of the events of the night of 23 to 24 November 2021, a description of the key actions, the MAIB's analysis of the events, and its conclusions and recommendations. The MAIB was not granted access to any information held by French authorities and was not able to examine the small boat involved in the event or any of the equipment on board.
- 16.9** A full summary of MAIB's report is beyond the scope of this chapter. However, some of the key findings and conclusions are as follows.
1. The vessel that flooded and partially sank was the boat designated by HM Coastguard as incident 'Charlie'.
 2. The occupants of the boat entered the water due to uncontrollable water entry, resulting in it becoming swamped.
 3. Those on board the boat raised the alarm using mobile phones and alerted both the UK and French emergency services by this means. Their location was identified by passing positions via WhatsApp, but these were static so there was no continuous updating of the location provided. The last known WhatsApp position was at 02:21, which may have been an hour before the boat became swamped and people entered the water.
 4. HM Coastguard did not have an overall picture of the small boat activity on the night, with the consequence that it was unable to know how many boats were crossing and to distinguish between them in terms of level of distress (identifying, triaging and tracking multiple small boats). As a result, HM Coastguard was severely limited in its ability to mount an effective search and rescue response. It could only prioritise incidents based on information available from visual contact, from calls from the Centre Régional Opérationnel de Surveillance et Sauvetage (CROSS) Gris-Nez, the French Coastguard station at Gris-Nez, and from the small boats themselves (rather than information based on overall surveillance).
 5. Conventional maritime traffic monitoring systems in the Dover Strait were ineffective for the purposes of detecting small boats as they were based on the Automatic Identification System, radar and very high frequency (VHF), none of which were available to the small boats. Radar was ineffective for the detection of small boats.
 6. HM Coastguard was aware that the lack of a fixed-wing flight would negatively affect the ability to have an overall maritime picture, but there was no predetermined contingency plan for situations where fixed-wing aircraft were unavailable. This was foreseeable, but the detrimental effects of its absence had not been fully recognised.

7. In the absence of a predetermined backup plan, on the night in question there was a plan to task the search and rescue helicopter, R163, to fly a patrol flight along the median line. However, by the time it was airborne, its tasking had changed to search and rescue. There was no evidence that any agency involved gave thought to the use of surface vessels as an alternative. HM Coastguard was unable to deploy any other surface assets for surveillance purposes in the absence of a fixed-wing flight because it had none of its own, and the RNLI and Border Force vessels were only available to HM Coastguard for search and rescue purposes.
 8. HM Coastguard was unable to reconcile the information from calls in real time or at all in some cases (to distil relevant information from multiple calls, including multiple calls from the same boat, correlate it with information from other sources such as the French tracker, and assign it reliably to an incident).⁸ The consequences were that important information would be missed for the purposes of search and rescue, including the difficulty of resolving incidents where there was insufficient information available to close an incident with sufficient certainty that it had been resolved. This may have contributed to the erroneous determination that incident 'Charlie' had been found and resolved.
 9. The utility of the Coastguard mobile phone in small boat search and rescue was the ability to obtain positions from small boats via WhatsApp. However, the mobile phone was not integrated into HM Coastguard's incident management system, calls to it were unrecorded and could not be reviewed, and the phone was neither continuously managed nor its calls logged, which increased the likelihood that information would be missed.
 10. Information flow from France was insufficient by itself to provide a clear understanding of the actual number of small boats expected to reach UK waters. On the incident night, no information was provided to HM Coastguard by the French authorities until prompted, despite CROSS Gris-Nez's awareness of four boats in French waters. This limited HM Coastguard's ability to make preparations or mount a proactive response, particularly in the absence of coverage from a fixed-wing aircraft.
 11. The use of different tracking designations for incidents by HM Coastguard and the French Coastguard added to the difficulty of identifying and reconciling discrete incidents.
- 16.10 The MAIB report noted a number of changes and capability developments in the response of the MCA and HM Coastguard to small boat crossings in the Dover Strait since November 2021, as follows.

8 See paragraph 7.72.

1. The award of the UK Second-Generation Search and Rescue Aviation Programme contract to Bristow Helicopters Limited to deliver rotary and fixed-wing services across the UK search and rescue region for a period of 10 years.
 2. The recruitment of additional staff including: additional Maritime Tactical Commanders to ensure that three are allocated to every watch at the JRCC, 20 additional operational staff at MRCC Dover, and two dedicated call handlers to take emergency calls from small boats.
 3. The updating of various HM Coastguard standard operating procedures relating to small boat crossings and migrants, including the requirements to:
 - use alphanumeric reference numbers when discussing specific small boats to avoid misunderstandings
 - provide alphanumeric references to the caller at the end of every call originating from a migrant boat and to ask them to use the reference if they call the emergency services again
 - obtain SMC approval to merge reported small boat incidents
 - record the rationale for closing an incident in the incident narrative
 - correlate the information recorded in the tracker documents, the operational support spreadsheets used to record information on small boats, with the information recorded in HM Coastguard's primary information recording system, ViSION.
 4. The commencement of work on a commercial solution to obtain geographical positions reliably from mobile phones and to avoid reliance on WhatsApp.
 5. The delivery of a reminder to HM Coastguard staff to make referrals to the MCA's regulatory compliance investigations team when vessels nearby a distress incident do not respond to a Mayday relay broadcast.
 6. The implementation of Project CAESAR, designed to provide dedicated aerial support in the Dover Strait, with additional drones and fixed-wing aircraft and livestream video footage to the operations room at MRCC Dover.
- 16.11** As to Project CAESAR, the MCA's corporate witness provided further evidence to the Inquiry that the first phase was delivered on 1 March 2022, with both a Schiebel S100 drone and a DA42 fixed-wing aircraft providing a single line of tasking, seven days a week for up to eight hours a day, subject to weather conditions and safety considerations. These assets provide live video imagery into MRCC Dover "to greatly increase HM Coastguard's operational situational awareness from the air". From 1 July 2022, the capability was further enhanced

with additional S100 drones and with the DA42 aircraft being replaced with larger and more capable DA62 aircraft, providing two lines of tasking available up to 16 hours every day.⁹

16.12 The MAIB report also summarised changes arising from Operation ISOTROPE, which was the name given to the Ministry of Defence’s assumption of military primacy and control of counter migration operations in the English Channel. Operation ISOTROPE came into force in March 2022. It was underpinned by an inter-departmental memorandum of understanding (MoU) signed by the Permanent Secretaries of the Ministry of Defence, the Home Office and the DfT on 8 April 2022 (and updated in May 2022 and September 2022).

16.13 The objective of Operation ISOTROPE was to ensure that small boat arrivals did not enter the UK on their own terms and, instead, were intercepted before or as they landed.¹⁰ HM Coastguard retained responsibility for search and rescue operations and the ability to task and co-ordinate any necessary assets to perform search and rescue operations, including civilian assets and personnel aligned to Operation ISOTROPE. Under Operation ISOTROPE, the number of Border Force maritime vessels available for small boat search and rescue was increased, resulting in an additional four crew transfer vessels. Additionally, the processing of people taken ashore from small boats was made more efficient, which improved the turnaround times of Border Force and RNLI surface assets. Operation ISOTROPE ended, as planned, on 31 January 2023 with the Home Office regaining primacy for counter migration operations in the English Channel.

16.14 Taking into account the changes that had been implemented by November 2023, when the MAIB report was published, it made two recommendations:

- that the MCA “[b]uild on existing liaison with French authorities to devise a tracking and identification system that, to the greatest extent possible, removes the possibility of confusion and error when compiling an overview of small boats attempting the crossing” (MAIB recommendation 1)
- that the MCA and Border Force “[d]evelop procedures for achieving, as far as is practicable, an overview picture of migrant boat activity during periods when aerial surveillance is limited to rotary wing aircraft or is unavailable” (MAIB recommendation 2).

Implementation of MAIB’s two recommendations

16.15 As to MAIB recommendation 1, in a letter dated 29 July 2024, the MCA explained that:

⁹ INQ010098/31-32/par2.22-2.23.

¹⁰ INQ000009/16/par23.

- it has “built on existing liaison with French authorities to devise a live internet-based tracking and identification system that, to the greatest extent possible, removes the possibility of confusion and error when compiling an overview of small boats attempting the crossing”
- in addition to the daily discussions that take place between MRCC Dover and CROSS Gris-Nez on crossing days, monthly (virtual) and quarterly (physical) meetings take place between the UK and French Coastguards to identify any further potential improvements that could be implemented in future”
- the live tracker had been used on every day that crossings have occurred for over a year (as at July 2024) and has resulted in no small boats entering the UK search and rescue region without first being recorded by the French Coastguard in the live tracker.

16.16 As to MAIB recommendation 2, the MCA explained that:

- in addition to intelligence cueing from the live tracker shared by the French Coastguard, extensive arrays of surveillance cameras are used on the French coast (to detect launches) and the UK coast (to detect arrivals), backed up by the provision of additional surface search vessels (five crew transfer vessels, two small boat recovery vessels, three Border Force contracted rigid hull inflatable boats, and RNLI all-weather and inshore lifeboats as tasked), with a further three fast reconnaissance vessels due to commence operations for Border Force in the third quarter of 2024
- the possibility of aerial surveillance being limited has also been reduced by Border Force contracting a larger Dash-8 maritime surveillance aircraft that can fly in more challenging conditions, reducing the likelihood of fixed-wing aircraft being unavailable for tasking
- HM Coastguard and Border Force meet daily to discuss the surveillance plan to detect small boats, with fortnightly tactical and operational meetings to discuss any observations and options for future improvement, in addition to monthly strategic meetings.¹¹

16.17 In its response to the MAIB recommendations, the Home Office stated that it had “procured additional capacity from [its] existing systems to ensure that [its] platforms are available for more hours on more days during periods of increased crossing activity”. This had included “additional aerial surveillance platforms and more flying hours to provide domain awareness over a greater geographic area over a greater period of time”. The Home Office explained that it had also procured a system that provides 24-hour coverage “over a substantial part of our area of operations to reduce our reliance on aerial surveillance platforms”.¹²

¹¹ INQ009977/2.

¹² INQ010470/1.

- 16.18** There is no doubt that the use of a live internet-based tracker between the HM Coastguard and the French Coastguard has provided a marked improvement on the systems that existed on 23 to 24 November 2021. It resolves the problem of the frequent delays experienced by HM Coastguard in receiving intelligence on small boats from the French Coastguard, as identified in Chapter 10. However, as noted in the preceding chapters (and in the US Coastguard case study, discussed shortly), there is a need for better Anglo-French co-operation beyond the issue of identification and tracking of small boats. This is addressed further in Chapter 17.¹³
- 16.19** The combination of the use of surveillance cameras, the increase in the number of surface assets, and increased co-ordination and co-operation between HM Coastguard and Border Force have contributed to attaining an overview picture of small boat activity during periods when aerial surveillance is limited to rotary-wing aircraft or is unavailable. HM Coastguard now has available a range of assets to enable it to obtain a recognised maritime picture in the absence of the fixed-wing aircraft. While there is an issue as to the suitability for rescue operations of the surface assets available to it from Border Force, this was not the subject of a recommendation by the MAIB. It is a matter dealt with in Chapter 17.¹⁴

The US Coastguard case study

- 16.20** In September 2022, HM Coastguard requested that the US Coastguard undertake a review of the search and rescue actions undertaken by HM Coastguard on 23 to 24 November 2021. The US Coastguard described this as “akin to a peer review for system improvement”.¹⁵ It produced a case study report dated 14 July 2023. The report made a number of findings, including the following.
- 1.** While HM Coastguard officers took prompt, decisive actions in response to the numerous small boat notifications received on the night of the incident, their response was complicated by the following factors.
 - a.** The watch officers were generally unaware of how many small boats were crossing the English Channel and had poor positional awareness of the vessels that were crossing.
 - b.** The case management system guidance for HM Coastguard watch officers was to create a unique incident number for each call, unless it could be immediately correlated with a previous report. At the end of

¹³ See paragraphs 17.56 to 17.58.

¹⁴ See paragraphs 17.46 to 17.50.

¹⁵ INQ008904/1.

the 24-hour period, there were 99 incidents in ViSION and only 27 small boats were confirmed to be underway. The only way to reconcile the duplicate incidents was to make several assumptions regarding possible correlations or repeats.

- c. The extremely high number of distress reports created confusion and the need to triage incidents quickly. The SMC exercised the authority to manage case decisions. However, the incident conclusion procedures were not well defined within HM Coastguard policy. When the assumption was made that a case was a repeat or could be correlated with a previous report of distress, the SMC closed the case with little or no oversight.
4. Search and rescue actions were co-ordinated with telephone and email communications between MRCC Dover and CROSS Gris-Nez. HM Coastguard and the French Coastguard used different naming conventions to identify small boats and each had divergent priorities, which created delay during the search and rescue response. There were also delays in emailing tracker spreadsheets.
5. Despite having a co-operative relationship, the 02:42 call between the MRCC Dover SMC and CROSS Gris-Nez marks the point in the response where search and rescue co-ordination became less effective. In that call, CROSS Gris-Nez informed the Dover SMC that the boat was sinking and there were people in the water. However, MRCC Gris-Nez seemed only to be focused on passing on information so that HM Coastguard could respond (as opposed to considering the possible tasking of a French vessel). The MRCC Dover SMC never explicitly requested assistance from the French Coastguard.
6. Every small boat crossing is classified as in the distress phase. High numbers of small boats transiting the Channel, all treated as distressed, require search and rescue officers to triage response efforts with limited and imprecise information.
7. Incident 'Charlie' was closed after the Valiant located and assisted a small boat. In addition, R163 completed a search in the area, and after the Valiant assisted, no further calls were received from small boat 'Charlie'. Therefore, the small boat that was assisted was assumed to be small boat 'Charlie'. The small boat was in the area in which the distressed boat was expected to be and had a similar number of people on board. The rationale for the correlation was reasonable. However, the decision was not reviewed, discussed or documented in real time.
8. When the information needed to confirm that a craft or people are no longer in distress was not available, categorising the case as 'active search suspension' in accordance with the International Aeronautical and Maritime Search and Rescue (IAMSAR) Manual is more appropriate than closing the case. In practice, suspending the search and closing the case would likely result in the same outcome. In both scenarios search efforts would stop.

However, the suspension would create an opportunity to review the facts and rationale for making a probable correlation, acknowledge the possibility that the distress situation might still exist, and communicate that responders should be vigilant for any new information that could re-activate the case.

9. As to staffing, as operational tempo increased, additional resources were not sought, or offered, in a manner consistent with the mission demand. Although assistance was provided by the JRCC, the brunt of the mission co-ordination was handled by the staff at MRCC Dover. The system of virtually surging watch officers from the JRCC potentially added a layer of complexity.

16.21 In its report, the US Coastguard made 14 recommendations which were directed, among other things, at enhancing co-operation between the UK and French authorities, and HM Coastguard's organisational processes, resource management and communications. HM Coastguard provided its response to the recommendations some 10 months later, on 28 May 2024.¹⁶ HM Coastguard's response was also addressed in the MCA's corporate evidence to the Inquiry.¹⁷

16.22 The recommendations in the report of the US Coastguard are set out below, together with HM Coastguard's response to each.

1. Institute a bilateral (France-UK) multi-agency task force that incorporates all stakeholder agencies relating specifically to small boats.

HM Coastguard did not accept this recommendation on the basis that it already has collaborative meetings and agreements in place with France, with the Mancheplan being the framework document.

2. Develop a shared common operational picture with visual mapping to plot, share, and fuse known and suspected small boats and track and task response resources.

HM Coastguard accepted this recommendation in part only. The ICU system was introduced in April 2023. It is a web-based application to assist in location and communication with people in distress. It enables text messages sent by HM Coastguard to people on small boats, and vice versa, to be automatically translated to the language selected. It also provides the location of a mobile phone to HM Coastguard automatically where there is cellular network coverage. In addition, there are plans to fit the 'Artemis' mobile phone system to aircraft. This is a system which would locate mobile phones even in areas with limited or no cellular coverage.

¹⁶ INQ004342.

¹⁷ INQ010098.

3. Develop a mass rescue operation plan specifically tailored for small boats. A mass rescue operation refers to the need for immediate assistance to large numbers of people in distress where no single organisation is fully equipped to mount an effective response. A mass rescue operation plan addresses the full scope of such responses including command and control, co-ordination, external stakeholders, and medical and law enforcement roles. Mass rescue operation plans often shift the organisational structure to an incident command system to best co-ordinate between the various organisations involved.

HM Coastguard did not accept this recommendation on the basis that there are already plans in place to respond to multiple small boat incidents and multiple people in the water from small boats.

4. Conduct joint exercises between UK and French Coastguards at the MRCC level as plans and standard operating procedures are revised. In addition, functional exercises with vessels and crews that are called on to assist in small boat operations would enable the bodies to develop best practice and identify equipment to assist in such rescues.

HM Coastguard accepted this recommendation and stated that it was implemented. HM Coastguard noted that the bilateral operational meetings include the sharing of updates and changes made to any standard operating procedures. There has been one multi agency exercise with the RNLI.

5. Small boat notifications should initially be evaluated as in the distress phase. As additional information is gathered, the SMC should formally re-evaluate the emergency phase.

HM Coastguard took no action in relation to this recommendation on the basis that it already formed part of its procedures as of 24 November 2021.

6. Develop an affirmative criterion for closing or correlating cases.

HM Coastguard took no action in relation to this recommendation on the basis that it considered that it already formed part of its procedures as of 24 November 2021. An update was issued to staff on 23 December 2021 to reinforce this requirement for staff suspending or terminating a search and rescue incident.

7. Institute a deliberate process to include an authority above the SMC to objectively evaluate the information and actions before suspending a search and rescue case for unlocated people or vessels. A similar process with articulatable factors should also be instituted for correlating multiple reports as a single incident.

HM Coastguard did not accept this recommendation on the basis that it already formed part of HM Coastguard's procedures as of 24 November 2021. HM Coastguard has a Tactical Commander, an on-call Strategic Commander, and a Duty Operations Director above the SMC. Further, HM Coastguard stated that all escalation requirements are captured in the Coastguard Information Portal, which is a repository of information (including standard operating procedures) for HM Coastguard employees.

- 8.** Develop standard procedures for rostering SMCs to minimise the loss of situational awareness and ensure appropriate area and resource familiarity.

HM Coastguard took no action in relation to this recommendation on the basis that it considered that it already formed part of its procedures as of 24 November 2021.

- 9.** Implement formal mental health and peer support networks to mitigate the fatigue and stress such cases can elicit.

HM Coastguard took no action in relation to this recommendation on the basis that it considered that it already formed part of its procedures as of 24 November 2021.

- 10.** Standard operating procedures or checklists should contain specific, prioritised questions that may decrease any ambiguities as to location, description, number of people onboard, and nature of distress during an incident. These checklists should be shared with other entities that may receive calls from small boat occupants.

HM Coastguard said that it had already implemented this recommendation via a specific information-gathering process conducted in December 2021.

- 11.** Consider requiring the use of on-call interpreters or a translation service to assist with collecting reports.

HM Coastguard accepted this recommendation and implemented it by way of the ICU system, which translates text messages sent between HM Coastguard and people on small boats.¹⁸

- 12.** Continue seeking mobile phone location data capability and have access integrated into HM Coastguard console systems for continuous monitoring and case documentation.

This recommendation was accepted and implemented again by the ICU system, which also provides the location of a mobile phone automatically.¹⁹

¹⁸ See paragraph 16.22(2).

¹⁹ See paragraph 16.22(2).

13. Use standard briefing templates and IAMSAR Manual terminology.

HM Coastguard accepted this recommendation. All standard operating procedures were reviewed in August 2022 and in March 2024 to ensure that the language was consistent with IAMSAR Manual terminology.

14. Watch officers must treat every distress alert as genuine until they determine otherwise. Supervisors must be alert to normalcy bias and take actions including regular training to counter the detrimental effects.

HM Coastguard accepted this recommendation and said that updates have been made to standard operating procedures to reinforce this requirement throughout the national network.

- 16.23** As is evident from this summary, HM Coastguard accepted a number of the US Coastguard's recommendations. However, its response to others was that there did not need to be any change. That was because it took the view that the recommendations already formed part of its policies and procedures as of November 2021. Having considered the evidence which the Inquiry received, including the MCA's further evidence in relation to these recommendations, I have concluded that some of the US Coastguard's recommendations require further implementation or prompt reconsideration by HM Coastguard. I return to this point in Chapter 17.

The internal review

- 16.24** The final of the three reports into the events of 23 to 24 November 2021 is the internal review conducted by HM Coastguard. A draft report was produced in May 2024. It contained a number of valuable recommendations at a relatively narrow, operational level. However, in my view, it falls short in its assessment of the effectiveness of the search and rescue response on 23 to 24 November 2021. That is because it does not grapple with the significant failings – which are identified in the Inquiry's report – in relation to planning for the night of the incident and the search and rescue response itself. These failings are described in detail in Chapters 9 to 12 and summarised in Chapter 15.
- 16.25** Instead, the internal review found, among other things, that the search undertaken by R163 was adequate, that the staffing on the night was adequate on the basis of remote assistance from HM Coastguard's national network, that there was no evidence of normalcy bias and that "the actions taken...in response to small boat incident [Charlie] were appropriate, based on the information which was available to the [SMC]..."²⁰ Overall, the internal review reached the conclusion, which I reject, that nothing it suggested would have materially

20 INQ008905/58/par4.16.1, 104/par6.1.18, 75/4.22.4.

changed the search and rescue response on 23 to 24 November 2021.²¹ That reasoning was repeated by the MCA's corporate witness in his oral evidence.²² He added that in the view of the MCA, none of the changes made in response to the MAIB and US Coastguard reports would have prevented the loss of life or made any difference to the outcome.²³

16.26 The conclusions of the internal review, together with the overly defensive response of the MCA's corporate witness to reasonable challenge during his evidence at the oral hearings, call into question the MCA's claim to be a learning organisation.²⁴ The shortcomings of the internal review reflect, in certain respects, a broader issue relating to the current supervisory framework for HM Coastguard. I return to this point in Chapter 17.²⁵

16.27 The draft report contains 21 recommendations. On the whole, these are directed at matters relating to HM Coastguard's operational procedures. They are summarised below, together with the actions taken to implement them (as set out in the MCA's corporate witness statement to the Inquiry).²⁶

1. Information gathering – All staff should be reminded that notifications of small boat incidents are to be created as new incidents unless it is already known by alphanumeric reference provided in the call. The recommendation was made because of the report's finding that a number of small boat incidents were not assigned an alphanumeric reference.

As a result of the recommendation, the Coastguard Information Portal was updated, and all staff were notified.

2. Information gathering – All staff should provide the alphanumeric reference number for the small boat incident to the caller at the end of every call and ask them to use it if they call the emergency services again. This recommendation was made to assist operators in identifying and confirming repeat callers.

As a result of the recommendation, the Coastguard Information Portal was updated.

3. ViSION and HM Coastguard communication – All staff should ensure that information recorded in the small boat tracker document must also be recorded in ViSION, HM Coastguard's primary information management system.

21 INQ008905/106/par7.1.2.

22 INQ010746/208/ln1-19.

23 INQ010746/208/ln20-23.

24 INQ010746/25/ln16.

25 See paragraphs 17.36 to 17.45.

26 INQ010098/128/par7.35.

As a result of the recommendation, the relevant standard operating procedure was updated, and staff were notified through the Coastguard Information Portal.

4. ViSION and HM Coastguard communication – All staff should consider the use of the ‘inform’ function in ViSION in small boat incidents so that resources are allocated to relevant incidents.

As a result of the recommendation, the standard operating procedure was updated, and staff were notified through the Coastguard Information Portal.

5. ViSION and HM Coastguard communication – All staff should be reminded to use the appropriate digital selective calling alert when making broadcast action (such as the distress alert for a Mayday broadcast). This recommendation was made because on 24 November 2021, the ‘urgency’ alert was used instead of the ‘distress’ alert.²⁷

As a result of the recommendation, staff were reminded via a ‘hot topic’ notification of the existing procedure on the Coastguard Information Portal.

6. ViSION and HM Coastguard communication – ‘Hot keys’ should be created on the integrated Communications Control System for the Port of Dover, CROSS Gris-Nez and the Belgian Coastguard at Ostend. This recommendation was made to ensure that when calls are made to HM Coastguard from these organisations, the officer can immediately see who is contacting them and prioritise taking the call, as appropriate.

As a result of the recommendation, hot keys were created and telephone numbers shared with those other organisations.

7. HM Coastguard procedures – All staff should be reminded to notify the MCA regulatory compliance investigations team when vessels nearby to a distress position do not respond to a Mayday relay broadcast. This recommendation was made because a number of vessels did not respond to the Mayday relay broadcast on 24 November.

As a result of the recommendation, the standard operating procedure was updated and all staff were notified through the Coastguard Information Portal.

8. HM Coastguard procedures – HM Coastguard’s information management team should create a specific small boat operations section in the Coastguard Information Portal. This recommendation was made to ensure that access to all small boat information is easily accessible to the national network.

27 See paragraphs 8.64 and 10.51.

As a result of the recommendation, a small boat dashboard was created within the Coastguard Information Portal.

- 9. HM Coastguard procedures** – A standard operating procedure should be created on the Coastguard Information Portal for the use of WhatsApp when responding to small boat incidents. This recommendation was made to ensure that a standard operating procedure was available to the national network on how to use WhatsApp in response to small boat incidents.

As a result of the recommendation, a standard operating procedure was created, and all staff were notified.

- 10. HM Coastguard procedures** – The ‘Small boat information gathering’ standard operating procedure should be updated to provide staff with a list of information they should try to obtain when on the telephone with people who are on small boats. This recommendation was made because in a number of calls, it was not possible to obtain names and telephone numbers before the call disconnected.

As a result of the recommendation, the standard operating procedure was updated.

- 11. HM Coastguard procedures** – All officers should be informed that when closing and merging incidents, SMC approval is required. This recommendation was made so that there is a record of why an incident was closed or merged and that the SMC was content for the action to be carried out.

As a result of the recommendation, a standard operating procedure was created, and staff were notified.

- 12. SMC and Tactical Commander** – SMCs should make an entry in every small boat incident to identify them as the officer responsible for the co-ordination of the small boat incident and to ensure that when the handover of an incident occurs, it is also recorded. This recommendation was made to ensure that the SMC for each small boat incident was recorded and evidence of handovers was made in the ViSION narrative.

As a result of the recommendation, staff were reminded of the existing procedure on the Coastguard Information Portal.

- 13. SMC and Tactical Commander** – Tactical Commanders should be reminded to ensure that ‘review, assess, guidance’ (RAG) statements are to be made within 30 minutes for each distress incident. This recommendation was made because during the night watch of 23 to 24 November 2021, the statements were missing from the ViSION log (and the RAG reviews did not take place).

As a result of the recommendation, staff were reminded of the existing procedure on the Coastguard Information Portal.

- 14. Stakeholder liaison – HM Coastguard should continue its engagement with the French Coastguard relating to small boat incidents and liaise with the French Coastguard before known ‘amber’ or ‘red’ days. This recommendation was made to encourage a better understanding of both the UK and French resources and capabilities.**

In response to the recommendation, HM Coastguard said that it continues to have meetings with the French Coastguard.

- 15. Stakeholder liaison – HM Coastguard should liaise with other emergency services who receive small boat 999 calls to develop a guide for information gathering. This recommendation was made since a number of calls were received on 24 November 2021 by various police forces, the Port of Dover and also South East Coast Ambulance Service, who were not aware of the information HM Coastguard required.**

As a result of the recommendation, HM Coastguard liaised with these external organisations to provide them with information on questions to ask callers from small boats.

- 16. Stakeholder liaison – HM Coastguard should liaise with 2Excel to explore any landing options in France. This recommendation was made as there were insufficient UK airports available on 24 November 2021.**

As a result of the recommendation, 2Excel has made the necessary enquiries. However, there are restrictions on the landing options in France.

- 17. Search planning – HM Coastguard should consider the establishment of a search planning cell within the network to respond to small boat incidents. This recommendation was made to maximise the network function when required to respond to small boat incidents.**

As a result of the recommendation, HM Coastguard has implemented a dedicated search planner for small boat incidents, although at the time of the report it was still considering whether to implement a search planning cell.

- 18. Post-incident actions – HM Coastguard should complete operational learning reviews for 10% of all incidents. This recommendation was made to ensure that officers review incidents to identify what went well and any improvements to completed incidents.**

The recommendation has been implemented by HM Coastguard.

- 19.** Post-incident actions – HM Coastguard managers should monitor the acknowledgement rate for all small boat information on the Coastguard Information Portal. This recommendation was made to ensure that officers were aware and understood changes made to standard operating procedures or operational detail for small boat incidents.

HM Coastguard is currently taking steps to implement this recommendation.

- 20.** Training and exercises – HM Coastguard should consider table-top exercises to ensure that officers test procedures in place for small boats incident response, with outputs and learning shared within the national network. This recommendation was made to enable officers to liaise with other stakeholders, to test procedures in an exercise environment and to ensure all officers in the national network are kept informed.

HM Coastguard stated that it had accepted the recommendation.

- 21.** Training and exercises – Any updates to small boat incident response should be captured in HM Coastguard technical training. This recommendation was made to ensure that officers within the national network were trained in small boat response.

HM Coastguard said that the recommendation was accepted and implemented.

- 16.28** All the changes recommended in the internal review were accepted and will no doubt improve HM Coastguard's processes. However, as with its response to the US Coastguard's review, HM Coastguard implemented many of the recommendations by way of written updates or reminders, whether through changes to standard operating procedures or updates notified via HM Coastguard's intranet, the Coastguard Information Portal. The Inquiry was told that HM Coastguard employees review this information as and when they have the time available. There is no mechanism which enables HM Coastguard to ascertain whether individual employees have reviewed the information. Self-learning when time is available is no substitute for recurrent training to ensure changes are effective and embedded in practice. I return to this point in Chapter 17.²⁸
- 16.29** HM Coastguard's internal review did not address some of the more substantial failings in the search and rescue response on the night of 23 to 24 November 2021. Some of these failings have been addressed by changes made since November 2021, outlined earlier in this chapter, including:
- the increase in staffing numbers at MRCC Dover and at the Maritime Tactical Commander level

28 See paragraphs 17.14 to 17.18.

- the increase in the number of Border Force surface assets available to HM Coastguard
- the increase in the variety and operational hours of aerial assets and the implementation of surveillance cameras, which have substantially reduced the need for contingency planning in the event that a fixed-wing aerial asset is unavailable
- the introduction of the ICU system which has improved communications with, and the ability to obtain geolocation information from, people on small boats.

16.30 As a result of such changes, it is clear that since November 2021, HM Coastguard has made significant progress in improving the effectiveness of its response to small boat search and rescue and ensuring that the events of 23 to 24 November 2021 are not repeated. However, matters remain outstanding. These are addressed in the next chapter.

Chapter 17:

Recommendations

- 17.1** This chapter sets out the Inquiry's recommendations. In making these recommendations, I have had regard to the conclusions reached earlier in this report as to the failings in the search and rescue response on the night of 23 to 24 November 2021. I have also considered the lessons already learnt from that incident, the recommendations of other bodies in relation to it, the degree to which those recommendations have been implemented (as set out in Chapter 16), and the broader oral and written evidence which the Inquiry received from a wide range of bodies as to improvements which can be made to search and rescue operations.
- 17.2** The Inquiry's recommendations fall into four broad categories.
- 1.** Recommendations specific to the search and rescue response on 23 to 24 November 2021 and to small boat crossings.
 - 2.** 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.
 - 3.** Recommendations relating to the UK organisations involved in maritime search and rescue activities.
 - 4.** Publication of implementing measures in response to the MAIB's recommendations following an investigation.
- 17.3** In my view, implementation of these recommendations will reduce the risk of a mass casualty incident such as the one that occurred on 24 November 2021 and will also contribute to an improvement in the effectiveness of search and rescue operations in the UK.
- 17.4** The broader policy issue of preventing small boat crossings lies outside of the Inquiry's Terms of Reference. It has not been considered by the Inquiry. However, ultimately the practice of small boat crossings must end. Quite apart from other reasons, this is imperative to prevent any further deaths of people travelling on board small boats. Crossing one of the busiest shipping lanes in the world in a small, unseaworthy and overcrowded boat is an inherently dangerous activity. It will never be possible to mitigate fully the risk of further deaths from small boat crossings.

(1) Search and rescue response to small boat crossings

- 17.5** A significant number of recommendations have already been made in the three reports into the events of 23 to 24 November 2021, which pre-date the Inquiry and were considered in Chapter 16. In response, HM Coastguard has undertaken substantial work to implement some of those recommendations and significant changes have been made, as outlined in Chapter 16. Some matters remain outstanding. The following recommendations address these matters.

Network flexing and remote working

- 17.6** The US Coastguard recommended rostering SMCs to minimise the loss of situational awareness in relation to small boats (US Coastguard recommendation 8). HM Coastguard took no action in response to this recommendation on the basis that it considered that it already formed part of its procedures as at November 2021.¹ The evidence before the Inquiry casts considerable doubt over the MCA's view that no action is required. HM Coastguard's model of network flexing is that staff based in HM Coastguard's various operational centres across the UK are able to work remotely in a different operational centre. As is clear from this report, this model resulted in mistakes being made on the night of 23 to 24 November 2021. The mistakes, which were primarily in record keeping, resulted in part from the reduced situational awareness experienced by those working remotely. Internal HM Coastguard reports on small boat search and rescue undertaken before the events of November 2021 had raised problems associated with reduced situational awareness when an SMC was working remotely from a different operational centre. The Inquiry heard evidence that reduced situational awareness with small boat search and rescue most commonly arose when the workforce was split between two different HM Coastguard operational centres (as opposed to the entire operations of an MRCC moving to another MRCC for remote working).²
- 17.7** I accept the evidence of the MCA's corporate witness, who stressed the centrality of network flexing and remote working for HM Coastguard's model of service delivery for its entire national network.³ The benefits are obvious, illustrated especially during the COVID-19 pandemic when, but for the national network and staff being able to work flexibly, the delivery of HM Coastguard's services would have been placed at significant risk.⁴ However, the evidence received by the Inquiry suggests that small boat search and rescue poses challenges for the network flexing model. That is because maintaining overall situational awareness with numerous ongoing distress incidents is different from non-small boat search and rescue where most often only one distress incident is involved.

¹ See paragraph 16.22(8).

² INQ010720/115/ln9-25.

³ INQ010746/71/ln1-18.

⁴ INQ010746/71/ln7-14.

- 17.8** The evidence before the Inquiry leads me to conclude that in small boat search and rescue, splitting HM Coastguard's operational staff between different operational centres may give rise to an unacceptable risk of loss of situational awareness. The risk could be particularly serious when an SMC is leading numerous small boat search and rescue operations remotely. Since November 2021, HM Coastguard has taken steps to enhance situational awareness with remote working. The MCA's corporate witness told the Inquiry about the introduction of 'TalkBox', which is an open communications channel used when HM Coastguard operational teams work together remotely. HM Coastguard has also implemented video conferencing, including iPads and Surface Hubs, which further enhance the ability of teams to work together virtually.⁵ It is unclear to me whether these further technological solutions have resolved the problem of situational awareness for small boat search and rescue. This is a question which HM Coastguard must regularly assess.

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.

Reconciliation of small boat incidents

- 17.9** The US Coastguard recommended that HM Coastguard develop an affirmative criterion for closing or correlating cases (US Coastguard recommendation 6). In response, HM Coastguard took no action. It took the view that this already formed part of its procedures as at November 2021.⁶ However, the standard operating procedure entitled 'Search suspension and termination', in force on 24 November 2021, did not contain sufficiently detailed guidance on the termination and suspension of search and rescue incidents.⁷ The MCA's internal review concluded that the process used for termination was inconsistent, with some small boat incidents having a clear conclusion, others remaining open until the end of the day, and yet others being closed with no recorded rationale.⁸ Further, in oral evidence to the Inquiry, the MCA's corporate witness accepted that reconciling duplicate incidents remained a problem for HM Coastguard.⁹

5 INQ010746/71/ln1-5.

6 See paragraph 16.22(6).

7 INQ000450.

8 INQ008905/58/par4.17.1.

9 INQ010746/206/ln15-19.

- 17.10** In the light of the evidence before the Inquiry, the reconciliation of multiple, duplicate small boat incidents remains an outstanding challenge for HM Coastguard. In response to the ongoing challenges around the reconciliation of duplicate small boat incidents, the MCA's corporate witness said that HM Coastguard was seeking funding for further technological solutions, potentially including artificial intelligence, to support and improve existing processes.¹⁰ This must be a priority for HM Coastguard. I support HM Coastguard's bid for future funding to secure technological upgrades in this area when available.

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.

Monitoring of resourcing needs

- 17.11** The operational response on 23 to 24 November 2021 was hampered by a lack of available search and rescue assets. A scarcity of search and rescue assets resulted in HM Coastguard, with the knowledge and agreement of Border Force Maritime, limiting the number of surface assets deployed on the night of the incident. There were also insufficient maritime and aerial assets during the day watch of 24 November 2021. The level of crossings in November 2021 caught UK authorities by surprise, as planning had been based on the numbers crossing by small boats declining after the summer period.
- 17.12** Resourcing of maritime search and rescue assets has improved since November 2021. That was the evidence before the Inquiry and it was brought home during my familiarisation visits to HM Coastguard and Border Force. However, resourcing needs are not static and may change again in future in light of the evolving tactics of the people smugglers and enhanced enforcement efforts. The events of November 2021 also underline that assessments should not be limited to physical assets such as vessels and aircraft but should also cover the availability and capacity of human resources.
- 17.13** Resourcing requires regular monitoring over time so that it matches need. It is self-evident that assessments should be based on the most accurate forecasts possible, including intelligence assessments of future levels of small boat activity. Assumptions about seasonal patterns in crossings have previously proven inaccurate. HM Coastguard's corporate risk register must contain candid

10 INQ010746/206/ln15-24, 207/ln1-5.

assessments of the level of risk relating to the resourcing of small boat activity in terms of physical assets and staffing.

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.

Staff training for small boat response

- 17.14** It is obvious from the discussion in Chapter 16 that HM Coastguard should deliver continuing training to its operational staff, which focuses specifically on small boat search and rescue. The evidence before the Inquiry was that in 2021 relevant operational staff did not receive any training specifically tailored to small boat search and rescue and that standard operating procedures were not always followed. Certain practices, which were not reflected in standard operating procedures, had developed at Dover MRCC. Although since November 2021 specific measures have been taken to assist staff in undertaking search and rescue in relation to small boats, I am not satisfied from the evidence I heard that all training needs for small boats search and rescue have been fully addressed. Reliance on self-learning through HM Coastguard's intranet – the Coastguard Information Portal – can be no substitute for effective, regular training.
- 17.15** One training concern relates to the need to avoid differential treatment of distress calls from small boats compared with those from other vessels. While this forms part of HM Coastguard's standard operating procedures, the evidence before the Inquiry indicates that in November 2021, the decisions of HM Coastguard staff were adversely affected by a widely held belief that callers from small boats regularly exaggerated their level of distress.
- 17.16** The MCA's corporate witness to the Inquiry denied that HM Coastguard operational staff were influenced by a belief that callers from small boats routinely exaggerated their level of peril. That does not take account of the evidence before the Inquiry, including that of the operational witnesses working on the night. Moreover, in its report on the night discussed in Chapter 16, the US Coastguard found that normalcy bias had developed in HM Coastguard staff and recommended that "[w]atch officers must treat every distress alert as genuine until they determine otherwise. Supervisors must be alert to normalcy bias and take actions including regular training to counter the detrimental effects" (US Coastguard recommendation 14).

- 17.17** There was some evidence before the Inquiry that exaggeration does occur although, when pressed, HM Coastguard was unable to provide the prepared scripts said to be used by callers. In some circumstances, it may be that callers from small boats inadvertently misstate their level of peril. That may be due to a genuine, subjective fear or their lack of familiarity with the sea. The vessels used in small boat crossings are inherently unsafe and the people in them may be in actual peril. Even if there are cases of exaggeration, calls from small boats must not be treated differently. HM Coastguard accepts that information must be taken at face value and then properly analysed, assessed and verified. It said that it had accepted and implemented the US Coastguard's recommendation.¹¹
- 17.18** However, I am concerned that more needs to be done. From the evidence given to the Inquiry, I am not persuaded that HM Coastguard fully recognises the effect of normalcy bias on its operational staff. There must be ongoing training and retraining in this regard. That should include the role of cognitive biases in decision-making on small boat search and rescue, including normalcy bias. In other words, HM Coastguard must ensure that its operational staff are fully aware of the risks of jumping to premature conclusions or being biased in certain directions, for example as a result of the widely held belief around exaggeration by callers from small boats.

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.

(2) Search and rescue involving mass casualty incidents

- 17.19** The events of 23 to 24 November 2021 constituted a mass casualty incident, that is an incident (or series of incidents) which causes casualties on a scale that is beyond the normal resources of the emergency services.¹² Those events are only one example of a mass casualty incident at sea, which can and do occur in a range of different contexts internationally, whether as a result of sea conditions, the condition or operation of a vessel, or the actions or omissions of the crew or others. While the organisations involved in search and rescue operations are dedicated to saving every life, the truth is that they will not always be successful in doing this. The objective must be to save as many lives as possible.

¹¹ See paragraphs 16.22(14).

¹² Cabinet Office (2013), 'Lexicon of UK civil protection terminology', version 2.1.1. Available at: www.gov.uk/government/publications/emergency-responder-interoperability-lexicon (accessed 11 November 2025).

The recommendations that follow are directed at the operational response to mass casualty incidents so that as many lives as possible can be saved.

Mass Persons in the Water Triage procedure

- 17.20** A mass casualty incident at sea requires the attending search and rescue agencies to make difficult decisions at speed in order to save lives. They have to determine where, and how, to allocate resources if the number of casualties exceeds the capability or capacity of the available assets at the scene. The Inquiry heard evidence about an In-Water Mass Casualty Triage Tool from Professor Tipton, Professor of Human and Applied Physiology at the University of Portsmouth, that he had developed together with his colleagues Colin Barton and Dr Patrick Morgan. The tool is designed to assist rescue agencies with the rapid and effective prioritisation of in-water casualties for rescue and medical attention, with the aim of reducing mortality and morbidity.¹³ The Inquiry also heard evidence from Mr Simon Ling, Head of Lifeboats at the RNLI, about how that organisation had taken the tool and used it in practice.¹⁴
- 17.21** The In-Water Mass Casualty Triage Tool poses a series of questions about the condition of a casualty in the water, along with their surrounding circumstances, to assist the rescue agency with classifying them within one of four categories for rescue. These range from W1 (the highest priority for rescue) descending in priority order to W2, W3 and finally W4 (rescue where resources allow).¹⁵ The In-Water Mass Casualty Triage Tool was first presented at the fifth World Maritime Rescue Conference in June 2023. It has since been peer reviewed and published in *BMJ Military Health*, an international journal concerned with the practice of military medicine.¹⁶ Before this, there was no policy framework, at least in the UK, to support the operational response to a mass casualty in the water incident.¹⁷ The Inquiry acknowledges the important work undertaken by Professor Tipton, his colleagues and the RNLI.
- 17.22** The Inquiry heard from Mr Ling how the RNLI had identified the need to issue guidance on triage in mass casualty incidents to its volunteers. It worked alongside Dr Morgan, one of the authors of the In-Water Mass Casualty Triage Tool, and HM Coastguard to develop a procedure to guide the operational response of its crews to a mass persons in the water incident.¹⁸ The resulting Mass Persons in the Water Triage procedure builds on the In-Water Mass Casualty Triage Tool. It comprises a flowchart, accompanied by a check card,

13 INQ010740/137-140/ln15-5, INQ010283/22-24/par4.14-4.18.

14 INQ010741/120-137/ln10-25.

15 INQ010283/23/Figure 3.

16 Colin A. Barton, Patrick Morgan and Michael J. Tipton (2024), 'Development of a novel "In-Water Mass Casualty Triage Tool"', *BMJ Military Health*. Available at: <https://doi.org/10.1136/military-2024-002855> (accessed 21 November 2025).

17 INQ010101/32/par73.

18 INQ010741/121-125/ln10-8.

which sets out a series of steps for crews attending a mass casualty incident to follow.¹⁹ The Inquiry heard evidence from Mr Ling about the successful deployment of the check card and the very real contribution it has already made in the response to a mass persons in the water incident. That included a tasking in August 2023 when the RNLI's Dover lifeboat responded to a Mayday call in the French search and rescue region and embarked 86 casualties, all of whom survived.²⁰

- 17.23** There was evidence to the Inquiry that HM Coastguard introduced a standard operating procedure entitled 'RNLI – Multiple person in the water triage' in February 2024.²¹ It endorsed the RNLI's use of the triage procedure as an initial response, until such time as on-scene capability was increased and conventional search and rescue practices could be resumed. HM Coastguard has informed the Inquiry that after two years of trials, it intends to adopt formally the procedure. Border Force has already issued the procedure as guidance to its crews involved in search and rescue operations.

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.

- 17.24** The Inquiry heard evidence from the RNLI that the Mass Persons in the Water Triage procedure has been tested during three exercises hosted by the RNLI at its support centre in Poole.²² The exercises were observed by representatives from HM Coastguard and UK Border Force. A further mass persons in the water exercise took place most recently in September 2025 which involved, for the first time, the participation of both Border Force and the RNLI. The exercise was observed by representatives from HM Coastguard. This is an encouraging step forward in improving information sharing between organisations involved in maritime search and rescue. It seems to me that more could be done to ensure that all those who could potentially be involved in responding to a mass casualty incident are familiar with and confident in applying the Mass Persons in the Water Triage procedure. I agree with the RNLI that there is real value in formal joint exercises with search and rescue partners to achieve this. The need for future exercises should be reviewed on every occasion that the Mass Persons in the Water Triage procedure is revised, or annually, whichever is

19 INQ009669, INQ009670.

20 INQ010741/122/In11-19, INQ010741/136-137/In10-25.

21 INQ005159.

22 INQ010741/133/In5-12.

soonest. I commend the efforts that the RNLI has already undertaken to provide essential training in mass persons in the water techniques, and in facilitating the introduction of equipment and procedures to effect them. Their expertise will be a valuable aid for others involved in mass casualty rescue efforts.

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.²³

- 17.25** The important work that has already been done in this field has the potential to benefit search and rescue agencies in responding to mass casualty events outside the UK. As far as the Inquiry could determine, there is no single applicable legal or policy framework, and no guidance at the international level. This has led to divergent practice, as highlighted at a MRCC Dover and CROSS Gris-Nez ‘small boat crossing operations’ meeting held in December 2023. It emerged at the meeting that the training received by the French Coastguard on recovery and triage of people in the water differed from the procedures adopted by the RNLI.²⁴ Divergent practice entails a real risk of a confused and confusing on-scene response when multiple rescue agencies are involved. Guidance from the International Maritime Organization (IMO) would contribute to the harmonisation of procedures concerning triage and the rescue of casualties in mass persons in the water incidents.

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.

Provision of information relating to survivability of people in the water

- 17.26** In the time it takes rescue assets to reach the scene of an incident, casualties may enter the water and become partially or fully immersed. The behaviour of a casualty before and on immersion can have a bearing on their likelihood of survival. The Inquiry heard evidence from Professor Tipton that useful behavioural advice may be communicated in such circumstances to improve survivability.²⁵ Some of this advice may be intuitive and reflects common sense. This would include properly securing lifejackets and finding something buoyant

23 See paragraphs 17.56 to 17.58 on other aspects of joint exercises.

24 INQ005148/4, INQ010741/134-135/ln11-8.

25 INQ010283/21/par4.12, INQ010740/135-137/ln23-1, INQ010740/142-143/ln17-8.

to hold on to. Other elements of the advice are not likely to be well-known or instinctively adopted. These include entering the water slowly to minimise cold water shock and staying still and floating, instead of swimming, to minimise the cooling effect of exercise.

- 17.27** The Inquiry has considered with care HM Coastguard's existing standard operating procedure 'Persons in the water' published in March 2021 and the accompanying update concerning 'Float to live' published in May 2024.²⁶ The advice contained within the guidance is narrower in scope than the matters identified by Professor Tipton in his evidence to the Inquiry and it does not make reference to the means by which that advice could be communicated to callers for whom English is not their first language. The Inquiry recognises the difficulties facing search and rescue organisations, the emergency services and others in communicating advice of this kind to callers facing immersion in water. The understandable distress and fear of people in the water may limit their ability to understand and follow such advice. The advice may require translation into a language that the caller understands. It may be communicated more easily in writing than verbally. The important point is to communicate it, so that the opportunity to make a difference to survivability is not lost.

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.

Search suspension and termination

- 17.28** Predicting survival time in cold water is a key component of search and rescue activity. It informs decision-making by those involved in search and rescue operations, including informing decisions on when to suspend or terminate search and rescue efforts. The predictive model currently used by HM Coastguard is the IAMSAR Manual's 'Maximum Observed Immersed [victim] Search Time' (MOIST) curve.²⁷ The Inquiry heard evidence which questions the extent to which the IAMSAR Manual curve provides a realistic upper survival time for people in the water in normal clothing.²⁸ Other predictive models in wide use include Keefe and Tikuisis' 'Cold Exposure Survival Model' and the US Army Research Institute of Environmental Medicine and US Coastguard's 'Probability of Survival Decision Aid'.²⁹

26 INQ010791, INQ010789.

27 INQ010283/14/par3.4ix-3.4x, INQ010740/144/ln15.

28 INQ010283/15-16/par4.1, INQ010740/122-124/ln13-12.

29 INQ010283/12/par3.4v, 4.4-4.6, INQ010740/124-131/ln13-17.

- 17.29** Despite the existence of these different models, the Inquiry heard evidence that the prediction of survival time remains an inexact science due to the large number of environmental and personal variables that can influence the model.³⁰ A lack of information about some or many of these variables substantially limits the applicability of any of the models to a particular set of circumstances.³¹ The key variables to collect are water temperature, the area of water (such as coastal or offshore), the age of the person in the water, and the use of an effective lifejacket.³²
- 17.30** While the first and second of these variables can be ascertained from meteorological systems, the third and fourth will often need to be ascertained directly from those in the water. Whereas HM Coastguard's standard operating procedure entitled 'Incidents involving migrants' directs call handlers to ask whether people on board are wearing life jackets, in practice this information seems not to be routinely collected.³³ The age of people on board is not included as information to be obtained in the 'Incidents involving migrants' standard operating procedure. It is included in the 'Person in the water' standard operating procedure, along with a number of other variables. HM Coastguard should amend its existing policies to ensure the collection of information from people in the water of the key variables for predicting survival time and should ensure that staff know the importance of collecting this information. To the extent that there may be practical issues with collecting this information in circumstances where there are multiple people in the water, HM Coastguard's policies should identify the variables to be prioritised for collection.

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.

30 INQ010283/12/par3.4vi, INQ010740/117-118/ln25-6, INQ010740/121-122/ln11-9.

31 In his oral evidence to the Inquiry, Professor Tipton stated that the National Water Safety Forum of which he is the current Chair operates a water incident database, or wave database, the data from which informs the different predictive models for survivability. He said that the database was operated with difficulty and recommended turning it into a proper national database: see INQ010740/140-141/ln19-5. It would seem sensible if the MCA liaised with the National Water Safety Forum to provide data to assist with the maintenance of its water incident database.

32 INQ010283/12/par3.4vi.

33 INQ000428.

The development of innovative search and rescue equipment

17.31 The Inquiry received evidence of the commendable success of the RNLI in developing bespoke equipment to limit the number of casualties from drowning before rescue can be effected. These innovations have been developed in conjunction with industry partners both in the UK and abroad. They include:

- an inflatable horse-shoe flotation device, which when thrown from a lifeboat in the vicinity of casualties will auto-inflate on impact with the water and provide flotation support³⁴
- the rescue doughnut, a giant inflating ring which is activated from a firing mechanism and which, when deployed, provides flotation for over 20 casualties³⁵
- the ‘sea stairs’, an inflatable platform that is deployed alongside the lifeboat which, using a sunken well and steps, provides a safe and efficient means to embark casualties.³⁶

The evidence of the RNLI, which I accept, is that the equipment has been proven to save lives.

17.32 HM Coastguard has provided the Inquiry with details of the wide range of domestic and international forums in which it participates. As the government agency responsible for search and rescue at sea, it needs to be informed of, and indeed to lead in, supporting the development of bespoke equipment and techniques to assist in search and rescue.

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.

(3) HM Coastguard and other search and rescue institutions

17.33 This section makes recommendations directed at the legislative framework for HM Coastguard, the arrangements for oversight of the MCA (including HM Coastguard), co-operation between stakeholders involved in search and rescue in the UK’s search and rescue region, and HM Coastguard’s procedures. Behind these recommendations is my concern to enhance the standing of HM

³⁴ INQ010101/25-26/par60.

³⁵ INQ010101/26/par62.

³⁶ INQ010101/28-29/par66.

Coastguard, to improve its operations, and to strengthen co-operation between it and other stakeholders involved in maritime search and rescue.

Legislative framework for HM Coastguard

- 17.34** There are two main bases for the recommendations concerning HM Coastguard's legislative framework. That it is outdated is obvious: the Coastguard Act 1925 (the Act) is a century old. The Act is a very short piece of legislation, consisting only of two operative provisions. The key provision, section 1, states that HM Coastguard is to perform duties previously performed by the coastguard on behalf of the Board of Trade, and of other duties that may be determined by the Board. There is nothing more about its functions.³⁷
- 17.35** In 1992 the then Secretary of State for Transport sought to remedy the legislative gap by way of a parliamentary statement.³⁸ Not only does that statement not have legislative force, but it also sets out the role of HM Coastguard at a very high level, defining it only by reference to HM Coastguard's responsibility for the initiation and co-ordination of civil maritime search and rescue within the UK search and rescue region. The MCA's corporate evidence to the Inquiry is that HM Coastguard discharges six functions, namely search and rescue, vessel traffic monitoring, maritime security, pollution response, maritime safety, and disaster and emergency response.³⁹ If HM Coastguard is to continue to perform all these important functions, this needs recognition in its constitutive Act. Given the importance of its role, HM Coastguard's functions and organisation should be clearly defined in up-to-date legislation.

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

Oversight of HM Coastguard

- 17.36** HM Coastguard is a division within the MCA.⁴⁰ The Secretary of State for Transport is ultimately accountable for the MCA.⁴¹ The MCA has broad functions, unrelated to those of HM Coastguard. These include promoting and administering the UK Ship Register, enforcing compliance with maritime rules, undertaking the survey and inspection of UK registered ships, and certificating independent survey organisations. In other words, the MCA and its resources are

37 As explained in paragraph 4.15, responsibility for HM Coastguard was transferred from the Board of Trade to the Secretary of State for Transport in 1983.

38 See paragraph 4.16.

39 INQ010098/3/par 1.5.

40 See paragraph 4.13.

41 INQ000955/4/par11.

not focused entirely on core HM Coastguard functions, including in particular the initiation and co-ordination of search and rescue.

17.37 The Inquiry received evidence from the DfT as to the various mechanisms by which it oversaw the discharge of the MCA's functions. As HM Coastguard is currently a division within the MCA, those oversight mechanisms cover in turn the discharge of HM Coastguard functions. The mechanisms which the DfT advanced in its evidence include:

- the MCA Sponsorship Board and attendance at the Board by DfT personnel
- an internal departmental review of the MCA undertaken in 2021
- ad hoc oversight arrangements, such as what were described as 'small boat huddles'
- the audit scheme of the IMO.

17.38 I do not consider that any of these is an entirely satisfactory mechanism for the DfT's oversight of the MCA (and by implication, the MCA's oversight of HM Coastguard).

1. The MCA Sponsorship Board is the primary method of oversight according to the agreement between the DfT and the MCA. It meets quarterly, but is used for only a 'high level' discussion of issues. While the DfT's corporate evidence was that the Sponsorship Board went through the highest risks facing the MCA, there is no evidence that the Board considered the new red-rated entry made to the MCA corporate risk register in November 2021.⁴² (This warned that HM Coastguard may become "overwhelmed due to unquantifiable levels of migrant Channel crossing activity occurring during periods of good weather".⁴³ A document prepared for the meeting also referred to this risk.⁴⁴) The DfT's corporate evidence was that this was a "limitation in the minutes". To my mind, it is unlikely that a discussion in relation to such an important issue would not be recorded in the meeting's minutes. There was no evidence from any participant that the issue was in fact discussed. However, if it was discussed, the omission from the minutes is indicative of poor record-keeping practice.
2. The internal departmental review in 2021 was limited in scope. It was stated to be a "light touch assessment to examine specific live issues and particular areas of MCA's work" in relation to "accountability and governance, and the relationship with the department only". It stated explicitly that "it did not go as far as examining efficacy and efficiency" of the MCA.⁴⁵

⁴² INQ010747/58-59/ln4-21.

⁴³ INQ000167/24.

⁴⁴ INQ010726/2/par12.

⁴⁵ INQ008152/4, 16, 57 cf, INQ010337/61/par174, INQ010747/68/ln4-12.

3. The small boat huddles, which are not a formal system for oversight, were initiated to discuss the response to Operation SOMMEN, the Home Office's interdiction and turnback policy, rather than a recognition of the need for proactive departmental engagement on the issue of small boats and the consequent pressures that were being placed on the MCA.⁴⁶ No formal minutes of the small boat huddles were kept, simply a list of action points.

- 17.39** Moreover, the IMO's audit scheme is designed to assess the extent to which Member States are complying with their obligations under various IMO instruments. Both the DfT and the MCA placed reliance on the IMO audit scheme. The audits are carried out every five years.⁴⁷ The 2021 audit was undertaken remotely. Further, it was a review of the UK's performance as an IMO State and not specifically of the MCA (or HM Coastguard).⁴⁸ A limited part of the audit scheme focused specifically on HM Coastguard's search and rescue functions.⁴⁹ It was not, and could not be, a comprehensive audit of HM Coastguard's operations and processes in respect of search and rescue.
- 17.40** As to HM Coastguard's internal review of the events of 23 to 24 November 2021, its shortcomings were identified in Chapter 16. The internal review raises a question as to HM Coastguard's ability to evaluate in the round its own performance. To my mind, an independent, external reviewer is likely to be more effective in this regard. A further issue with reviews such as HM Coastguard's internal review (and indeed the US Coastguard case study) is that they occur after incidents take place. They do not proactively and periodically identify the strengths and weaknesses in HM Coastguard's operations.
- 17.41** In its evidence to the Inquiry, the DfT relied on the mechanisms referred to above as constituting part of its oversight of the MCA. The DfT also explained how, since the events in question, improvements have been made to the way they oversee the MCA. These include a renewed framework agreement in 2025, improved methods of collaboration, information sharing and record keeping between the DfT and MCA, including at Sponsorship Board level, and creating and recruiting new Civil Service roles tailored to the MCA.⁵⁰
- 17.42** To my mind, there needs to be peer review, conducted by those with knowledge of the body being reviewed, but independent of it and able to offer an impartial evaluation. Models of peer review vary but can involve site visits, meetings and interviews with key individuals within the body and also with stakeholders, and

46 INQ010747/34-35/ln25-20.

47 INQ010746/58/ln10-14.

48 INQ008173/3/par1.8.

49 INQ008173/51 (Annex 1, page 13).

50 Department for Transport (2025), 'Executive agency framework document: The Maritime and Coastguard Agency'. Available at: <https://assets.publishing.service.gov.uk/media/687e669488c74f0fd15c96e9/mca-exec-agency-framework.pdf> (accessed 16 October 2025).

consideration of a sample of incidents. The US Coastguard case study was a peer review, but it was only undertaken because HM Coastguard requested it. Moreover, HM Coastguard was not obliged to accept its recommendations and there was no monitoring of the implementation of those which were accepted.

- 17.43** Against this background, and despite the improvements implemented since 2021, my conclusion is that the mechanisms currently in place for the review and oversight of the functions discharged by HM Coastguard are inadequate. There are various possible solutions for this, but the most sensible would seem to lie in HM Coastguard's description of itself as "the UK's only national emergency service".⁵¹ Unlike other emergency services in the UK, HM Coastguard is currently in the unique position of being without independent oversight.
- 17.44** An example of independent oversight of an emergency service is provided by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS). It has oversight of fire and rescue services in England, and police forces in England, Wales and Northern Ireland along with the British Transport Police. It also inspects other bodies such as HM Revenue and Customs and the National Crime Agency. HMICFRS operates under a statutory framework established by the Police Act 1996 and the Fire and Rescue Services Act 2004. These Acts define its core purpose, which is to promote improvements in policing and fire and rescue services to enhance public safety. It independently assesses the effectiveness and efficiency of these services, providing public reports and recommendations for improvement. Those reports are readily accessible and include graded judgments in various areas, such as 'outstanding', 'good', 'adequate', 'requires improvement', or 'inadequate'. The objective, in the public interest, is to provide high-quality professional advice to bodies, using experienced officers and other subject-matter experts, to identify best practice in order to improve performance.
- 17.45** In my view HM Coastguard would benefit from similar oversight. The MCA's corporate evidence to the Inquiry was that "there is a very small global network of individuals that have the relevant experience and exposure" to undertake a credible review of HM Coastguard.⁵² While the co-ordination of search and rescue is complex, I do not accept that HM Coastguard's processes cannot be reviewed externally. An independent reviewing body can be expected to recruit suitably qualified people, perhaps on a part-time basis, to design and advise on relevant review processes, to conduct reviews, and to make suitable recommendations. HMICFRS plainly does this in respect of police forces and fire and rescue services. The 1979 International Convention on Maritime Search and Rescue, the 1974 SOLAS, the IAMSAR Manual and the Mancheplan provide a ready set of regulatory and legal requirements against which to assess the

51 INQ010098/3/par1.3.

52 INQ010746/60/ln15-25.

search and rescue function. Additionally, quite apart from search and rescue, functions like recruitment, training, organisation, record keeping, procurement, resource allocation and the use of information technology are those faced by any other emergency service.

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.

Responsibility for surface assets and their suitability

- 17.46** It is striking that despite having primary responsibility for search and rescue, HM Coastguard does not own or contract any surface vessels. Border Force is regarded as an additional facility to HM Coastguard.⁵³ That characterisation does not reflect the operational reality which is that, on current arrangements, Border Force conducts 90% of small boat rescue operations.⁵⁴ This is not the purpose or function of Border Force. Rather, Border Force's central purpose is to secure UK borders by carrying out immigration, customs and other controls for people and goods entering the UK.⁵⁵
- 17.47** For so long as Border Force continues to undertake a significant portion of search and rescue, there are two issues. The first has so far proved theoretical. It is the risk that preservation of life will be less of a priority than Border Force's primary function of controlling the UK's borders. So far that has not occurred. All that I have seen indicates a dedication on the part of Border Force officers to undertake search and rescue with small boats when tasked by HM Coastguard. That is underpinned by the training Border Force provides to its operational personnel which makes clear that ensuring the safety of life at sea is of paramount importance during search and rescue operations for small boats.
- 17.48** The second issue is more immediate. It is that, on the Home Office's own evidence, its vessels are not suited to search and rescue activity.⁵⁶ While the crew transfer vessels acquired by Border Force from 2021 are said to be an improvement on the cutters and coastal patrol vessels, limitations remain,

53 INQ001334/6, INQ001161/1, INQ002370, INQ002371, INQ002382, INQ010741/52-53/ln20-11, INQ002359.

54 INQ010137/36-37/par94. On the whole, the remainder are conducted by the RNLI and other voluntary lifeboat services.

55 INQ010137/3/par7.

56 INQ010137/11-12/par23, 28/par72, 36/par93, INQ010134/24-25/par66.

including that they are not designed to be used when the wave height approaches or exceeds one metre.⁵⁷ This puts pressure on the RNLI which, as a result of the limitations of Border Force assets, is required to effect rescues in more dangerous sea conditions.

- 17.49** All of this is consistent with the observations of the Hon Alexander Downer AC, who was commissioned by the Home Office to conduct an independent review of Border Force in 2022. Mr Downer explained that the Border Force vessels were designed not for conducting search and rescue operations, but for law enforcement purposes. Where it was predictable that search and rescue operations would be stood up on a semi-permanent basis, he said that a more appropriate resource should be deployed than Border Force vessels. His recommendations included the following:

“Border Force maritime should not be providing an ongoing search and rescue function in the English Channel. Neither Border Force nor Royal Navy vessels are appropriate to this task. Appropriate vessels and crews should be sought under contract to conduct this task.”⁵⁸

- 17.50** The government at the time did not pursue this recommendation. The Home Office corporate witness was unable to explain why the recommendation was not pursued, although he noted that it was a political rather than operational decision, and that consideration of the issues in the Downer report was superseded by Operation ISOTROPE.⁵⁹ Under Operation ISOTROPE the military assumed command and control in respect of small boat operations. It began in early 2022 and concluded on 31 January 2023.

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.

Co-operation between Home Office or Border Force and HM Coastguard

- 17.51** In so far as the current arrangements continue, and HM Coastguard relies on Border Force assets for search and rescue in the Channel, there will continue to be a need for co-ordination and co-operation between the two organisations. HM Coastguard and Border Force have worked together in relation to small

57 INQ010137/11-12/par23.

58 INQ009671/47 (Recommendation 10.1).

59 INQ010742/203-206/ln16-5.

boats since 2018. However, there has been no MoU between the two setting out how this should occur.⁶⁰ By contrast, there has been an agreement in place between HM Coastguard and the RNLI since 2010 and a formal MoU since 2020.⁶¹ There was also an MoU in place between April 2022 and January 2023 in respect of Operation ISOTROPE.⁶²

- 17.52** The MCA could offer no explanation as to the absence of an MoU.⁶³ I am not persuaded by the views expressed by the MCA that the absence of an MoU had “no impact in the working relationship or how Border Force made their assets available as additional facilities to HM Coastguard”, that the introduction of an MoU “wouldn’t add anything, in terms of [HM Coastguard’s] response”, and that an MoU would not “change the operational working relationship or the response that happens on a daily basis”.⁶⁴ The fact is that MoUs are frequently used across government to define areas of co-operation between departments.
- 17.53** Given the current critical importance of Border Force assets to search and rescue in the English Channel, to my mind it is unsatisfactory that there only exists a common understanding between the MCA and Border Force that Border Force vessels will be tasked for the purposes of search and rescue.⁶⁵ There is a need for clarity as regards a number of matters, including the assets which will be made available to HM Coastguard, the tasking process, target response times, and how any tensions between search and rescue and Border Force’s enforcement responsibilities will be addressed.
- 17.54** There is also the issue of information sharing. There was a deficiency in information sharing between the Home Office and HM Coastguard on the night of 23 to 24 November 2021. The Clandestine Channel Threat Command, within the Home Office, had received intelligence at 18:22 on 23 November 2021 estimating there could be hundreds of people arriving by small boat in the UK search and rescue region. However, this valuable intelligence does not appear to have been shared with HM Coastguard.⁶⁶ Information sharing has improved in relation to the small boat activity with the co-location of HM Coastguard, Border Force and Home Office officials at MRCC Dover, but it remains an area where defined protocols are likely to assist.

60 INQ010746/122-123/ln16-9, INQ010746/123-124/ln24-2. See also paragraph 7.32.

61 INQ000655, INQ000096.

62 See paragraph 16.12.

63 INQ010746/123/ln11.

64 INQ010746/123/ln11-17, 124/ln6-17, 125/ln13-15.

65 INQ010098/26-27/par 2.7.

66 See paragraphs 8.13 and 10.4.

17.55 For all these reasons, there should be an MoU between the Home Office or Border Force and HM Coastguard regarding search and rescue in relation to small boats in the English Channel. The document might cover, among other things:

- the functions and responsibilities of the parties
- the surface assets which are available to respond to search and rescue in the English Channel
- the process for tasking surface assets
- the target response times when surface assets are tasked to incidents in the English Channel
- the management of friction between search and rescue requirements and Border Force's enforcement responsibilities
- periodic review of the effectiveness of the arrangements
- information sharing.

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.

Co-operation between search and rescue stakeholders

17.56 The US Coastguard recommended that HM Coastguard conduct joint exercises with the French Coastguard at the MRCC level, as well as joint functional exercises involving all vessels and crews called on to assist in small boat operations (US Coastguard recommendation 4).⁶⁷ HM Coastguard accepted this recommendation and stated that it was implemented. However, the RNLI's evidence to the Inquiry is that there has been no joint live play (as opposed to tabletop) exercise involving the active participation of the RNLI, HM Coastguard and Border Force.⁶⁸

17.57 The US Coastguard's recommendation of practical joint exercises is very sensible. It would enable relevant organisations to develop best practice and identify equipment to assist in small boat rescues. The RNLI's evidence is that operations would benefit from joint exercises between the UK and French stakeholders to test interoperability, share learning, and develop command,

⁶⁷ See paragraph 16.22(4).

⁶⁸ INQ010101/31-32/par70

control and co-ordination within a multi-agency response scenario.⁶⁹ The MCA's corporate witness accepted in his oral evidence to the Inquiry the importance of joint training.⁷⁰

- 17.58** Exercises should, at a minimum, involve all UK stakeholders, including HM Coastguard, Border Force and the RNLI. It would seem sensible that these exercises take place at set intervals so that all parties involved can make adequate plans for relevant staff to attend. Consideration should be given to inviting international search and rescue partners, including the French Coastguard. Participation by the French Coastguard and other national search and rescue partners has obvious challenges, but UK agencies need to use best endeavours to have them attend. In making this recommendation, I do not underestimate the substantial commitment in time and resources required to design, organise and deliver joint exercises.

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.

Mass rescue operation plan

- 17.59** One of the US Coastguard's recommendations in its case study was the development of a mass rescue operation plan specifically tailored for the risk presented by small boats (US Coastguard recommendation 3).⁷¹ HM Coastguard did not accept that recommendation. Their justification was that there were already existing plans to respond to multiple small boat incidents and multiple people in the water.⁷² The mass rescue operation plan which the US Coastguard envisaged is broader than the mass casualty triage procedure discussed above. It has at its core inter-agency co-operation, given that during periods of small boat activity the response might be beyond the normal search and rescue capabilities of HM Coastguard and the French Coastguard. The US Coastguard stated that:

“[Mass rescue operation] plans address the full scope of such responses to include command and control, coordination, external stakeholders, medical and law enforcement roles, public and external affairs and that [mass rescue operation] plans often shift the organizational structure to an Incident Command System (ICS) to best coordinate across agencies, prioritize resources, and leverage all authorities.”

69 INQ010101/31-32/par70-71.

70 INQ010746/130-131/ln10-9.

71 INQ008904/19.

72 INQ004342/3, 5. See paragraph 16.22(3).

This recommendation seems very sensible. It warrants serious reconsideration by HM Coastguard.

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.

Enforcement of the obligation to render assistance under Regulation 33 of SOLAS

- 17.60** Chapter 2 considered the legal framework applicable to search and rescue at sea. That includes the obligation on vessels to render assistance to people in distress at sea pursuant to Regulation 33(1) of Chapter V to the Annex to SOLAS. This obligation is an essential safeguard for anyone who finds themselves in danger, regardless of their race or nationality, or the purpose for being on the water.
- 17.61** Despite its fundamental importance, I am concerned about the possibility that the enforcement mechanisms available to the MCA's regulatory compliance investigations team are not being utilised to their fullest extent. Enforcement action taken by the MCA for a potential breach of Regulation 33(1) of Chapter V to the Annex to SOLAS is rare. A substantial contributing factor is the lack of referrals by HM Coastguard. The head of the MCA's regulatory compliance investigations team confirmed that there have been no prosecutions and no referrals from HM Coastguard to the regulatory compliance investigations team for non-compliance with Regulation 33(1) since at least 2021. This means that there was no referral (and no prosecution) in respect of the low response rate to the Mayday relay broadcast for incident 'Charlie'. There has also not been any referral from HM Coastguard since a reminder to staff in 2023, following the MAIB report, to make referrals to the regulatory compliance investigations team when vessels near to a distress position do not respond.⁷³ This is particularly troubling in the context of incident 'Charlie'. As outlined earlier, only three vessels responded to the Mayday relay on 24 November 2021: three of 17 vessels identified by the MAIB as passing within 6nm and 20 minutes of the broadcast position, and three of the seven to nine vessels identified by the MCA as having been in the vicinity of the broadcast position at the time of each broadcast.⁷⁴
- 17.62** It seems to me that the obligation under Regulation 33(1) is a substantive one, to proceed to render assistance, and not a procedural one, to reply or not to reply to the broadcaster of the Mayday relay. The wording of the broadcast in

⁷³ INQ010788/12/par33.

⁷⁴ INQ010445/61-62/par1.16.1, INQ010787/3/par9. See paragraphs 10.47 to 10.48 and 15.27.

relation to incident ‘Charlie’, which asked “any vessel that can assist [to] call Dover Coastguard”, is not determinative of the need for an enforcement referral. In the circumstances, the failure to respond to HM Coastguard’s Mayday relay broadcast is evidence at first sight of a failure to proceed to render assistance to incident ‘Charlie’. That failure would seem to constitute a breach of Regulation 33(1) unless the master of the ship did not hear the Mayday relay, the ship was unable to provide assistance, or it was unreasonable or unnecessary for it to do so.

- 17.63** The evidence of the MCA’s corporate witness to the Inquiry identified the challenges facing commercial vessels transiting the Dover Strait in providing assistance to a small boat in distress. The vessels’ ability to provide assistance may be limited in light of the safety risks associated with a large vessel altering course and the potential for a small boat to be overwhelmed or swamped by the wake of the larger vessel.⁷⁵ That is not to say that such vessels are never able to provide assistance, or that it would always be unreasonable or unnecessary to expect them to do so. The Assistant Director of HM Coastguard Policy, Standards and International outlined in July 2021 the different types of assistance that may be rendered, including standing off the vessel in distress until dedicated search and rescue assets arrive on scene, or providing lifesaving apparatus.⁷⁶
- 17.64** Whether a vessel is unable to provide assistance must be assessed on a case-by-case basis, taking into account the nature of the distress call. It is not a determination that can be made by HM Coastguard (who cannot speak to the thought process of the master of the ship). A referral should be made to the regulatory compliance investigations team if a vessel has not responded to a distress signal, and by virtue of either its flag or geographical location it comes within the jurisdiction of the Merchant Shipping (Safety of Navigation) Regulations 2020 for the purposes of enforcement action. Only then can the regulatory compliance investigations team investigate whether there has been a breach.

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.

⁷⁵ INQ010787/3/par10-11, 13.

⁷⁶ INQ003049, INQ003050.

(4) Publication and monitoring of implementing measures in response to MAIB recommendations

- 17.65** The final recommendation is distinct from the others and relates to the publication by the MAIB of information relating to the implementation of its recommendations.

Information on the implementation of the MAIB's recommendations

- 17.66** The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 (SI 2012/1743) (the Regulations) impose on the MAIB an obligation to make publicly available the information which it receives about the implementation of the valuable recommendations it makes, or any explanations for their non-implementation. Publication is to be made annually, or at such intervals as the MAIB sees fit.⁷⁷ It is subject to the obligation to notify all those mentioned in the information of the intention to publish, and to consider any representations made.⁷⁸
- 17.67** The MAIB publishes an annual report which includes progress reports on recommendations made in the report year and preceding years. In respect of both recommendations regarding the events on 23 to 24 November 2021, the annual report for 2023 (dated October 2024) observes that “appropriate action [was] implemented”. The annual report contains no further information about implementation measures. The progress report in relation to other incidents (and those in other annual reports) are similarly brief, merely indicating for example, “appropriate action planned: 31 March 2025” or “appropriate action planned: no date”. Where a recommendation is rejected, a very brief summary of the justification is provided.
- 17.68** The outcome of the MAIB's current approach was that the Inquiry was unable to obtain the details of the implementation of the recommendations the MAIB made in its report into the events of the 23 to 24 November 2021 from the information it made publicly available. However, following a request from the Inquiry, the MAIB provided excerpts from the information provided to it as to the status of the implementation of its recommendations. This information is summarised in Chapter 16.⁷⁹
- 17.69** There may be doubts as to whether the brief statements on the implementation of recommendations contained in the MAIB's annual report meet its obligations under Regulation 16(4)-(5) to make publicly available information about

77 Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, Regulation 16(4)-(5). Available at: www.legislation.gov.uk/ukxi/2012/1743/contents (accessed 21 November 2025).

78 Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, Regulation 16(6)-(7). Available at: www.legislation.gov.uk/ukxi/2012/1743/contents (accessed 21 November 2025).

79 See paragraphs 16.15 to 16.16.

implementing measures or any explanation for not taking implementing measures.⁸⁰ There is no need for me to give any legal opinion about this, since in my view, as a matter of policy, it is in the public interest to publish more information in respect of the details of implementing measures. If needs be, the Regulations should be amended to require this.

- 17.70** In addition, it seems to me that the information regarding the implementation of recommendations may be of such importance that it should be made publicly available on the MAIB's website as soon as it is received. The MAIB's recommendations are directed at the prevention of future accidents. It is important that those with an interest in maritime safety and members of the public can readily access information relating to the implementation of the MAIB's recommendations as soon as that information is available. Given that the Regulations require information on implementation to be sent within 30 days of receipt of a recommendation, publication in the MAIB's annual report is clearly unsatisfactory given the possible time that could take.
- 17.71** As indicated, the Chief Inspector has discretion under the Regulations as to the timing of publication. In my view, the starting position should be the publication of full and detailed information on implementation as soon as possible after the MAIB receives it, unless there are strong reasons not to do so. Interested parties should not have to wait for the publication of the MAIB's annual report, which as explained, contains little detail on the status of implementation measures. If, contrary to the view I have expressed, this approach is not permitted under the Regulations, the Regulations should be amended as well to put beyond doubt my view about timing of information on the responses the MAIB receives about the implementation of its 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 Regulations should be amended accordingly.

Response to recommendations

- 17.72** One of the aims of this Inquiry has been to reduce the risk that a mass casualty event similar to that which occurred on 23 to 24 November 2021 is repeated. The

⁸⁰ See paragraph 17.66.

recommendations identified in this chapter are designed to achieve this, but will only do so if they are implemented. Since there is no mechanism for the Inquiry to monitor the implementation of its recommendations following the publication of the report, it is vital that the government takes on the responsibility, with public reporting on the progress made in implementing them. I would make myself available to support this process in any way that is appropriate. Reporting on progress and independent monitoring are means by which public trust and confidence in the Inquiry's processes can be maintained.

Appendices

Appendix 1:

Terms of Reference

Scope and Purpose

1. The Inquiry will examine, consider and report on the events of 24 November 2021 when at least 27 people died attempting to cross the Channel in a small boat.
2. The Chair is to conduct an investigation into these events in order to:
 - a. Ascertain who the deceased were and when, where and in what circumstances they came by their deaths.
 - b. 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.
3. The procedure and conduct of the Inquiry will be directed by the Chair.
4. In conducting this inquiry, the Chair will consider the investigation already carried out by the Marine Accident Investigation Branch into the incident.

Timing

5. The Chair will report to the Secretary of State for Transport as soon as is practicable, taking into account any ongoing or future legal proceedings. The Secretary of State for Transport will be responsible for publishing the report.

Appendix 2:

List of Issues

The Inquiry in fulfilling its Terms of Reference will take account of and build on the MAIB Report (8th November 2023)¹ and will avoid so far as practicable duplicating the work of the MAIB.

I. The victims and survivors

- a.** Who were the victims and who were the survivors?
- b.** How did they come to be in the small boat on 24th November 2021?
- c.** How and when did the victims come by their deaths?

II. The law of the sea and the applicable legal framework

- a.** What are the obligations of coastal states, and in particular of the United Kingdom, in respect of the establishment, operation and maintenance of effective search and rescue services at sea?
- b.** What are the UK's obligations under domestic law to have appropriate systems in place to protect life at sea?
- c.** What obligations do vessels have to render assistance to persons in danger or distress?
- d.** How are these obligations enforced?

III. The operational systems in place in the UK as at 23rd-24th November 2021 to respond to small boats attempting to cross the Dover Strait

- a.** Which were the relevant persons, structures, organisations, departments, and bodies within departments within these systems as at 23rd-24th November 2021, and what were their relationships to each other? What protocols, memoranda of understanding, and similar documents set out those relationships? How have these relationships evolved in response to the increase in small boat crossings since 2018? As at 23rd-24th November 2021, how did those relationships work in practice?

¹ Report on the investigation into the flooding and partial sinking of an inflatable migrant boat resulting in the loss of at least 27 lives in the Dover Strait on 24 November 2021.

- b.** What is the nature of the relationship between the relevant UK persons, structures, organisations, departments and bodies within departments and their counterparts in France? What protocols, memoranda of understanding, and similar documents set out those relationships?
- c.** What assets and equipment were available to persons, structures, organisations, departments, and bodies within departments in the response to small boat crossings? How were decisions on the deployment of resources reached?
- d.** To what extent were the operational systems reliant on volunteers and/or voluntary organisations and/or their assets?
- e.** What plans and strategies did those persons, structures, organisations, departments, and bodies within departments have for anticipating and responding to small boats attempting to cross the Dover Strait, including in particular:
 - i.** What plans existed for responding to periods of suspected high activity?
 - ii.** What plans existed for responding to distress calls in poor weather conditions?
 - iii.** How were small boats detected or tracked in the Dover Strait?
 - iv.** How were calls from or in relation to a small boat managed? What instructions or guidance existed about obtaining information from passengers on small boats in the course of calls?
 - v.** How were incidents involving small boats recorded and updated? And how and on what basis were such incidents closed?
 - vi.** How were decisions to suspend a search and rescue mission reached?
 - vii.** What was the system for the handling and prioritisation of incidents?
 - viii.** What search methods were available for locating small boats and for locating people in the water? What were their limitations and restrictions?
 - ix.** What methods were available to differentiate between boats and to identify particular vessels?
 - x.** What methods were available to effect the rescue of those in need of assistance?
 - xi.** How did the 'Mayday' relay procedure operate and how was it enforced?

IV. The events of 23rd and 24th November 2021

The Inquiry considers that further investigation into the events of 23rd and 24th November 2021 is appropriate, which will include the following areas:

The victims and survivors

- a.** What communications were made by and to the victims or survivors in relation to the incident prior to their death or rescue?
- b.** To what extent was the loss of life avoidable?

The search and rescue operation

- c.** The adequacy of staffing levels and staff training
- d.** The adequacy, availability and tasking of assets, including for surveillance
- e.** The adequacy of interdepartmental co-ordination
- f.** The adequacy of the systems and equipment used to communicate with the occupants of small boats
- g.** The adequacy of the issuance of and response to the Mayday Relay
- h.** The adequacy of information sharing and co-operation between the UK and French coastguards
- i.** The adequacy of the system for reconciling and closing and suspending any search and rescue mission in respect of incidents involving small boats

V. Inspection and lesson learning prior to 24th November 2021

- a.** Had any investigations, reports, lesson-learning exercises, inspections, or similar been carried out, including with other countries, in relation to the systems for responding to small boats attempting to cross the Dover Strait prior to 24th November 2021? If so, by whom and what did they conclude?
- b.** Had any recommendations been made? If so, what were they and had they been implemented? If not, who was responsible for that decision and what were the reasons?
- c.** What information had been obtained by relevant persons, structures, organisations, departments, and bodies within departments from the experience of any comparable crossing attempts in other countries? Did the extent of the loss of life in any such cases differ? If so, why?

VI. Recommendations

- a.** What actions have been taken since November 2021, including with other countries, to prevent or reduce the risk of a similar incident occurring?
- b.** What progress has there been in response to the recommendations made by the Marine Accident and Investigations Branch in November 2023?
- c.** What information has been obtained by relevant persons, structures, organisations, departments, and bodies within departments from the experience of any comparable crossing attempts in other countries? Did the extent of the loss of life in any such cases differ? If so, why?
- d.** What if any other recommendations are appropriate to minimise the risk of a similar incident occurring?

Appendix 3:

Pre-incident chronology

This pre-incident chronology sets out some background context to the events of 23 to 24 November 2021, drawn from documentation disclosed to the Inquiry team. It is not intended to be exhaustive.

Date	Event	Inquiry reference
2017	The Royal National Lifeboat Institution (RNLI) begins attending migration-related search and rescue incidents in the English Channel.	INQ010101
2017 to 2022	The RNLI deems the facilities at Dover for the handover of “rescue casualties” to be “lacking and under resourced to meet the demand” in the period from 2017 to 2022, creating a bottleneck and delay, impacting on the ability of RNLI assets to redeploy, and prolonging the length of crew service.	INQ010101
01/2017	‘Strategic overview of search and rescue in the United Kingdom of Great Britain and Northern Ireland’ is published by the Maritime and Coastguard Agency (MCA). This provides a framework for the strategic and operational oversight of UK search and rescue and describes the background, scope and responsibilities of UK search and rescue.	INQ000412
11/05/2017	The Home Office (HO) publishes guidance for Immigration Enforcement officers on ‘Clandestine illegal entrants’. The guidance refers to “small boats” as a means of entry.	INQ004467
01/11/2017	Framework document for the MCA is published by the Department for Transport (DfT) and MCA.	INQ000955
2017	By the end of 2017, the RNLI has attended 5 small boat crossing incidents. No people are rescued.	INQ010101

Date	Event	Inquiry reference
Early 2018	Border Force Maritime Command (BFMC) provides a dedicated Liaison Officer working within the Maritime Rescue Coordination Centre (MRCC) Dover during days of predicted high demand, until the Joint Control Room is developed by the Clandestine Channel Threat Command (CCTC). ¹	INQ010137
01/2018	7 migrants cross the English Channel using small boats. ² (There are no further crossings until June 2018.)	INQ010134
18/01/2018	The UK and France sign the Sandhurst Treaty, which aims to improve co-operation on border security and to tackle illegal migration. The UK commits £45.5 million to implement the terms of the treaty.	INQ010134 INQ009676 INQ004467
28/03/2018	HM Coastguard (HMCG) ViSION user guidance (CAPITA) version 4.24 is adopted.	INQ006204
30/05/2018	An updated version of the Anglo-French Joint Maritime Contingency Plan for the English Channel, known as the Mancheplan, comes into effect. (It is in force on 23 to 24 November 2021.)	INQ000095
06/2018	4 migrants cross the English Channel using small boats. (There are no further crossings until August 2018.)	INQ010134
08/2018	10 migrants cross the English Channel using small boats.	INQ010134
Summer 2018	HO observes in a published statement that small boats are beginning to be used more frequently.	INQ004467
Autumn 2018	From autumn 2018, there are cross-government meetings between the DfT, HO, MCA and Border Force (BF) to discuss the UK's response to small boat crossings and departmental roles.	INQ010337

1 References in the chronology to MRCC Dover, Dover Coastguard and Dover Coastguard Operations Centre are to the same location and reflect the underlying source material.

2 Terminology used in the chronology reflects the underlying source material. It does not indicate adoption by the Inquiry of that terminology.

Date	Event	Inquiry reference
09/2018	7 migrants cross the English Channel using small boats.	INQ010134
10/2018	23 migrants cross the English Channel using small boats.	INQ010134
11/2018	110 migrants cross the English Channel using small boats.	INQ010134
11/2018	A UK-France Centre Conjoint d'Information et Coordination opens in Calais. It is staffed by BF, Police aux Frontières, Immigration Enforcement and National Crime Agency officers.	INQ010134 INQ004467
11/2018	From November 2018, UK BF assets and crews are tasked to assist HMCG in intercepting and responding to small boat crossings. Initially, BF vessels carry out proactive patrols of the English Channel, but, as crossings increase, to make best use of resources, patrolling is significantly reduced and vessels become more reactive.	INQ010137 INQ006110 INQ006116 INQ006117 INQ006186
08/11/2018	HMCG's sixth Unorthodox Channel Crossings User Group meeting minutes record that "the issue regarding migrants" has been on the rise and "the rescue boat from Calais will attend" if cross-Channel swimmers and their support vessels encounter migrant small boats.	INQ000172
11/12/2018	An Anglo-French Accident Technical Group meeting takes place. There is discussion of search and rescue operations involving migrants in the Dover Strait and associated risks and challenges.	INQ000176
12/2018	A surge of small boat crossings is noted between October and December 2018.	INQ004467
04/12/2018	Ministerial meeting with the Secretary of State for the Home Department (Home Secretary) on small boats.	INQ008165 INQ008162

Date	Event	Inquiry reference
13/12/2018	A migrant boat is intercepted by a French vessel in French waters, and the migrants initially refuse to leave their craft stating their wish to go to the UK.	INQ006122
19/12/2018	Update submission to the Home Secretary and Minister for Immigration on steps to address illegal crossings in the Channel by small boat, with annexes including a high-level action plan.	INQ006122 INQ006123
28/12/2018	The Home Secretary declares a major incident following the crossing of approximately 200 people in small boats.	INQ004467
31/12/2018	The Home Secretary makes a military aid to civil authorities request to the Ministry of Defence (MOD) requesting immediate assistance in countering illegal migration in the Channel, including by the deployment of a Royal Navy vessel to back-fill operations until the arrival of a BF cutter from the Aegean.	INQ008971
12/2018	138 migrants cross the English Channel using small boats. By the end of 2018, a total of 299 migrants cross the English Channel using small boats.	INQ010134
2018	By the end of 2018, the RNLI attends 24 small boat crossing incidents, rescuing 106 people. The RNLI estimates that the average number of occupants on a boat in 2018 is 7.	INQ010101
01/2019	HO create a Clandestine Threat Board, to set the operational and tactical response to clandestine entry into the UK, and feed into the Strategic Coordination and Oversight Group.	INQ004467
02/01/2019	The military aid to civil authorities request is accepted by the MOD minister for 30 days. HMS Mersey is deployed and hands over to HMS Enterprise on the 21 January 2019.	INQ008971 INQ008979

Date	Event	Inquiry reference
Approx 03/01/2019	HMCG standard operating procedure relating to migrant activity is updated on or around 3 to 7 January 2019. (A previous version had been created in 2016.)	INQ000413 INQ006131
24/01/2019	The Home Secretary and his French counterpart agree a joint action plan on combating illegal migration involving small boats in the English Channel. A declaration is signed relating to the UK-France Centre Conjoint d'Information et Coordination.	INQ004467 INQ010134
01/2019	45 migrants cross the English Channel using small boats.	INQ010134
01/02/2019	HO request to extend deployment of HMS Enterprise to the 10 February 2019 is agreed by MOD.	INQ008972
02/2019	88 migrants cross the English Channel using small boats.	INQ010134
03/2019	66 migrants cross the English Channel using small boats.	INQ010134
04/2019	80 migrants cross the English Channel using small boats.	INQ010134
05/2019	The HMCG Aeronautical Rescue Coordination Centre (ARCC) moves from using the ViSION system 4 to system 5, receiving 2 days of training. Migration of the rest of HMCG to system 5 is delayed for technical reasons (with maritime HMCG still using system 4 at 23 to 24 November 2021).	INQ009628
05/2019	The provision of one BF cutter and 2 coastal patrol vessels for search and rescue purposes is formalised in May 2019 by Operation DEVERAN.	INQ010137
09/05/2019	HO considers the return of migrants rescued at sea by BF assets to France.	INQ006154

Date	Event	Inquiry reference
15/05/2019	Operation DEVERAN Operational Order is approved. Operation DEVERAN is the BF-led maritime response at sea to the threat of facilitated illegal migration using small boats. (Operation DEVERAN is the overarching BF maritime plan until March 2022, when MOD takes primacy for small boats under Operation ISOTROPE.)	INQ000619 INQ010137
16/05/2019	At an Anglo-French Accident Technical Group meeting, it is recorded that “migrants in small, overcrowded craft are still a significant problem”.	INQ000172
05/2019	150 migrants cross the English Channel using small boats.	INQ010134
23/06/2019	The Joint Maritime Security Centre (JMSC) Operational Mandate is approved by its board.	INQ000003 INQ010337 INQ010098 INQ010134
06/2019	HO ‘Small boats response: lessons learned review’ is published internally.	INQ006136
06/2019	163 migrants cross the English Channel using small boats.	INQ010134
07/2019	Internal HMCG document sets out suggested staffing levels by reference to HMCG data.	INQ007223 INQ001329
07/2019	Concerns begin to be raised within the DfT about BF assets being “tied up delivering primarily SAR [search and rescue] in the Channel”, meaning that they are not available for tasking on other missions.	INQ010337
01/07/2019	Emails between the DfT, MCA and other colleagues about a cross-Whitehall meeting on migrants and small boats. These refer to an example question: “perhaps response should be an MCA / RNLI lead rather than Border Force”.	INQ008137

Date	Event	Inquiry reference
05/07/2019	Note, briefing and readout of cross-Whitehall meeting on migrants crossing the Channel in small boats.	INQ008158 INQ008159 INQ008160 INQ006139
12/07/2019	HMCG produces a document setting out illegal migration incident statistics for 2019, which records that 579 migrants have been recovered to date during 2019.	INQ000117
15/07/2019	'General maritime small boat incursions: break report' version 1 is published.	INQ004455
23/07/2019	Email sending readout from small boats meeting, noting responsibility for search and rescue is the driver of this planning meeting.	INQ001119
24/07/2019	Small Boats Planning Group meeting 1 held with attendance from BF, the Joint Maritime Operations Coordination Centre, MCA, MOD and DfT.	INQ001131
07/2019	195 migrants cross the English Channel using small boats.	INQ010134
08/2019	342 migrants cross the English Channel using small boats.	INQ010134
09/2019	An addendum to the France/UK joint action plan is agreed to seek to reduce the number of successful migrant crossings, while reaffirming that "loss of life at sea is to be avoided at all costs".	INQ004467
16/09/2019	'Annex 1: Critical incident update 12 August 2019' of the 'Small boats monthly situation report' from the Joint Slavery and Trafficking Analysis Centre identifies the first reported fatality from a small boat crossing in UK waters.	INQ006143
09/2019	210 migrants cross the English Channel using small boats.	INQ010134

Date	Event	Inquiry reference
10/2019	75 migrants cross the English Channel using small boats.	INQ010134
01/11/2019	BFMC standard operating procedure entitled 'Cutter migrant rescue operating procedures Operation DEVERAN 01-11-2019' is circulated.	INQ003920
19/11/2019	The first 2Excel fixed-wing aircraft contracted to the MCA becomes available.	INQ010335
11/2019	151 migrants cross the English Channel using small boats.	INQ010134
12/12/2019	HMCG mission conduct policy version 7 is circulated.	INQ008922
12/2019	278 migrants cross the English Channel using small boats. By the end of 2019, a total of 1,843 migrants had crossed the English Channel using small boats.	INQ010134
2019	By the end of 2019, the RNLI attends 61 small boat crossing incidents, rescuing 230 people. Using BF and HO data, the RNLI estimates that the average number of occupants on a small boat crossing the English Channel in 2019 is 11.	INQ010101
2020	HMCG review of maritime staffing identifies a risk of potential inconsistency with the adoption of recommended staffing levels and actions taken when a station operates below these levels. It also identified risk to the continuous delivery of functions without denigration of service and the ability to manage demand surge and major incident response at short notice.	INQ007223 INQ001329
2020	The DfT notes that in 2020, "as the scale of the small boats issue increased, so too did the engagement between the Home Office and DfT. DfT's focus was on ensuring that the Home Office was properly apprised of HMCG's SAR [search and rescue] obligations and representing HMCG's interests in inter-departmental contexts".	INQ010337

Date	Event	Inquiry reference
2020-2021	According to the HO corporate witness, the UK/ France bilateral relationship is strained as a result of Brexit, fishing rights disputes, AUKUS submarine deal and Operation SOMMEN (maritime turnaround tactics), although exchange of operational planning products continues.	INQ010134
2020-2021	Migrant numbers arriving by small boat start significantly increasing as boats get larger.	INQ010137
2020-2021	Briefing for the DfT Minister for Maritime on the legal framework for small boats migration. This addresses HO working to develop options to permit the interception of migrants in small boats and their “return at sea” to France, and the DfT raising concern about the proposed tactics.	INQ001929
01/2020	94 migrants cross the English Channel using small boats.	INQ010134
01/2020	From January 2020 to 2022 there is an overall increase in MCA taskings for 2Excel. This is a “planned and contracted increase which was in parallel to the increase in Small Boats”.	INQ010335
01/2020	JMSC holds tabletop exercise to examine a variety of common scenarios relating to the response to small boats, to identify capability gaps and possible improvements.	INQ010134
06/02/2020	At an Anglo-French Accident Technical Group meeting, it is noted that “migrants in small boats still represent a significant problem”, and that both MRCCs need to have a “daily preparation and a fluent dialog [sic]”. It is also noted that the UK is trialling maritime drones, to be used for search and rescue and other missions.	INQ000177
02/2020	183 migrants cross the English Channel using small boats.	INQ010134

Date	Event	Inquiry reference
03/2020	During the first COVID-19 lockdown, small boats become almost the only method of illegal entry to the UK, resulting in a trend of increased crossings, with numbers continuing to rise steeply post-lockdown.	INQ010134
12/03/2020	On or around this date, HMCG produces an updated standard operating procedure relating to migrant activity on small boats.	INQ000413
03/2020	188 migrants cross the English Channel using small boats.	INQ010134
21/04/2020	Strategic briefing titled 'Commission from small boats workshop – tactical options to interdict migrant vessels' issued to Dan O'Mahoney in his role as Director of the JMSC. The briefing identifies a range of tactical options available in 4 scenarios related to small boats.	INQ002350
Before 30/04/2020	HO designates the Serious and Organised Crime Group to own the co-ordination of HO maritime security strategy.	INQ001049
30/04/2020	Home Secretary writes to the Secretary of State for Transport (Transport Secretary) to invite him to a briefing on small boats, and to agree an approach on the issue, including by setting up a joint taskforce.	INQ001049
30/04/2020	DfT emails are sent about a small boats briefing.	INQ001084
04/2020	558 migrants cross the English Channel using small boats.	INQ010134
05/2020	An entry is made in the MCA corporate risk register relating to "the unilateral use of force by Home Office law enforcement bodies to deter, disable or return vessels carrying migrants to the French coast presents a very significant risk to the safety of life at sea" and identifying it as presenting an "intolerable risk" for HMCG.	INQ000167

Date	Event	Inquiry reference
04/05/2020	MCA briefing note on the small boats issue and HO policy/process review is drafted to set out the background to small boats issues and address specific questions before a meeting with ministers.	INQ002387
05/05/2020	DfT email to the MCA provides updates on developments and offers a further discussion.	INQ001947
06/05/2020	Readout of DfT/MCA meeting with Minister Kelly Tolhurst, including on the International Convention for the Safety of Life at Sea (SOLAS) and the return of small boats to France.	INQ001163
13/05/2020	DfT and MCA briefing note addressing their search and rescue role in UK waters. This includes consideration about a developing HO proposed tactic to disable migrant vessels, which HMCG considers is unnecessary to safeguard life at sea and poses a risk to the safety of those on board. It also raises concerns about legal risk in relation to the policy.	INQ002510
20/05/2020	HO holds an exercise and trial of tactics to prevent small boats arriving in the UK (led by Daniel O'Mahoney as exercise Commander). Other organisations are involved in planning this and attend the exercise, including HMCG.	INQ004968 INQ002504
21/05/2020	Review of MCA tasking of aerial surveillance aircraft for proactive illegal migration patrols.	INQ006155
05/2020	743 migrants cross the English Channel using small boats.	INQ010134

Date	Event	Inquiry reference
06/2020	The clandestine operations response team (CORT) “was formed within IE [Immigration Enforcement] as a dedicated response team to address the increasing numbers of small boats crossing the Channel”. CORT was primarily landside and works with BFMC surface assets and other UK agencies. It is noted that “at this point, each element of the Home Office and partner agencies were working mostly in isolation without a unifying strategy and operational plan”.	INQ010134
10/06/2020	Email is sent by the HO to various recipients with readout of Home Secretary and Transport Secretary meeting on maritime security on 9 June 2020. The readout states that the Secretary of State for Transport considered the current approach to rescues at sea was encouraging people to attempt the crossing and that there should be a cross-government approach, with additional surveillance capabilities.	INQ009136
06/2020	727 migrants cross the English Channel using small boats.	INQ010134
01/07/2020	National Maritime Security Committee meeting which discussed the “significant increase” in crossings and agreed that small boats should be ranked higher in the maritime risk assessment.	INQ009109
09/07/2020	MCA's Operation EOS (Tasking Policy for Migrant Surveillance Patrols) is published. Operation EOS is “HM Coastguard's proactive deployment of fixed-wing air assets for SAR [search and rescue] purposes in the Southeast of the UK in response to small boat activity”.	INQ000459 INQ010098
22/07/2020	The MCA plans to formalise Vessel Traffic Service (VTS) training (later overtaken by a reorganisation of VTS in April 2021).	INQ007384

Date	Event	Inquiry reference
23/07/2020	MCA Board meeting agenda item 3 (Chief Executive report July 2020) acknowledges a dramatic increase in the number of crossings of “often more than 100 in a day”.	INQ008042
28-29/07/2020	Update from cross-Channel illegal migration co-ordinator on meeting to discuss closer co-operation for deployment planning and information exchange with France, and discussions about sharing information from aerial surveillance with French authorities.	INQ004977
30/07/2020	HMCG commences a series of red day meetings. The situation at Dover is discussed, and it is noted that keeping on top of administration is becoming a challenge when BF uses different references. It is suggested that “the spreadsheet” could be shared with BF so that both can populate the same document. These are MCA internal-only meetings until 16 November 2021.	INQ010098 INQ009930
31/07/2020	Request is sent to the National Maritime Information Centre by HMCG for the HMCG spreadsheet to be shared with BF.	INQ009930
07/2020	1,111 migrants cross the English Channel using small boats.	INQ010134
08/2020	Following a military aid to civil authorities request from the HO, MOD vessels undertake trials with BF to test the turnaround policy. No migrants are involved in the trials. It is noted that the Army Unmanned Aerial System Watchkeeper has delivered effective intelligence, surveillance and reconnaissance support to Operation DEVERAN.	INQ009649 INQ008978

Date	Event	Inquiry reference
08/2020	The CCTC is created within HO, absorbing CORT. It is established to lead the overall cross-government response to clandestine entry to the UK and is responsible for the intelligence picture around small boat crossings, including engagement with French authorities on countering organised crime, and the collection, assurance and dissemination of data on migrant crossings. (At 23 to 24 November 2021, the HO operational response to small boat crossings is led by the CCTC.) Daniel O'Mahoney (author of the HO corporate statement INQ010134) is appointed as the Director of the CCTC on its creation and remains in post at the time of the incident (and until December 2022).	INQ010137 INQ001108 INQ010134
04/08/2020	Minutes of HMCG red day meeting record an "overview on the current position at Dover with staffing, VTS and migrant incidents and hence the reason for these meetings and the need for support from the National Network".	INQ009929
06/08/2020	Minutes of the HMCG red day meeting record "spreadsheet shared and BF numbers updated as day progresses". There is discussion about arrangements for network flexing to support Dover.	INQ009931
19/08/2020	Small boat incident. An MCA standards review of this incident records that there was an extensive search for a vessel which was not located in the Channel, although it was later established that the casualties had safely come to shore. There was effective initial call connection, but it was not possible to obtain positional information, and there were delays in information recording. There was a Mayday relay 'free format' an hour and 40 minutes into the incident – it was suggested this should have taken place sooner. There is a reference to intense pressure on Dover and the RNLI, impacting on operations due to fatigue and malaise. There is also some criticism of the search planning. Recommendations are made about recording in ViSION and considering earlier broadcast action.	INQ008902 INQ010098

Date	Event	Inquiry reference
28/08/2020	Following a military aid to civil authorities request from the HO, the MOD provides uncrewed aerial systems over the Channel to monitor migrant routes, supporting this with both crewed and uncrewed surveillance flights.	INQ009649
08/2020	1,469 migrants cross the English Channel using small boats.	INQ010134
03/09/2020	Discussion points for meeting between the DfT and MCA on 3 September 2020.	INQ001337
04/09/2020	Readout of MCA/DfT meeting sent by the DfT, including agreement about criteria to assess whether the MCA or Border Force is most appropriate to respond to incidents, and that volunteers are coming under pressure from local communities about their involvement in intercepting migrants. The Secretary of State is to be made aware of pressures and resource implications for the MCA.	INQ001164
09/09/2020	Minutes of the HMCG red day meeting note that MRCC Dover is low on staffing numbers.	INQ000214
Autumn 2020	In autumn 2020 (Daniel O'Mahoney's evidence to Inquiry) or summer 2021 (Matthew Leat's evidence), the Joint Control Room is established at MRCC Dover. HO personnel are located in the Joint Control Room to share information such as images from HO drones to support HMCG search and rescue operations and co-ordinate the HO's 'land side' response to small boat crossings.	INQ010134 INQ010098
09/2020	Exchange of emails about draft Home Office policy statement (INQ010118) and impact assessment addressing small boats and returns at sea for input from other organisations, including the DfT, MCA, International Maritime Organization, MOD and others.	INQ009388 INQ010118 INQ010119
17/09/2020	The Home Secretary is briefed on small boat funding and performance impact. The note sets out historic and planned costs.	INQ009676

Date	Event	Inquiry reference
24/09/2020	Clandestine threat briefing pack containing information for the period April to June 2020.	INQ004462
30/09/2020	At a migrant activity interoperability meeting between HMCG and the Centre Régional Opérationnel de Surveillance et de Sauvetage Gris-Nez, under the agenda item 'SAR resources available within SRRs', a minute records the French assets available. ³ It is also noted that "both sides have insufficient assets to deal with heavy days". It is recorded that Gris-Nez uses an iPad to communicate with migrants by WhatsApp. HMCG says they will look to do this too.	INQ000217
09/2020	1,949 migrants cross the English Channel using small boats.	INQ010134
10/2020	HMCG publishes a major incident plan, which remains in force at the date of the incident. It makes no specific reference to migrant incidents.	INQ000415
01/10/2020	Bristow's 'SAR Operational Support Operations Manual Part A Supplement' is published.	INQ005345
01/10/2020	HMCG and the RNLI sign a memorandum of understanding (MoU) on co-operation in search and rescue.	INQ000096

3 References in the chronology to MRCC Gris-Nez, CROSS Gris-Nez and Cros Gris-Nez are to the same location, and reflect the terminology used in the underlying source.

Date	Event	Inquiry reference
16/10/2020	HO produces a slide pack addressing the activity of its operations room in relation to small boats. This includes setting up a presence at MRCC Dover. The document addresses “SAR v Law Enforcement”, stating that search and rescue incidents will be co-ordinated by Dover Coastguard, and will remain under their co-ordination until declared as a law enforcement incident. Search and rescue cannot be discontinued unless the vessel is not in distress in any way. It is noted that the policy and procedures for a termination of search and rescue are still being “worked through” by HMCG, the RNLI and BF.	INQ000416
19/10/2020	HMCG guidance on Dover WhatsApp use is published.	INQ006747
10/2020	474 migrants cross the English Channel using small boats.	INQ010134
11/2020	First meeting of the CCTC Delivery Board is held (attended by DfT).	INQ001108
11/2020	A report is presented to Parliament on the inspection by the Independent Chief Inspector of Borders and Immigration of the Home Office’s response to in-country clandestine arrivals (‘lorry drops’) and to irregular migrants arriving via ‘small boats’ from May to December 2019. This concludes that the HO’s involvement in the response to the surge in small boats is having a negative impact on other business areas. It concludes that the HO does not have the capacity or capabilities to manage this threat effectively. The report addresses contingency plans for dealing with a surge in arrivals. The report makes recommendations, including to engage cutter and coastal patrol vessel crews in consultation to review and address concerns, and to ensure that all crew members have personal equipment needed to perform their duties effectively and safely, and that standard operating procedures are comprehensive and updated in line with events.	INQ004467

Date	Event	Inquiry reference
02/11/2020	MRCCs Dover and Gris-Nez meeting, which records that there seems to be some inconsistency about communication, and that telephone and email communication has been a little slow for migrant incident information.	INQ000219
09-10/11/2020	Migrant activity interoperability meeting between MRCCs Dover and Gris-Nez on 2 December 2020, which records that French colleagues have been slow with informing the UK about ongoing migrant operations and providing their tracker, requiring chasing. On the same date, Cros Gris-Nez raises for discussion the use of remote piloted aircraft systems for migrant search and rescue operations, suggesting Dover Coastguard Operations Centre could benefit from this, and that the French are also trying to get one.	INQ000218
17/11/2020	Readout from small boats meeting between BF, the DfT and the MCA recording concern about HO turnaround proposals.	INQ001105
20/11/2020	The MCA briefs the DfT Minister for Maritime on developments and concerns on proposed HO policy on returns at sea.	INQ005060
20/11/2020	Document for MCA Sponsorship Board December meeting – agenda item 3 (Chief Executive high-level summary). This addresses concerns about small boats and proposed BF tactics such as pushing boats over the median line and towing laden boats at sea.	INQ001016
23/11/2020	Meeting to discuss termination of search and rescue protocol.	INQ005046
28/11/2020	The UK and France sign a joint statement on collaboration on tackling illegal migration.	INQ010134
11/2020	761 migrants cross the English Channel using small boats.	INQ010134

Date	Event	Inquiry reference
03/12/2020	Submission from the MCA to the Transport Secretary addressing the MCA's concerns about the HO proposed turnaround policy, and their potential contravention of international search and rescue obligations.	INQ010098 INQ001171 INQ001174
03-09/12/2020	The CCTC Commander (Daniel O'Mahoney) sends a submission to the Home Secretary and Minister for Immigration Compliance regarding the CCTC's winter preparedness, to be read in conjunction with the winter preparedness clandestine response. This confirms that Met Office analysts have been commissioned to provide an enhanced product to predict the likely locations and scale of migrant activity to improve prediction of activity. The CCTC is also considering deploying a Royal Navy autonomous surveillance vessel, known as MADFOX, from January 2021 but this is delayed due to regulation issues and its use does not progress beyond testing.	INQ010134 INQ008340 INQ008338
16/12/2020	Following a military aid to civil authorities request from the HO, the MOD provides 2 personnel to form an intelligence exploitation team in support of the multi-agency hub.	INQ009649
17/12/2020	Operation ALTAIR – Gold Commander's Strategy is published within the HO.	INQ005230
21/12/2020	Operation ALTAIR is launched as the cross-government response to end the viability of small boats crossings as a route to entering the UK illegally. Operation ALTAIR's strategic aims are to "save lives, secure the UK border, improve public confidence and identify vulnerable people".	INQ010134 INQ000619 INQ010445
12/2020	209 migrants cross the English Channel using small boats. By the end of 2020, a total of 8,466 migrants have crossed the English Channel using small boats.	INQ010134
2020	In late 2020, RVL Aviation responds to industry engagement opportunities with the HO.	INQ010102

Date	Event	Inquiry reference
2020	By the end of 2020, the RNLI has attended 159 small boat crossing incidents, rescuing 1,374 people. Using BF and HO data, the RNLI estimates that the average number of occupants on a boat in 2020 was 13.	INQ010101
01/2021	2Excel's provision of Panther fixed-wing aircraft to the MCA is enhanced with a third Panther aircraft added to the Panther contract, to meet a requirement for increased flying hours.	INQ010335
01/2021	An MoU is signed between the HO and the MCA in respect of the exchange of information.	INQ000100
11/01/2021	MRCCs Dover and Gris-Nez hold a joint meeting at which MRCC Gris-Nez raises concerns in relation to operational capability in the context of recent migrant incidents. MRCC Gris-Nez are concerned about a change in direction of small boat travel creating a much larger area of water to cross.	INQ000181
14/01/2021	Operational response conference call between HMCG, BF and the RNLI. There is a discussion of recent incidents involving migrant activity. It is recorded that intelligence had been requested from partners on changes to launch sites and tactics caused by French law enforcement success.	INQ000182
01/2021	224 migrants cross the English Channel using small boats.	INQ010134
02/2021	308 migrants cross the English Channel using small boats.	INQ010134
03/2021	There is a trial of the use of crew transfer vessels for small boat operations by BF.	INQ010137
04/03/2021	Operational response conference call between HMCG, BF and the RNLI, recording discussions about marking small boats and a possible trend of medical emergencies occurring on small boats.	INQ000189

Date	Event	Inquiry reference
04/03/2021	Operational response conference call between HMCG, BF and the RNLI, recording the RNLI raising concern in relation to the age of BF vessels. BF states that “fleet renewal” is in process.	INQ000189
09/03/2021	Anglo-French Accident Technical Group meeting (UK/France), recording that migrant incidents remain common.	INQ000192
16/03/2021	DfT email to the MCA on ‘Small boats: check in’ acknowledging that the crossing statistics were “very large” and “much bigger month on month compared to previous years”. It stated that it was anticipated that the numbers would be very high in the summer.	INQ004881
29/03/2021	Internal publication of the following documents: • HMCG ViSION – Multiple call, scenario and incident functions • HMCG incident coordination • HMCG network conference call instructions • HMCG C-Scope simulated tracks	INQ000435 INQ006199 INQ003767 INQ000437
03/2021	831 migrants cross the English Channel using small boats.	INQ010134
04/2021	The Operation DEVERAN operational plan is revised and updated. Among other things, it states that work is underway to move the crew change date of the DEVERAN surge cutter. This will allow the surge cutter to cover the time of the crew change of the primary DEVERAN cutter, thereby enhancing operational capabilities.	INQ000619
04/2021	HO Criminal and Financial Investigations Officers are deployed onto squadron vessels on a regular basis to “enhance the Law Enforcement response” to small boat crossings.	INQ000619

Date	Event	Inquiry reference
01/04/2021	MRCCs Dover and Gris-Nez meeting. Concern is noted about migrant incidents being left at the median line before UK vessels are on scene, with an action for Dover to investigate direct communications between French and UK assets on scene.	INQ000194
08/04/2021	HMCG policy: 'SAD – mobile communications devices' is published internally.	INQ003796
09/04/2021	HMCG policy: 'SAC – search patterns' is published internally.	INQ000431
09/04/2021	HMCG policy: 'SAC – datum point' is published internally.	INQ003785
15/04/2021	Annotated agenda for and readout from MCA/DfT meeting about ongoing discussions with BF about balancing SOLAS obligations with BF objectives.	INQ001338 INQ001175
26/04/2021	HMCG alerting and tasking general guidance published internally.	INQ006200
04/2021	750 migrants cross the English Channel using small boats.	INQ010134
05/2021	From May 2021, tactical watercraft (including jet skis) are to be deployed by BF under Operation DEVERAN.	INQ000619
03/05/2021	MRCCs Dover and Gris-Nez meeting, at which there is “discussion around direct comms between French & UK assets on scene (VHF CH67 or 68) to ensure casualty vessel is not left unattended”. An action is set for Dover MRCC to speak to BF on this.	INQ000193
04/05/2021	HMCG search and rescue co-ordination and response and maritime assistance policy published internally.	INQ000430
06/05/2021	HMCG zone flexing policy published internally.	INQ000456
09/05/2021	BF email circulating revised Operation DEVERAN Operational Order.	INQ002059

Date	Event	Inquiry reference
10/05/2021	HMCG and the RNLI sign MoU on co-operation in international activity.	INQ000098
12/05/2021	At an operational response conference call attended by HMCG, the RNLI and BF, the RNLI raises a “concern or observation” around BF requesting Dover Coastguard to task Dover all-weather lifeboats, when BF had “reached their hrs”.	INQ000195
29/05/2021	An incident occurs involving a small boat, which resulted in an HMCG Tier 3 incident review. Various issues are raised, and recommendations made, including in relation to information shared between France and HMCG.	INQ008909
05/2021	1,627 migrants cross the English Channel using small boats.	INQ010134
Summer 2021	HMCG is notified by the HO that the predictions of crossings for 2022 could reach 60,000 people. HMCG determines that additional staffing is required for small boats incidents.	INQ010098
06/2021	HMCG provides a Coastguard Clandestine Operations Liaison Officer to be based in the Joint Control Room and to liaise with HO teams.	INQ010098
06/2021	An MCA training document on confirmation bias and human factors is created on or around June 2021.	INQ000362
06/2021	The CCTC, via the HO, requests support to develop new operational plans to respond to the diversification of the small boat threat and the potential of new launch sites.	INQ009649 INQ008980
04/06/2021	An MoU is signed between the HO and MCA for the provision of the MCA spotter aircraft (provided by RVL Aviation) for proactive reconnaissance trials.	INQ000097

Date	Event	Inquiry reference
07/06/2021	MRCCs Dover and Gris-Nez meeting, at which there is ongoing discussion about “direct comms between French & UK assets on scene (VHF CH67 or 68) to ensure casualty vessel is not left unattended”.	INQ000196
10/06/2021	HMCG policy distress phase checklist is published internally.	INQ000438
11/06/2021	At an operational response conference call attended by HMCG, the RNLI and BF, the RNLI states that during an incident there had been no positive communication from BF, who were “very grumpy and there appeared to be no mutual friendliness”.	INQ000198
14/06/2021	In response to an earlier CCTC request, MOD provides one planner to the CCTC for a period of 4 weeks from this date.	INQ009649 INQ008980
28/06/2021	In response to an earlier CCTC request, MOD provides one Liaison Officer to the CCTC for a period of 4 months from this date.	INQ009649 INQ008980
30/06/2021	It has become clear to the HO, “... by the end of Q2 (i.e. by 30 June 2021) that that year’s total [small boats] arrivals were likely to eclipse that of 2020”.	INQ010134
30/06/2021	The Home Secretary chairs a ‘Small boats – operationalisation of maritime tactics’ meeting. At around this time, a timeline has been prepared setting out steps to be taken in relation to turnaround.	INQ004299 INQ001089
06/2021	2,177 migrants cross the English Channel using small boats.	INQ010134
07/2021	BFMC brings the first crew transfer vessel (Hurricane) into live service, which goes on to replace a coastal patrol vessel. The crew transfer vessel has “a platform which was well suited to migrant rescue, particularly given its size and stability”. Hurricane is intended to be deployed during the busiest periods because it is better suited to search and rescue and can carry larger numbers.	INQ010134 INQ010137

Date	Event	Inquiry reference
07/2021	Regular, often weekly, small boats meetings start to be held by the DfT, attended by members of the DfT Maritime Security Division, HMCG and DfT legal advisers. Issues discussed include matters such as the Nationality and Borders Bill and communications strategy (the DfT corporate statement emphasises that any discussion of operational matters at these meetings was at a high level). These meetings, which are not minuted, take place via Microsoft Teams.	INQ010337 INQ010098
01/07/2021	HO makes a military aid to civil authorities request to the MOD for support to the CCTC in the form of planning, development of tactics, assets and personnel to support the SOLAS operation. The request is subsequently cancelled.	INQ009649 INQ008936
01/07/2021	HMCG policy: 'Vessel – sinking or taking water' is published internally.	INQ000453
01/07/2021	HMCG policy: 'Vessel – unsure of position' is published internally.	INQ000455
02/07/2021	The MCA contracts Language Line Solutions to provide an interpreting service. The HMCG document relating to this states that it can be used for operational purposes "whenever language is causing a problem". The procedure (which involves providing a code, introducing the speaker, briefing the interpreter and other steps, before interpretation is provided) is set out in the document.	INQ006203
05/07/2021	MRCCs Dover and Gris-Nez meeting, at which there is further discussion about "direct comms between French & UK assets on scene (VHF CH67 or 68) to ensure casualty vessel is not left unattended".	INQ000197
07/07/2021	The HO makes 2 military aid to civil authorities requests to MOD for planning support to Operation DEVERAN in the development of an operational capability to safely turn around migrant vessels.	INQ009649

Date	Event	Inquiry reference
09/07/2021	DfT/MCA small boats actions tracker is circulated.	INQ002940
11/07/2021	Search and rescue incident involving a small boat which results in an HMCG Tier 1 review. It is noted that the floor of the craft had collapsed as a UK BF asset arrived on scene. Various issues are identified, in particular in relation to obtaining and recording information. It is also noted that certain capabilities had not been used. Actions for improvement are recorded.	INQ008906
12/07/2021	RNLI concerns are raised that HMCG is tasking lifeboats to assemble and go afloat preventatively without specific search and rescue taskings in order to provide resilience to BF. An operational decision is made to not respond to incidents that are not deemed as search and rescue or distress calls.	INQ003092
12/07/2021	HMCG 'Flowchart for migrant incident – termination of SAR' is published.	INQ003004
16/07/2021	DfT/MCA small boats action tracker is circulated.	INQ003061
19/07/2021	Meeting between the MCA and DfT, at which the standing down of search and rescue and BF tactics are discussed.	INQ001335
20/07/2021	The UK and France sign further joint statement on tackling illegal migration.	INQ010134
21/07/2021	The RNLI informs the DfT of plans for media engagement in relation to migrant crossings. The RNLI states that the level of activity being carried out by crews in the South East region is at an all-time high, and there is growing concern and frustration at having to defend the core purpose of the RNLI. The RNLI refers to concerns raised on the 12 July 2021, and states that there is a fear that crews are being put in an impossible position and subject to significant hostility in their personal lives and are losing the support of their employers as they are tasked so heavily during calm weather.	INQ003092

Date	Event	Inquiry reference
22/07/2021	The Chief Coastguard sends an email stating that he is disappointed that recipients had not come up with a solution to increase the effectiveness of the leadership and migrant incident response at Dover. He is concerned that HMCG is unable to demonstrate that migrant incidents are being managed and recorded in the same way as other distress or alert phase incidents, and this must change.	INQ003103
25/07/2021	Monthly small boat placemat, at which a 'forward look' records it is likely that small boat activity will increase in the next few months, with small boat activity peaking in August and September 2021. At the time of publication, June 2021 has the highest number of "boat migrants" recorded to date.	INQ003066
27/07/2021	Home Affairs Select Committee visit to Dover to review various areas, including the Joint Control Room and MRCC, and Tug Haven facilities.	INQ003174
29/07/2021	HMCG internal email about migrant operations in Dover and plans for changes to arrangements.	INQ003195
29/07/2021	Decision is made to increase the complement at Dover to 2 "MAROPS" (understood to refer to Maritime Operations) controllers (this is ratified at a meeting on 13 October 2021).	INQ007384
29/07/2021	In response to a question in the House of Lords, the HO confirms the assets available in the BF fleet, and that as a minimum a cutter and 2 coastal patrol vessels will be permanently deployed to cover the Dover Strait.	INQ000009
30/07/2021	The Clandestine Operations Liaison Officer is working with HMCG to develop a training package for HMCG Search and Rescue Mission Co-ordinators (SMCs) and Commanders relating to small boats, but the training is said to be on hold at that time due to issues with releasing the updated small boat standard operating procedure and protocol more widely.	INQ003217

Date	Event	Inquiry reference
07/2021	3,512 migrants cross the English Channel using small boats.	INQ010134
08/2021	In August and September 2021, presentations on small boat procedures are delivered to officers at the JRCC, MRCC Dover and MRCC Humber. Training includes information on the use of the small boats tracker shared between HMCG and BF, known as the UK shared tracker.	INQ010098 INQ008914
Early 08/2021	Proposed protocol is being tested. It is planned that the small boat protocol and standard operating procedures will be implemented in September. Input is being given on the draft standard operating procedure and protocol.	INQ003239 INQ003294 INQ003316
08/2021	HMCG commences recruitment for additional staff at MRCC Dover, resulting in the appointment of 9 officers.	INQ010098
03/08/2021	A search and rescue incident involving a small boat, resulting in an HMCG Tier 1 review, with concerns noted about the use of the remote SMC, and providing more officers at Dover.	INQ008907

Date	Event	Inquiry reference
04/08/2021	A migrant incident activity report is produced by the HM Coastguard Clandestine Operations Liaison Officer on a particularly busy day for crossings. This refers to the use of scripts used when contacting emergency services, specifically referring to “vessel sinking”, “critically ill individuals” and “loss of engine”. The report notes that: • there had been a delay in sharing the French migrant tracker, which already contained over 23 incidents when it was shared • as the apparent number of migrant vessels in distress had increased, there had been a loss of effective communication with the remote SMC, which had consequences to shared situational awareness and a joint understanding of risk • during a 10-minute aerial tasking meeting, 4 distress phase incidents had been created (many, on review, from the same vessel) • there were issues with sufficiency of resources to attend incidents – one migrant vessel had been left for over 2 hours with a single BF jet-ski, and resources were becoming stretched (there were often no available assets) • later during the incident, the newly appointed SMC had focused on analysing where there were overlaps or duplication in incidents • the Maritime Operations Officers had been struggling with the amount of information, logging it, analysing it and communicating with the remote SMC, and had inadequate time for breaks.	INQ007279

Date	Event	Inquiry reference
	These were not new observations: BF colleagues had also raised that previous red days had seen staff at MRCC Dover displaying signs of tiredness bordering on exhaustion with a consequent drop in performance, particularly when there had been multiple red or amber days, with the same team (often with Maritime Operations Officers under training) having to manage the response. The Clandestine Operations Liaison Officer identifies the critical risks arising from the above to include: • loss of organisational reputation • staff retention, welfare and morale • loss of life at sea from ineffective or inadequate preparation and/or response • failure to recognise or declare a major incident when the criteria have been met – the definition of major incident is an event or situation with a range of serious consequences which require special arrangements to be implemented by one or more responder agency • inability to adequately defend the organisation at any subsequent investigation, inquest or enquiry which focuses on post-incident reviews and/or lessons learnt. The Clandestine Operations Liaison Officer makes 9 recommendations as follows. 1. The presence of an SMC physically based at MRCC Dover for all amber and red days. 2. Sufficient trained personnel at MRCC Dover for all amber and red days to support the SMC. 3. Conducting adequate preparation and resourcing when there is credible intelligence and/or information to indicate that an amber or red day is likely.	

Date	Event	Inquiry reference
	4. The implementation of standard operating procedures and protocols that are tested, trained, exercised and regularly reviewed. 5. The implementation of migrant specific post-incident reviews both internally and with partner agencies to ensure that lessons are learnt, and that new strategy and/or tactics can be developed. 6. Welfare support for staff who are exhibiting any signs of stress, tiredness and/or a drop in performance due to repetitive exposure to amber and red days. 7. The proportionate and careful use of 'broadcast action' when dealing with multiple migrant incidents in distress and 'broadcast actions' which can be focused on specific vessels by using C-Scope/Automatic Identification System. 8. Early access to the French migrant tracker can ensure that the operations room aren't overwhelmed with information immediately and have sufficient time to assess the data. This was apparent when Thursday (5 August) started with 7 incidents on the French tracker as opposed to 23 incidents on Wednesday. 9. The creation of one UK migrant incident tracker which all parties (HMCG and BF) can access and input into.	

Date	Event	Inquiry reference
04/08/2021	DfT/MCA small boats action tracker is circulated.	INQ003244
05/08/2021	BFMC publishes a turnaround tactic and delivery plan for Dover between 9 and 29 August 2021. This is a planning document setting out a timeframe and content for training towards operational delivery of the small boats turnaround tactic.	INQ003252
06/08/2021	DfT/MCA small boats action tracker is circulated.	INQ003257 INQ003261
15/08/2021	A further migrant incident activity report is produced by HMCG's Head of International Liaison, which "mirrored or further supported" some of the observations, risks and recommendations made in the report dated 4 August 2021. It notes loss of life as a risk and makes recommendations which largely mirror those in the 4 August review. The report addresses actions required at the strategic, tactical and support level. The review highlighted that there was a risk of loss of life through ineffective or inadequate preparation and/or response, as well as a negative impact on staff retention, welfare and morale. It states there is a risk from failure to recognise that yellow, amber and red days "are not SAR [search and rescue] business as usual" and that, despite being usually accurately predictable within 48 to 72 hours' notice, "no mitigations are being put in place as would be for other events with possible major SAR implications". It also notes that there is a risk of being unable to adequately defend the organisation in a subsequent inquest or inquiry.	INQ003323
16/08/2021	Chief Coastguard requests an urgent internal meeting to discuss the Dover migrant response.	INQ003320

Date	Event	Inquiry reference
17/08/2021	HMCG internal email setting out points for discussion relating to reports of the 4 August 2021 and 15 August 2021, including key areas of concern and recommendations. Concerns include lack of situational awareness and challenges of the remote SMC, staff at capacity for long periods, numerous migrant trackers, high level migrant activity not restricted to red days, and not making a declaration of a major incident when high intensity days would meet that definition.	INQ003322
17/08/2021	HMCG internal email states that MRCC Dover is low on staff numbers, experience and competence, and appeals to qualified staff from elsewhere within the HM Coastguard network to undertake work at Dover until around October, by which time new staff will have been trained.	INQ003327
17/08/2021	HMCG training presentation on migrant incidents phases of response.	INQ008914
18/08/2021	MRCCs Dover and Gris-Nez meeting, at which there is further discussion about “direct comms between French & UK assets on scene (VHF CH67 or 68) to ensure casualty vessel is not left unattended”. Dover had spoken to BF a few months back, but this requires further discussion and would be taken to the BF tabletop exercise for discussion, with a target date of the 31 August 2021. A request is also made for the French migrant tracker to be emailed to Dover as often and early as possible, with the French agreeing to feed this back to their operations room.	INQ000199
19/08/2021	Discussion by HMCG Maritime and Aviation Operational Lead about direct very high frequency (VHF) communications between BF and French vessels, which concludes that this will not be possible as VHF communications were not secure, and the operations were too sensitive.	INQ003333

Date	Event	Inquiry reference
21/08/2021	A further HMCG debrief on migrant activity sets out initial themes identified, with a full debrief report to follow. The document identifies issues at the strategic, tactical and support level, including that there was no information flow from JMSC, that intel flow from the Joint Control Room and BF was slow, that the lack of situational awareness resulting would delay tactical and operational decision-making with knock-on impacts to working with the RNLI, and that staff were overwhelmed by volume of work and were unable to remove themselves from operational level work to take tactical command, while operational staff were also overwhelmed. The document stated that situational awareness and information flow were impeded by partners working on Airwave while HMCG worked on VHF and identified that there needed to be dedicated operator monitoring of Channel 16. The document notes: “Welfare of staff – it was very clear that the BF JCR [Joint Control Room] staff, Dover ops team and [NAME OF STAFF MEMBER] were all under significant stress and effectively “firefighting”. All were unable to take any effective breaks, and/or refreshments which compounded human factor and welfare risks.” The document also identified that the risks arising from these issues included loss of life through ineffective or inadequate preparation and/or response, as well as loss of situational awareness.	INQ003379
23/08/2021	Stephen Whitton sends an email to HMCG officers (including George Papadopoulos) and BF staff to discuss turnaround tactics and the roles, working practices and training that will be required for it.	INQ003344
24/08/2021	HMCG policy: ‘Emergency telephone call handling’ is published internally.	INQ005185
25/08/2021	DfT/MCA small boats action tracker is circulated.	INQ008052

Date	Event	Inquiry reference
25/08/2021	Email from JRCC Manager records that the Chief Coastguard wants a dedicated fixed-wing aircraft for migrant activity surveillance for all red and amber days, and that this has been discussed and agreed with 2Excel.	INQ003365
27/08/2021	Email chain commencing on 27 August 2021 and ending on the 15 November 2021, during which time BF request and attempt to obtain access to the UK shared tracker.	INQ010051
09-29/08/2021	HO-led training programme on turnaround tactics.	INQ003252 INQ003333
End of August 2021	Arrangements are being made for the roll-out of training for the new migrant incident standard operating procedure and search and rescue termination protocol, with a plan for the documents to be published internally by 6 September 2021.	INQ003384 INQ003387
08/2021	3,053 migrants cross the English Channel using small boats.	INQ010134
August and September 2021	The HO observes a substantial increase in the number of crossing attempts, indicating that the outturn for the year is likely to significantly exceed that of 2020.	INQ010134
August and September 2021	Training is delivered within HMCG on small boat procedures, including use of the HMCG tracker, and on the use of the incident migrant activity standard operating procedure and search and rescue termination protocol. Full training is not provided to all SMCs during the initial period due to shift working.	INQ010098 INQ004663 INQ008914 INQ003396 INQ004550
09/2021	HMCG launches a second recruitment campaign, resulting in 5 officers being recruited.	INQ010098
01/09/2021	HMCG emails about tasking for migrant activity, indicating the Chief Coastguard wanted a dedicated fixed-wing asset for surveillance on red and amber days and noting that 2Excel had agreed to this plan.	INQ003400

Date	Event	Inquiry reference
02/09/2021	The Clandestine Operations Liaison Officer requests assistance in drafting a formal agreement for the sharing of the HMCG tracker with BF.	INQ009941
07/09/2021	MCA Board meeting held. An update is provided on the latest position on migrant crossings, including an increase in crossings due to recent good weather, and the creation of a new team who would work a shift pattern coinciding with anticipated crossing to minimise pressure on the national network. An update is provided on surveillance cover during recent peak crossing periods.	INQ003736
09/09/2021	An exercise is conducted where HMCG exercised command and control of new small boat tactics with BF. This is held at the Joint Control Room at MRCC Dover to test communications and decision-making with BF and HMCG.	INQ010098
09/09/2021	DfT/MCA small boats action tracker is circulated.	INQ003424
09/09/2021	BF holds training on turnback termination protocol tactics, with further planned training on 13 September.	INQ000200
09/09/2021	HMCG policy: 'SAR incidents involving migrants' is published internally.	INQ000449
10/09/2021	At an operational response conference call attended by HMCG, the RNLI, and BF, it is recorded that recent small boat incidents involved "one trip only vessels" which are not made to commercial standards and are not seaworthy, posing a much greater risk of search and rescue. The RNLI notes that the migrant vessels are "bigger and less safe" and raise the burden on their crews/volunteers.	INQ000200
11/09/2021	The Times report on planned procurement by the HO for BF, including replacing the existing cutter fleet, since its 5 cutters are "at least 17 years old and are regularly out of service for repair".	INQ000009

Date	Event	Inquiry reference
13/09/2021	Protocol for HMCG termination of search and rescue.	INQ007381
14/09/2021	Stephen Whitton sends an email to George Papadopoulos and other HMCG and BF staff confirming that his team have continued to train in delivering the Operation SOMMEN tactics while a decision from the Home Secretary remained pending.	INQ003449
16/09/2021	MRCCs Dover and Gris-Nez meeting attended by the Dutch Coastguard. MRCC Gris-Nez sends apologies.	INQ000216
20/09/2021	HMCG policy: 'SMC roles and responsibilities' is published internally.	INQ000401
22/09/2021	At an operational response conference call attended by HMCG, the RNLI and the Border Force Liaison Officer, it is noted that an unspecified email had a "negative impact for the RNLI", and it is noted that the "RNLI would rather know when BF are low on assets so they can feed it back to the crews".	INQ000201
22/09/2021	In a draft letter titled '2021 09 22 - Draft letter to centre - UK France position and maritime tactics RM.docx' which appears to have been drafted by the MCA, readiness to deploy maritime turnaround tactics and concerns in relation to France's view of the tactic are discussed.	INQ003472
23/09/2021	MCA Sponsorship Board meeting note and actions, including an update on numbers of crossings (over 1,000 people rescued in 3 days in early August and 814 people rescued across 84 incidents on 21 August). The Board noted "diplomatic issues with France" and pressures on fixed-wing aircraft.	INQ008057
23/09/2021	A CCTC campaign plan assessment workshop for Operation SOMMEN takes place. The aim of the exercise is to review the Operation SOMMEN procedures and HMCG search and rescue termination for small boats.	INQ010098

Date	Event	Inquiry reference
24/09/2021	Updated MCA aircraft tasking policy (Operation EOS HMCG) version 1.12 is published internally.	INQ005198
24/09/2021	MRCCs Dover and Gris-Nez meeting, which discusses a recent small boat incident in which a French ship's offer of assistance and rescue had been refused by some of the migrants. MRCC Dover asks if there were “any thoughts around [deploying a second rescue craft] for future incidents that may result in... multiple people in the water”. There are also discussions about issues of clarity concerning who had overall co-ordination, and Dover not knowing about the incident until seen by a UK helicopter. MRCCs Dover and Gris-Nez discuss how they could “make this better”.	INQ000208
27/09/2021	Report for MCA Board October 2021 meeting – agenda item 3 (Chief Executive’s organisational report) concerning plans by BF to implement turnaround tactics, stating “at the time of writing, Number 10 has not authorised the use of the tactics – we do not know why”.	INQ003509
28/09/2021	The CCTC informs the HO and Minister for Immigration Compliance and Justice that BFMC stands ready to deploy turnaround tactics and answer further questions arising from a submission on 16 September 2021 seeking policy clearance.	INQ003508
28/09/2021	DfT/MCA small boats action tracker is circulated.	INQ009215
29/09/2021	At an operational response conference call, the RNLI notes that there has been a busy weekend for Walmer RNLI, who have been out for over 6 hours, and that there are concerns around landing people at Ramsgate.	INQ000212
30/09/2021	HMCG temporary operating instruction ‘Migrant – red/amber end-of-day sweep tasking’ is published internally.	INQ006195
30/09/2021	DfT/MCA small boats action tracker is circulated.	INQ008050

Date	Event	Inquiry reference
30/09/2021	The Chief Coastguard issues a UK ARCC temporary operation instruction, stating that on red migrant weather crossing days a fixed-wing aircraft would be provided on scene to support Dover HMCG, and that on amber days an aircraft would be held in readiness at Lydd/Southend. The operating instruction notes that the primary function of the fixed-wing assets is to build a recognised maritime picture to support maritime operations, which “ideally...should match the Migrant Tracker”. The operating instruction also recognises that, by the end of each day, not all vessels on the migrant tracker would be accounted for, and that an end-of-day search would be requested following the conclusion of red and amber day taskings.	INQ006195
09/2021	3,053 migrants cross the English Channel using small boats.	INQ010134
10/2021	The DfT produces an interim report into the MCA which makes a number of recommendations. The report does not make any substantive recommendations on HMCG's search and rescue operations.	INQ010337 INQ008152
October and November 2021	HM Chief Inspector of Prisons conducts an unannounced inspection of the facilities at Tug Haven in Dover, which is the location where migrants were disembarked from Border Force vessels and processed by BF and Immigration Enforcement officers.	INQ010134
04/10/2021	Paper for MCA Board October 2021 meeting – agenda item 9 (response to the DfT review of the MCA recommendations), containing responses from the MCA to the DfT review of the MCA.	INQ008153

Date	Event	Inquiry reference
05/10/2021	MCA Board meeting at JRCC, Fareham, containing information about the MCA response to the DfT review of the MCA. The document stated that the MCA Board was surprised and disappointed by the lack of consultation with the MCA as the report and recommendations were developed.	INQ000961
06/10/2021	Email sending key points from the DfT small boats huddle meeting.	INQ001112
06/10/2021	HMCG policy: 'Incidents involving migrants' is published internally.	INQ000440
07/10/2021	The MCA holds an initial meeting to discuss how best to procure additional assets for the purpose of situational awareness in the Channel. (This is the first step in the initiation of Operation CAESAR.)	INQ001370
07/10/2021	A multi-stakeholder tabletop training exercise involving HMCG, BF, the RNLI and the police takes place to test the termination of search and rescue and whether BF can begin Operation SOMMEN.	INQ010098
07/10/2021	DfT/MCA small boats action tracker is circulated.	INQ003541
08/10/2021	Incident involving small boats, resulting in an HMCG operational learning report. This records that there had been a lack of communication with specific information from Dover Coastguard to aerial assets.	INQ008554
09/10/2021	Incident involving small boats, resulting in HMCG operational learning report. This records that there had been better search plans provided than during the previous day's incident, but poor co-ordination or details as to what to do when helicopters came across migrant vessels.	INQ008555
09/10/2021	The first operational flight of Operation Reveal takes place. Under Operation Reveal, RVL Aviation are proactively tasked by the CCTC to detect, assess and track small boats at sea.	INQ010102

Date	Event	Inquiry reference
12/10/2021	HMCG declared and additional resources document is published internally.	INQ003768
12/10/2021	The CCTC requests that the JMSC facilitate a mass casualty training exercise.	INQ005264 INQ010134
12/10/2021	A Small Boats Tasking and Co-ordination Forum meeting chaired by the HO takes place. It is noted that use of the Tekever drones continues to be suspended by the Civil Aviation Authority.	INQ003689
13/10/2021	HMCG temporary operating instruction 'SMC support to Dover' is published internally.	INQ006190
13/10/2021	HMCG policy: 'Search suspension and termination' is published internally.	INQ000450
14/10/2021	DfT/MCA small boats action tracker is circulated.	INQ003605
14/10/2021	HMCG temporary operating instruction 'Adoption of named search areas for migrant SAR' is published internally.	INQ006192
14/10/2021	HMCG Maritime Tactical Commander incident review version 2, providing information on the role of a Maritime Tactical Commander, is published internally.	INQ003775
15/10/2021	HMCG aircraft tasking policy for migrant surveillance patrols is published internally.	INQ000461
18/10/2021	At an operational response conference call attended by HMCG, the RNLI, and BF, it is noted that it has been a very busy weekend with beach landings, RNLI deployments and many duplicates of incidents, despite it being a 'green' day.	INQ000202
18/10/2021	HMCG temporary operating instruction 'Adoption of named intelligence areas for small boat Channel crossings where improved situational awareness is required' is published internally.	INQ006191

Date	Event	Inquiry reference
19/10/2021	HMCG policy: 'Contacting on call duty personnel' is published internally.	INQ003766
21/10/2021	DfT/MCA small boats action tracker is circulated.	INQ003681
26/10/2021	HMCG policy: 'ARCC small boat response' is published internally.	INQ001456
28/10/2021	At an operational response conference call attended by HMCG, the RNLI, and BF, it is noted that migrants are making attempts to cross on 'green' days.	INQ000210
28/10/2021	DfT/MCA small boats action tracker is circulated.	INQ003697
29/10/2021	A CCTC meeting entitled 'Resourcing SOLAS 2022' is held to address the issue of resourcing search and rescue at sea. It is suggested at the meeting that civilian vessels be commissioned for search and rescue operations, with BF personnel.	INQ010337
10/2021	2,701 migrants cross the English Channel using small boats.	INQ010134
11/2021	An MoU between HMCG and the National Police Chiefs' Council on the co-ordination of search and rescue resources at coastal incidents in England and Wales comes into effect. It refers to Operation Waypoint, HMCG's major incident plan.	INQ008911
11/2021	Dominic Golden (ARCC) states that he is aware of a growing trend of inaccurate and exaggerated information being passed to HMCG and others from small boats.	INQ009628
11/2021	HMCG launches a third recruitment campaign, resulting in 8 officers being recruited.	INQ010098
11/2021	A new risk is added to the MCA corporate risk register that: "HM Coastguard may become overwhelmed due to unquantifiable levels of migrant Channel crossing activity occurring during periods of good weather".	INQ000167

Date	Event	Inquiry reference
11/2021	HMCG SAR-H and ASV (understood to refer to aerial surveillance and verification) diagram identifying aerial assets available to HMCG for search and rescue incidents.	INQ008920
03/11/2021	Emails about emerging trends and aviation tasking for migrant boats.	INQ003708
04/11/2021	JMSC facilitates a mass casualty exercise that is attended by Kent Police, the RNLI, BF, South East Coast Ambulance Service and HMCG.	INQ010134
04/11/2021	Minutes of MCA Board meeting held on the 2 November 2021.	INQ008142
04/11/2021	HO staff member begins working on a draft of the Border Force MCC mass casualties at sea response plan.	INQ005268
04/11/2021	Multi-organisation live training exercises referred to by the names 'Martingale' and 'Amber' are carried out to provide "proof of concept for helicopter deployed life raft operations, and to explore the use of this tactic in the Channel migrant and mass rescue operations environment".	INQ008908 INQ009672
04/11/2021	HMCG alerting and tasking operations guide is published internally.	INQ006201
05/11/2021	DfT/MCA small boats action tracker is circulated.	INQ003709
08/11/2021	HMCG drafts review of recommended staffing levels proposes a different approach to MRCC staffing levels, encompassing an increased headcount at Dover for small boats activity.	INQ001329
08/11/2021	GWMAH 7608/21 small boat placemat version 1 is published internally.	INQ005293
09/11/2021	Concerns are raised at a HMCG red day meeting about staffing levels.	INQ000215

Date	Event	Inquiry reference
09/11/2021	The issues relating to the suspension of the Tekever drone (see entry dated 12 October 2021) are resolved and Tekever are flying drones AR3 and AR5 again.	INQ010337
Approx 10/11/2021	The MOD agrees a military aid to civil authorities request from the JMSC for support for co-ordinated “exercise joint blockade” on behalf of the HO, which is to take place on 23 to 25 November 2021. It is to focus on the UK response to an escalating blockade by foreign vessels of a UK port.	INQ008937 INQ009649
10/11/2021	Emails about small boats huddle actions/tracker.	INQ001099
11/11/2021	The HO receives the ‘go ahead’ from HO cyber security to access HMCG’s UK shared tracker. The request to access the tracker is with HO IT and is confirmed as a priority task.	INQ003714
11/11/2021	A report on the JMSC facilitated mass casualty exercise on 4 November 2021 is published. The report sets out the exercise, the response of the organisations involved and issues arising from their responses. It notes recommendations and opportunities to improve.	INQ009672
11/11/2021	1,250 migrants cross the Channel in 36 boats. This is an “unprecedented number”.	INQ010337
11/11/2021	A critical incident is declared at the migrant processing facility at Tug Haven in respect of overcrowding due to the number of incoming migrants received over the course of the day.	INQ010134
11/11/2021	Western Jet Foil, a new purpose-built migrant reception facility at Dover, opens.	INQ010134
11/11/2021	HMCG policy: ‘Vessel – reported in difficulties’ is published internally.	INQ000433

Date	Event	Inquiry reference
12/11/2021	A BF Gold Call is held, which focuses on BF's response to migrant crossings. In an internal follow up email sent by the DfT, it is recorded that a critical incident has been declared in response to the unprecedented number of crossings in the previous 24 hours, and the situation at Tug Haven is described as a "humanitarian crisis". BF is said to be under huge resource pressures to deal with the numbers, and BF maritime teams are also under significant pressure. It is also noted that: "BF do not have suitable vessels to rescue people due to the types of some crafts used for crossings and are relying heavily on RNLI as they have the right vessels for the wave height. BF shared concerns regarding the resilience of the RNLI due [to] these pressures."	INQ004159
12/11/2021	A cross-Whitehall meeting is held in relation to the small boat situation, which addresses the operational response, contingency planning and diplomatic engagement with the French. Following the meeting, the DfT circulates a note of the meeting internally within the DfT and MCA, noting that there is an issue of processing migrants at Tug Haven, and that deployment of the turnaround tactic could be a concern when capacity is tight because it means less vessels available for search and rescue. The DfT note records that "key things for us" include "any concerns around impacts on Dover operations, because of these high numbers...Any concerns around RNLI/HMCG capacity/pressures", recording that an MCA attendee had "raised no immediate concerns. But it was definitely a problem".	INQ001101 INQ010337 INQ001966
12/11/2021	Cabinet Office email to the DfT on HMCG/RNLI thresholds and SitRep indicators, requesting that the DfT look at determining a threshold at which HMCG/RNLI capacity would likely be overwhelmed.	INQ003715

Date	Event	Inquiry reference
12/11/2021	The DfT requests information from HMCG on assets available for search and rescue in the Channel in relation to small boats, stating that it has been flagged that search and rescue resource was not infinite, and that there would be a problem if capacity was maintained at such a high level. However, the DfT request continued, it was understood that capability was suitable for the immediate outlook. In reply, HMCG provides details about capacity and pressure due to the recent volume of crossings and about the duration of call outs.	INQ001055 INQ010337 INQ003718 INQ007893 INQ001949
12/11/2021	The HO responds to a DfT summary of the cross-Whitehall meeting, stating: “My sense is that the maritime element of small boat operations continues to run as BAU [Business as Usual] (though stretched). The critical incident is focused on the land response. Thus, no need therefore to stand up any multi-agency contingency plans, but let's stay connected over the weekend.” The email requests that if there were to be a request for wider support at sea, there be deconfliction with planning for other activities.	INQ007886 INQ008099
15/11/2021	Emails between HMCG and the HO relating to granting the HO access to HMCG's UK shared tracker.	INQ010051
15/11/2021	Further DfT email about search and rescue capacity, noting that multiple days of consecutive activity at sea put pressure on the RNLI crews and availability to respond, noting that the current lifeboat provision is based on historical search and rescue data for the area before the occurrence of small boat crossings in the Channel.	INQ007893
15/11/2021	Operation DEVERAN weather assessment predicts with moderate confidence that due to small boat crossings on the night of the 23 to 24 November 2021 were unlikely.	INQ000131

Date	Event	Inquiry reference
15/11/2021	Annotated agenda (dated 11 November 2021) for discussion and summary of discussion between Brian Johnson (MCA) and Minister Courts on the 15 November 2021, confirming that turnaround tactics had been signed off, but that there had been no requests to terminate search and rescue activities. The agenda states: “There will be winter crossings, but our attention is turning to preparations for when the weather improves in the spring.” The summary states that there was “concern about potential to run out of capacity in peak Spring season”.	INQ001336 INQ001179
16/11/2021	There is an incident a week before 23 November 2021 when false information had been provided from small boats, which is said to have made triaging calls difficult.	INQ010140
16/11/2021	Operation DEVERAN weather assessment predicts with moderate confidence that small boat crossings on the night of 23 to 24 November 2021 are unlikely.	INQ000134
16/11/2021	1,200 people are intercepted crossing the Dover Strait.	INQ010445
16/11/2021	At an HMCG red day meeting, it is noted: “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.”	INQ000209
16/11/2021	HMCG Duty Operations Director guidelines are published internally.	INQ000457
17/11/2021	DfT email about search and rescue capacity, referring to discussions on the subject which “doesn't get at the problem of describing stress on the capability and the ceiling at which that capability will be overwhelmed”.	INQ007893

Date	Event	Inquiry reference
Approx 17/11/2021	A Cabinet Committee, the Domestic and Europe (Illegal Migration) Committee, is established, because of the scale of the challenge of the arrival of illegal migrants in small boats.	INQ006725 INQ004191
17/11/2021	The CCTC Commander gives evidence to the Home Affairs Select Committee about the HO's aerial operation to counter small boats crossing.	INQ000009
17/11/2021	Operation DEVERAN weather assessment predicts, with a moderate degree of confidence, that due to weather small boat crossings on the night of 23 to 24 November 2021 are unlikely.	INQ000137
17/11/2021	HMCG policy: 'SAC instructions to SRUs' is published internally.	INQ003795
18/11/2021	HMCG responds to the DfT request on 12 November 2021 for information on assets available for search and rescue in the Channel in relation to small boats. In their response, HMCG states that BF and RNLI assets are tasked, but that BF responds to 89% of small boat incidents. HMCG explains that they are currently working to increase air presence to support situational awareness and are due to send a submission to the minister seeking approval for unmanned drone and fixed-wing air support.	INQ010337 INQ008168 INQ008169
18/11/2021	The MCA makes a submission to the DfT for approval of increased capacity in coastguard aviation, which is noted.	INQ000103 INQ000106
18/11/2021	A ministerial briefing regarding the capacity of HMCG aviation assets carrying out search and rescue services notes that HMCG planes have reached the limits of their operating capacity. The briefing states that the numbers of small boats crossing and the consequent demand for aviation assets is expected to increase.	INQ006725

Date	Event	Inquiry reference
18/11/2021	An Operation DEVERAN joint activity review meeting is attended by HMCG, BF, the HO and Tekever. It is noted that attendees had recognised that the separation of search and rescue co-ordination and the duplication of effort have impacted on shared situational awareness, joint understanding of risk and effective communications, and created risks to effective search and rescue. It is agreed that a co-location of the Border Force Maritime Liaison Officer and aerial asset positions within the MRCC should be trialled, but that this can only commence once access to the joint incident migrant tracker is available to all parties. This is an action from the meeting. It is also recognised that BF and RNLI assets are functioning at the highest level of their capacity, and that for BF this situation is at a critical level which will need to be resolved. In relation to air assets, it is noted that the tasking of, communication with and situational awareness derived from the use of aerial assets is somewhat disjointed.	INQ009957
18/11/2021	Operation DEVERAN weather assessment predicts (without a confidence indicator) that due to weather small boat crossings on the night of 23 to 24 November 2021 are unlikely.	INQ000140
18/11/2021	BF gains live access and the ability to edit the shared UK tracker.	INQ009632
18/11/2021	HMCG remote SMC policy is published internally.	INQ000446
19/11/2021	Operation DEVERAN weather assessment predicts (without a confidence indicator) that due to weather the likelihood of small boat crossings on the night of 23 to 24 November 2021 is unlikely.	INQ000143
19/11/2021	HMCG sends an email to all HMCG stations stating that a decision has been made to provide MRCC Dover with enduring, reliable, operational network support to co-ordinate the search and rescue response to small boats crossings.	INQ003731

Date	Event	Inquiry reference
19/11/2021	Ad hoc HMCG red day meeting is attended by HMCG, the MCA and the RNLI.	INQ000203
19/11/2021	An Operation ALTAIR Gold Call takes place.	INQ009674
19/11/2021	Ad hoc HMCG red day meeting is attended by HMCG, the MCA and the RNLI. The RNLI raises a concern about crew fatigue and a shortfall on Saturday morning, which they will be planning for, and which they are hoping to manage if one lifeboat station goes off with crew fatigue. There is discussion about how to manage this, and whether to consider a rostering system.	INQ000204
19/11/2021	HMCG temporary operating instruction 'Transfer of maritime zones 11 and 13' is published internally.	INQ006193
20/11/2021	827 people are intercepted crossing the Dover Strait.	INQ010445
20/11/2021	RNLI Ramsgate refuses a search and rescue tasking from HMCG to rescue a small boat in the English Channel, on the basis that BF are not doing their jobs, and people are not in the water. HMCG has to wait for BF vessel Hurricane (at the time on another tasking) to attend the incident, when 25 people are recovered.	INQ004359 INQ010098 INQ000712
20/11/2021	A small boats update call takes place with HMCG, the RNLI and the JRCC (Air and Maritime Commanders) in attendance. It is noted that there had been a refusal to launch by RNLI Ramsgate the previous night due to no BF assets being active, with a note that the RNLI would speak to the coxswain to understand the decision-making and report back.	INQ000205
20/11/2021	27 small boat occupants are rescued from the water as part of Operation DEVERAN.	INQ008357
20/11/2021	An ad hoc HMCG red day meeting is held with attendees from HMCG and the RNLI. There is a discussion in relation to harbour access in Rye, RNLI crewing, the earlier refusal of the RNLI to launch from Ramsgate and BF availability.	INQ000220

Date	Event	Inquiry reference
22/11/2021	DfT email acknowledging receipt of the MCA's submission dated 18 November 2021.	INQ000106
22/11/2021	The MCA annual report and accounts 2020 to 2021 is ordered to be printed. The annual report records risks associated with the safety of migrants crossing the English Channel as a priority concern.	INQ000166
22/11/2021	A draft HO submission is shared with the DfT via HMCG. It addresses the inadequacy of surface assets to deliver SOLAS operations and states that BF maritime and RNLI assets are regularly being overwhelmed by the increased volume of small boat crossings.	INQ001971 INQ010337
22/11/2021	Stephen Whitton sends an email to Daniel O'Mahoney confirming that he cannot identify any periods of time with sufficiently calm weather during which Operation SOMMEN could be deployed.	INQ010137
22/11/2021	Operation DEVERAN weather assessment predicts (without a confidence indicator) that due to weather small boat crossings on the night of 23 to 24 November 2021 are likely.	INQ000146
22/11/2021	HMCG sends tasking requests to 2Excel in respect of fixed-wing aircraft to survey small boat activity and support search and rescue in the Dover Strait on the night of 23 to 24 November between 03:00 and 08:00 (Operation EOS).	INQ001186 INQ000148 INQ001188
22/11/2021	HMCG red day meeting to discuss the week ahead, attended by 14 people (HMCG personnel, RNLI, 2Excel), but with apologies from BF who send a written briefing instead.	INQ010445 INQ000206 INQ010137
22/11/2021	2Excel informs HMCG that due to having only one aircraft available overnight on 23 to 24 November they will not be able to cover the whole tasking period.	INQ001186

Date	Event	Inquiry reference
22/11/2021	2Excel sends an internal email noting a significant risk in the period discussed at the HMCG red day meeting (23 to 25 November).	INQ001190
22/11/2021	HMCG asks 2Excel to confirm what times they will be able to provide coverage, so that HMCG can identify gaps that need cover.	INQ001191
22/11/2021	2Excel informs HMCG that they will look at their plan again and revert.	INQ001192
22/11/2021	2Excel updates HMCG that they are working to get enough crew to provide full coverage and will revert with a further update.	INQ001194
22/11/2021	HMCG acknowledges 2Excel's update and states they will wait until 2Excel provides a final outcome on coverage.	INQ001195
22/11/2021	Duncan Ley sends an email requesting volunteers to travel to Dover to assist the MRCC with the operational response to anticipated small boats activity during the night shifts on 23 to 24 November 2021.	INQ010445 INQ006765
23/11/2021	Paper for MCA Sponsorship Board December meeting agenda item 2.1b (risk) provides an overview of current risks in the corporate risk register. This concerns the risk in relation to HO tactics.	INQ000960
23/11/2021	HMCG policy: 'Emergency calls and SMS text messages' version 3 is published internally.	INQ005192
23/11/2021	HMCG policy: 'Terminating a call originating from a migrant vessel' is published internally.	INQ010468

Date	Event	Inquiry reference
23/11/2021	Letter from Daniel O'Mahoney to the Home Secretary providing a detailed update on small boats. The letter states that there have been nearly 25,000 arrivals for the year to date with preventions over 20,000, which is treble the number for the same period in 2020, and acknowledges a critical incident at Tughaven on 16 November 2021 due to shortage of accommodation.	INQ002233
24/11/2021	HMCG policy: 'Migrant boat incident updates' is published internally.	INQ000434
24/11/2021	HMCG temporary operating instruction 'Small boat crossings TACOM [Tactical Command] situation reports' is published internally.	INQ006194
24/11/2021	Paper for MCA Board meeting December 2021 stating that HMCG is responding to increasing numbers of small boat crossings and noting that this is predicted to continue and will place pressure on HMCG staff, BF and RNLI surface assets. It also records that work is taking place to examine means of addressing the challenge, and that a tabletop exercise will take place on 2 December 2021 with various stakeholders.	INQ000965
11/2021	6,971 migrants cross the English Channel using small boats.	INQ010134
2021	By the end of 2021, a total of 28,526 migrants have crossed the English Channel using small boats.	INQ010134
2021	By the end of 2021, the RNLI has attended 240 small boat crossing incidents, rescuing 5,636 people. Using BF and HO data, the RNLI estimates that the average number of occupants on a boat in 2021 was 28.	INQ010101

Appendix 4: Inquiry team

Legal team	
Role	Name
Lead Counsel	Rory Phillips KC
Deputy Lead Counsel	Sarah Le Fevre
Counsel	Dr Rowena Moffatt
Counsel	Teniola Onabanjo
Counsel	Alice Meredith
Counsel	Reka Hollos
Counsel	Dr Kate Parlett
Counsel	Genevieve Woods
Counsel	Tom Davies
Solicitor to the Inquiry	Stephen Brown
Deputy Solicitor to the Inquiry	Helen Moss
Deputy Solicitor to the Inquiry	Zoe Staniforth
Solicitors' team	Connie Cramp
Solicitors' team	Frances Edwards
Solicitors' team	Tanvir Hanif
Solicitors' team	Sophie King
Solicitors' team	Scott Marks
Solicitors' team	Shreya More
Solicitors' team	Mahala Pinchen
Solicitors' team	Leona Reid
Solicitors' team	Avin Seerruttun

Secretariat	
Role	Name
Secretary to the Inquiry	Oliver Mulvey
Deputy Secretary to the Inquiry	Sam Goodey
Inquiry Secretariat	Ros Gibson
Inquiry Secretariat	James Gilderoy
Inquiry Secretariat	Jamie Gillen
Inquiry Secretariat	Finsu Gurung
Inquiry Secretariat	Farhia Haji
Inquiry Secretariat	Maryam Haque
Inquiry Secretariat	Leena Joshi
Inquiry Secretariat	Alan Mercer
Inquiry Secretariat	David Oluyemi
Inquiry Secretariat	Michael Perie
Inquiry Secretariat	Alec Poole

Experts and consultants	
Role	Name
Expert	Professor Michael Tipton MBE
Expert	Iain Ivory
Expert	Sytech
Consultant	Captain John Simpson

Service providers	
Role	Name
Document management services and digital platform provider	Epiq
Witness and attendee support services	Hestia
Hearing premises and support	International Dispute Resolution Centre
Hearing technology and transcription services	Opus2
Interpretation and translation	Divergent Language Solutions
Website design and report typesetting	Design102

Ushers	
Role	Name
Usher	Naomi Gledhill
Usher	Kathy Knox
Usher	Karen Northwood
Usher	Brenda Pinnock
Usher	Christine Smith
Usher	Kathleen Turner

Appendix 5: Witnesses

**Witnesses who gave oral and written evidence to the Inquiry
(in alphabetical order)**

Name	Title (as at 23 to 24 November 2021, unless otherwise stated)
Christopher Barnett	Team leader, HM Coastguard
Mike Bill	Divisional Commander, HM Coastguard
Richard Cockerill	Team leader, HM Coastguard
James Crane	Team leader, HM Coastguard
Stuart Downs	Maritime Operations Officer, HM Coastguard
James Driver	Current Head of Maritime Security Division, Department for Transport
Neal Gibson	Search and Rescue Mission Co-ordinator, HM Coastguard
Dominic Golden	Aviation Tactical Commander in the Aeronautical Rescue Coordination Centre, HM Coastguard
Graham Hamilton	Deputy Director of Search and Rescue, Bristow Helicopters Ltd
David Jones	Maritime Tactical Commander, HM Coastguard
Matthew Leat	Current Assistant Chief Coastguard, HM Coastguard
Simon Ling	Head of Lifeboats, Royal National Lifeboat Institution
Christopher Norton	Director and Co-Founder, 2Excel Aviation Ltd
Daniel O'Mahoney	Director of the Clandestine Channel Threat Command, Home Office
Issa Mohamed Omar	Survivor

Name	Title (as at 23 to 24 November 2021, unless otherwise stated)
George Papadopoulos	Staff Officer for Small Boat Crossings Search and Rescue, HM Coastguard
Professor Michael Tipton MBE	Professor of Human and Applied Physiology at the University of Portsmouth (expert witness)
Kevin Toy	Commander of HMC Valiant, Border Force Maritime Command, Home Office
Christopher Trubshaw	Captain of Search and Rescue Helicopter, Bristow Helicopters Ltd
Karen Whitehouse	Border Force Higher Officer, Border Force Maritime Command Centre, Home Office
Stephen Whitton OBE	Head of Border Force Maritime Command, Home Office
Thomas Willows	Immigration Officer, Border Force Maritime Command Centre, Home Office

Family members whose statements were read during the Inquiry hearings (in alphabetical order)

Name	Name of relative(s)
Karim Hamad Abdulrahman	Bryar Hamad Abdulrahman
Bayan Hemedemin Saleh Ahmed	Mhabad Ali Ahmed
Ahmed Mohammed Ahmed	Afrasia Ahmed Mohamed Akoi
Mohammed Ali Ismail Ali	Hasan Mohamed Ali
Saman Alipour	Sirwan Alipour
Ali Areef	Halima Mohammed Shikh
Qader Awla	Mohammed Qader Awla
Tesfahun Hailu Gebrehiwet	Meron Hailu Gebrehiwet
Hailu Gebrehiwet	Meron Hailu Gebrehiwet
Henok Hailu Gebrehiwet	Meron Hailu Gebrehiwet
Freweyni Hayiemariam Gitet	Niyat Ferede Yeshiwendim
Yassin Hassan Hamad	Rezhwan Yassin Hassan
Abdullahi Mohamud Hassan	Halima Mohammed Shikh
Noori Mohammedameen Hassan	Maryam Noori Mohammedameen
Rasul Farkha Hussein	Pshtiwan Rasul Farkha Hussein
Rizghar Hussein	Kazhal Amhed Khidir Al-Jamoor Hadiya Rizghar Hussein Mubin Rizghar Hussein Hasti Rizghar Hussein
Emebet Kefyalew	Fikiru Shiferaw Tekalegn
Ismael Hamad Khudhur	Muslim Ismael Hamad
Sarhad Pirot Mohammed	Serkawt Pirot Mohammed
Zana Mamand Mohammed	Twana Mamand Mohammed

Name	Name of relative(s)
Hussein Mohammedie	Mohammed Hussein Mohammedie
Mustafa Mina Nabi	Zanyar Mustafa Mina
Ferede Yeshiwendim Nadew	Niyat Ferede Yeshiwendim
Shamal Ali Pirot	Shakar Ali Pirot
Andargachew Shiferaw	Fikiru Shiferaw Tekalegn
Morris Sleshi Tewelde	Niyat Ferede Yeshiwendim
Shakir Baker Brindar Zewki	Bilind Shakir Baker

Witnesses who provided written evidence to the Inquiry (in alphabetical order)

Name	Role (at time of statement)
Jennifer Armstrong	Deputy Director, Ministry of Defence
Mary Atkinson	Campaigns and Network Manager, Joint Council for the Welfare of Immigrants
Dr Jacob Berkson	Shift team member and media liaison, Alarm Phone
Nigel Brookes	Assistant Chief Constable, Kent Police
George Close	Former Maritime Tactical Commander, HM Coastguard
Leigh Curtis MBE	Executive Director of Service Delivery, Air Ambulance Charity Kent Surrey Sussex
Gary Ferguson	Head of Specialist Operations, RVL Aviation Ltd
Mael Galisson	Independent Journalist
Imogen Hardman	Head of Field Operations – France, Care4Calais
Sharon Harmer	Business Operational Support Lead, Met Command and Control, Metropolitan Police Service
Oliver Higgins	Deputy Director, National Crime Agency
Neil Honeyman	Chief Technology Officer, Small Boats Operational Command, Home Office
Iain Ivory	Independent Consultant, Hermitage Comms LLP (Expert Witness)
Duncan Ley	Former Joint Rescue Coordination Centre Manager, HM Coastguard
Jacob Lugg	Former Operations Controller, 2Excel Aviation Ltd
Kani Mamand Mohammed	Family member
Nikolai Posner	Board member, Utopia 56
Anna Richel	Former Co-ordinator, Utopia 56

Appendix 6:

Acronyms and specialist terminology

Acronym/term	Meaning
2Excel	2Excel Aviation, specialist aircraft operator used for search and surveillance
ALTAIR	Operation involving the use of fixed-wing aircraft by HM Coastguard for reconnaissance
AR3	A drone manufactured by Tekever and operated by Border Force in the English Channel
ARCC/UK ARCC	Aeronautical Rescue Coordination Centre
BF	Border Force
BFMC	Border Force Maritime Command
Border Force MCC	Border Force Maritime Command Centre
Bristow	Bristow Group Inc., specialist operator of helicopters
CCTC	Clandestine Channel Threat Command
Concerto	Oil/chemical tanker sailing under the flag of Singapore, present in the English Channel on 23 to 24 November 2021
Coxswain	Person in charge of an all-weather lifeboat
CROSS	Centres Régionaux Opérationnels de Surveillance et de Sauvetage (Regional Operational Centres for Monitoring and Rescue)
Cutter	Patrol vessel
DEVERAN	Border Force-led maritime operation responding to the threat of illegal migration using small craft
DfT	Department for Transport

Acronym/term	Meaning
Dover Strait	Strait at the narrowest part of the English Channel, marking the boundary between the Channel and the North Sea
DRORA	Defect Related Operational Risk Assessment
Dungeness	Location on the Kent coast, site of a RNLI lifeboat station and a nuclear power station used as a navigation marker by some small boats in the Channel
EOS	Operation related to the UK response to small boats, including maritime search and rescue
Flamant	Vessel operated by the French Coastguard
GasChem Shinano	An LPG tanker sailing under the flag of Portugal, present in the English Channel on 23 to 24 November 2021
Goodwin/Goodwin Sands	10-mile long sandbank located off the coast of Kent
Gris-Nez	Location on the French Coast (Cap Gris-Nez), site of French command centre for activity in the Channel
HMCG	His Majesty's Coastguard
HMC Hurricane	UK Border Force cutter
HMC Searcher	UK Border Force cutter
HMC Valiant	UK Border Force cutter tasked to incident 'Charlie'
HMICFRS	His Majesty's Inspectorate of Constabulary and Fire and Rescue Services
HO	Home Office
IAMSAR	International Aeronautical and Maritime Search and Rescue
IMO	International Maritime Organization
ISOTROPE	Operation involving the transfer of maritime primacy and responsibility for responding to small boat crossings in the English Channel to the Royal Navy from January 2022 to January 2023

Acronym/term	Meaning
JMOCC	Joint Maritime Operations Coordination Centre
JMSC	Joint Maritime Security Centre
JRCC	Joint Rescue Coordination Centre
King Air	Type of fixed-wing aircraft produced by Beechcraft and operated by 2Excel
La Manche	French name for the English Channel
MAIB	Marine Accident Investigation Branch
Mancheplan	Anglo-French Joint Maritime Contingency Plan dated 2018
Maritime Prefect	Authority responsible for maritime safety in France
MAROPS	Maritime Operations Officers within HM Coastguard
MCA	Maritime and Coastguard Agency
MOD	Ministry of Defence
MoU	Memorandum of understanding
MRCC	Maritime Rescue Coordination Centre
Nm	Nautical mile
OP/OPERATION ALTAIR	See 'ALTAIR'
OP/OPERATION DEVERAN	See 'DEVERAN'
OP/OPERATION EOS	See 'EOS'
OP/OPERATION ISOTROPE	See 'ISOTROPE'
Panther	Modified Piper PA-31 Navajo fixed-wing aircraft, operated by 2Excel
R-163/RESCUE-163	Callsign for rescue helicopter operated by Bristow Group Inc. for HM Coastguard
RNLI	Royal National Lifeboat Institution
RVL	RVL Group, a specialist aviation provider

Acronym/term	Meaning
SAC	Search area coverage
SAD	Search area determination
Sandettie	Lightvessel station located at Sandettie Bank in the English Channel
SAR	International Convention on Maritime Search and Rescue 1979
SMC	Strategic Maritime Commander or Search and Rescue Mission Co-ordinator
SOLAS	International Convention for the Safety of Life at Sea 1974
Solent	Strait within the English Channel, separating the coast of Hampshire from the Isle of Wight
SRR	Search and rescue region
TACOM	Tactical Command
Tekever	Company specialising in aerospace and surveillance technology which manufactures drones used by the Home Office in the English Channel
UK ARCC	See ARCC
UK SAR-H	UK Search And Rescue Helicopter Programme
UNCLOS	United Nations Convention on the Law of the Sea
Valiant	See ‘HMC Valiant’
VHF	Very high frequency radio channel
ViSION	Digital system used by HM Coastguard to log actions and decisions
VTs	Vessel Traffic Service

Appendix 7:

Guide to references

This appendix is a guide to the references contained in the Inquiry report. It sets out the conventions adopted in footnotes and in references contained within the text.

The documents which are referenced in the Inquiry report have been disclosed to Full Participants and published on the Inquiry website (<https://cranston.independent-inquiry.uk>).

Documents

[Inquiry reference number/Page number/Paragraph number]

Example reference	Meaning
INQ010140/4/par13	Document reference INQ010140 at page 4, paragraph 13
INQ010388/2	Page 2 of document reference INQ010388
INQ004467/57/fn87	Footnote 87 on page 57 of document reference INQ004467

Witness statements and reports

[Inquiry reference number/Page number/Paragraph number]

Example reference	Meaning
Statement of Neal Gibson INQ010392/24-26/par56-57	Paragraph 56 to 57 on page 24 to 26 of document reference INQ010392
Report of Professor Michael Tipton INQ010283/17/par4.3	Paragraph 4.3 on page 17 of document reference INQ010283

Transcript references

[Inquiry reference number/Page number/Line number]

Example reference	Meaning
INQ010715/33/ln4-11	Lines 4 to 11 on page 33 of document reference INQ010715
Oral evidence of Michael Bill INQ010719/21/ln11-16	Lines 11 to 16 on page 21 of document reference INQ010719

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