



## The UK Cranston Inquiry Report Lessons from the Response to a Small Boat Maritime Rescue Incident

On 5 February 2026, the UK Government published The Cranston Inquiry Report concerning the small boat maritime incident that occurred in the Dover Strait on 24 November 2021. The Inquiry was established to examine the response of the authorities, draw together the lessons to be learned, and make recommendations aimed at reducing the risk of a similar tragedy happening again.

The Cranston Inquiry Report:

<https://www.gov.uk/government/publications/the-report-of-the-cranston-inquiry>

This article looks at the incident, its background, the issues it revealed, and the lessons that can be drawn from the Inquiry Report. It focuses on the response of the maritime rescue authorities. It does not address wider questions relating to the prevention of irregular small boat crossings themselves or other measures aimed at reducing the occurrence of such incidents at source.

### 1. Outline of the Incident

In the early hours of 24 November 2021, a small boat attempting to cross the Dover Strait from the French side capsized, resulting in the deaths of more than thirty people.

That night, the UK rescue authorities responded to a distress call from the capsized boat and carried out search and rescue operations. In the end, however, they were unable to rescue all those on board. According to the Inquiry's findings, the response was marked by shortcomings at several stages: the watch arrangements, the handling of information, coordination with other agencies, and the instructions given to assets at the scene. These shortcomings overlapped, and ultimately led to a situation in which a boat that had not in fact been rescued was mistakenly believed to have been accounted for. The following sections set out these circumstances in order.

The main UK organisations involved in the response were as follows. The lead body for maritime rescue was the Coastguard, which falls under the Department for Transport. Under the Coastguard, a number of Maritime Rescue Coordination Centres, or MRCCs, are responsible for directing and coordinating rescue operations in their respective areas. In this case, the MRCC responsible for the Dover Strait handled the response. The actual rescue effort involved not only the Coastguard, but also

the maritime arm of Border Force, which falls under the Home Office, as well as voluntary rescue organisations. Because the incident took place in the Dover Strait, coordination with the French search and rescue authorities on the opposite side of the Channel was also required.

On the night of the incident, three people were on duty at the MRCC, including the watch manager. Of those three, only the watch manager was fully qualified. The other two were still in training: one was authorised to carry out only certain limited tasks, while the other had not yet reached the stage at which operational work could safely be entrusted to them. The watch therefore fell short of the recommended staffing level of three operationally competent staff, and the watch manager was unable to take a break throughout the twelve-hour shift. There was also meant to be a system under which a senior MRCC officer would review the watch manager's decisions, but that safeguard did not function that day.

That night, several small boats, including the one that later capsized, were attempting to cross the Dover Strait, and the MRCC was dealing with each of them separately. The team had to receive distress calls, confirm location information, communicate with the French authorities, and issue instructions to vessels and aircraft at the scene. These tasks all converged at once. Under that pressure, entries into the incident management system were delayed. In addition, the maritime and aviation teams were using different versions of the same system, which made it difficult to share information properly between them. There were also no settled rules, staff training, or agreed procedures for preserving communications on the smartphones used to exchange messages with callers. These weaknesses compounded one another and made it harder to organise the information coming in. As a result, information about the same small boat was treated as if it related to separate incidents, and the records for one incident became duplicated in some places and fragmented in others.

The instructions given to the organisations involved were also insufficient. There was no formal arrangement defining the division of responsibilities between the Coastguard and Border Force Maritime, and the Coastguard, Border Force Maritime, and voluntary rescue organisations had not conducted joint training together. Against that background, no formal search plan was prepared for the incident. The helicopter sent to the scene was not told that it was searching for a sinking boat or for people in the water. Nor was it given specific instructions on the search object, the search area, or the spacing between search tracks. It therefore proceeded to the area without the detailed guidance that the situation required.

In these circumstances, the watch manager mistakenly identified a small boat rescued by a patrol vessel in a separate incident as the boat involved in this distress case. As a result, the boat that had not yet been rescued was wrongly understood to have been accounted for. The capsized boat and the people in the water were therefore left unrecovered, and they lost their lives.

The incident was treated as "resolved" during the night. No further search was conducted for those in need of rescue until 12:57 p.m. on 24 November, when a nearby vessel reported finding several bodies in the surrounding waters.

This incident occurred against a particular and highly unusual background in the Dover Strait. It cannot be properly assessed by looking only at the response on the night itself. At the time, large numbers of

small boat crossings were taking place day after day, and the UK rescue authorities had been operating under intense and sustained pressure before and after the night of the accident. The incident must be understood in that wider context.

From mid-November 2021 onwards, small boat crossings in the Dover Strait had become particularly active. According to records from the time, around 1,200 people were involved in operations on 16 November, and 827 on 20 November. On 22 November, a meeting was even held to discuss how to respond to large-scale crossings. The Inquiry Report also states that, by 6:22 p.m. on 23 November, information had been shared among the relevant agencies that several hundred people might reach the UK search and rescue region over the course of 24 November. In other words, this was not a sudden, isolated accident in otherwise calm conditions. It was a complex incident that occurred in the midst of a prolonged period of mass rescue activity.

## 2. Issues Revealed

### (1) Structural Shortage of Resources

The first issue was a structural shortage of resources. The problem was not simply the staffing level on that particular night. The Inquiry found that shortages at the MRCC had existed before November 2021, and that the risks associated with those shortages had been recognised repeatedly. Yet effective corrective action had not been taken. A chronic shortage had been allowed to continue, and when a high-pressure situation arose on a particular night, the response capacity was pushed beyond its limits. This points to a structural vulnerability.

There were also structural constraints on decisions about whether to deploy vessels and aircraft at the scene. Because many small boat incidents were also expected during the day shift on 24 November, those on duty had to decide how far they could commit limited rescue resources during the night. The Inquiry Report explains that the wish to preserve resources in anticipation of a heavy day shift was one reason for caution in deploying additional and more suitable rescue assets, in particular lifeboats operated by voluntary rescue organisations. This meant that, under conditions of sustained pressure, frontline decision-makers were continually being forced to choose between conserving resources for the next day and responding fully to the situation before them that night. What the incident revealed, therefore, was not a simple lack of capacity in response to a single event. It was an insufficient level of preparedness for a prolonged, high-intensity operational environment.

### (2) Confused Information and Weak Multi-Agency Coordination

The second issue was the absence of a mechanism for integrating information, and the lack of a fully developed framework for coordination among multiple agencies. The problem was not simply that there was a great deal of information. It was that the organisation did not have a reliable way to bring that information together into one coherent picture. Procedures for recording information in the incident management system, consistency between the systems used by the maritime and aviation teams, and rules governing the use of smartphones for communication with callers had not been properly established in advance. As a result, information relating to the same incident was processed separately, and the organisation as a whole could not clearly grasp who held which pieces of

information. This became the ground on which the later misidentification by the watch manager, and the mistaken belief that the boat had already been rescued, could occur.

In addition, although several organisations were involved — the Coastguard, Border Force, voluntary rescue organisations, and the French search and rescue authorities — there were fundamental gaps in the arrangements among them. There was no settled division of roles, and joint training had not been put in place. It had not been made sufficiently clear in ordinary times who should share what information, at what stage, and who should be responsible for making particular decisions. This case therefore shows more than confusion at the operational front line. It shows that a cross-organisational framework for dealing with complex, multi-agency incidents had not been fully established before the crisis occurred.

### (3) Insufficient Rescue Capability for an Event Beyond Ordinary Assumptions

The third issue was the lack of preparedness in rescue capability for an event that went beyond ordinary assumptions. Here, “capability” does not mean only seamanship or the ability to detect an object at sea. It refers to a broader set of rescue skills: preparing a search plan for a sinking small boat and for people in the water; responding to large numbers of people in distress; setting priorities; assessing survivability in cold water; and handling distress calls from small boats. These are not matters that can simply be dealt with as an extension of routine search and rescue work. They need to be developed as specific capabilities that can function under compound conditions: at night, in cold water, across language barriers, and while several incidents are unfolding at the same time. This incident exposed the fact that such capabilities had not been firmly established within the organisation.

There was also an issue of organisational perception, which affected the speed and nature of the response. The report notes that within the Coastguard there was a widespread view that callers from small boats tended to exaggerate the seriousness of their situation, and that this perception delayed a response based on the worst-case scenario. This was not merely an individual error of judgment. It suggests that an assumption embedded within the organisation distorted the assessment of risk itself. What was needed in this case was therefore not only stronger technical capability, but also a rescue culture prepared to act on the assumption that the worst may be happening.

### 3. Lessons

Several lessons can be drawn from these issues.

First, prolonged mass-rescue situations cannot be handled indefinitely through frontline effort and temporary improvisation alone. The fact that chronic staffing shortages had been recognised but not adequately remedied was a serious underlying factor in this incident. To prepare for similar cases in the future, demand must be forecast in ordinary times, and systems must be in place to secure the necessary personnel, assets, and funding. The Inquiry’s recommendation that anticipated shortages should be reported promptly to the responsible department, with corrective action requested, reflects precisely this point.

Second, the inability to integrate information can be more dangerous than a lack of information itself. In this case, the problem was not that there was too little information. On the contrary, too much information was arriving through several channels, and the mechanisms for organising and consolidating it could not keep pace. This led to duplicate records and misidentification. Going forward, investment will be needed in tools that can identify and merge duplicate incidents, in a single common operating picture shared by all relevant actors, in prompt recording of information, and in clear procedures for sharing information among agencies. This should include a formal arrangement defining the respective responsibilities of the Coastguard and Border Force Maritime.

Third, there are complex incidents that cannot be managed by ordinary rescue skills alone. Responding to large numbers of people in distress, searching for people in the water, assessing survivability in cold water, processing location information from remote callers, and handling distress reports in multiple languages are not simply extensions of routine search and rescue work. They are capabilities that must be strengthened in their own right. The Inquiry's recommendations support this point: the formal introduction of procedures for prioritising large numbers of people in the water, continued joint training among the relevant agencies, efforts to promote similar procedures internationally through appropriate international bodies, and stronger training for small boat incidents.

#### 4. Conclusion

What should be emphasised most about this case is that it was not a failure caused by a single factor. It was a compound incident in which several problems overlapped: a shortage of personnel, information overload, the difficulty of coordinating multiple agencies, and shortcomings in rescue capability. Together, these factors led to an unresolved maritime distress incident being treated as if it had already been resolved. In this sense, the case was not merely one tragic accident at sea. It was an incident in which systems, operations, human resources, and qualification arrangements were all tested at the same time.

The case also brings into focus the importance of staffing and qualification requirements. Even if the number of personnel appears sufficient, effective operational capacity cannot be secured if there are too few qualified staff. Conversely, if too much decision-making responsibility is concentrated on a small number of qualified people, the whole system becomes fragile. The fact that the watch manager was unable to take a break during a twelve-hour shift and was reportedly exhausted illustrates this point clearly. In preparing for similar incidents in the future, it is therefore necessary to look not only at increasing staff numbers, but also at qualitative matters: securing qualified personnel, maintaining continuous training, ensuring workable handovers, and establishing a functioning system under which senior officers review key decisions.

Finally, this incident shows that the kind of event we hope will never happen did not occur as a one-off exception. It occurred under conditions that may well arise again. For that reason, it is important not simply to mourn the outcome or end the discussion by assigning blame. We need to look carefully at what reflected the limits of the system, what reflected the limits of operational practice, and what reflected problems in organisational culture. The significance of the Cranston Inquiry Report lies not only in recording a tragic loss of life, but also in giving clear form to a structure of failures that might have been avoidable.

Serious accidents rarely arise from a single cause. More often, they occur when several errors and weaknesses come together. This incident, too, can be understood in that way. The Inquiry Report reminds us that, to prevent a similar tragedy from happening again, the relevant authorities must continue to examine, even in ordinary times, whether they are prepared for complex incidents, whether their staffing and qualification systems are sound, whether their ability to integrate information is strong enough, and whether their rescue culture is ready to act on the basis of the worst-case scenario.

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