1
2 MARCHIONESS/BOWBELLE
FORMAL INVESTIGATION UNDER
3 MERCHANT SHIPPING ACT 1995
4
5
6 Held at:
7
CENTRAL HALL, WESTMINSTER,
8 STOREY'S GATE,
LONDON SW1H 9NH
9
10 on
11
Monday, 2nd October 2000
12
13 --------------------
14
Before:
15
16 LORD JUSTICE CLARKE
(The Wreck Commissioner)
17
CAPTAIN T. BAILEY
18 COMMODORE D. SQUIRE
(Assessors)
19
20 --------------------
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25 PROCEEDINGS
DAY 1
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29
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1 A P P E A R A N C E S
LORD WILLIAMS OF MOSTYN, The Attorney-General,
2 MR N. TEARE Q.C., MR D GOLDSTONE and MS S. LECK appeared
on behalf of the Attorney-General.
3
MR NICHOLAS PURNELL Q.C. and MR SIMON GAULT (instructed by Hill
4 Taylor Dickinson, Solicitors) appeared as counsel on
behalf of British Dredging Limited and South Coast
5 Shipping Company Limited
6 MR MICHAEL CAPLAN (instructed by Kingsley Napley, Solicitors)
appeared as counsel on behalf of Douglas Henderson
7
MR SIMON RUSSELL-FLINT (instructed by Russell Jones & Walker,
8 Solicitors) appeared on behalf of Mr Terence David
Blayney.
9
MR PETER DOYLE (instructed by Venters Reynolds, Solicitors)
10 appeared on behalf of Edward John Quantrill.
11 MR JOHN REEDER Q.C. and MR NEVILLE PHILIPS (instructed by Shaw
and Croft, Solicitors) appeared on behalf of Tidal Cruises
12 Limited.
13 MR MATTHEW SELIGMAN (instructed by Pattinson & Brewer,
Solicitors) appeared on behalf of Debra Lesley Faldo and
14 Andrew David McGowan.
15 MR CHARLES MACDONALD Q.C. and MR NIGEL COOPER (instructed by
The Treasury Solicitor) appeared as counsel on behalf of
16 The Department of the Environment, Transport and The
Regions.
17
MS SHEILA CAMERON Q.C. and MR ANDREW NEWCOMBE (instructed by
18 Winckworth Sherwood, Solicitors) appeared as counsel on
behalf of the Port of London Authority.
19
MR CHARLES HADDON-CAVE Q.C. and MR NIGEL JACOBS (instructed by
20 Irwin Mitchell, Solicitors) appeared as counsel on behalf
of The Marchioness Action Group.
21
MR MICHAEL MANSFIELD Q.C. and MR NIGEL MEESON (instructed by
22 Taylor Joynson Garrett, Solicitors and Birnberg Peirce &
Partners, Solicitors) appeared as counsel on behalf of The
23 Marchioness Contact Group.
24 MR RONALD THWAITES Q.C. and MR JOHN BEGGS (instructed by the
Solicitor's Department of The Metropolitan Police Service)
25 appeared on behalf of The Metropolitan Police Service
26 MR IAIN JAMES PHILPOTT appeared in person
27 MS RENEE HALLEZ appeared in person
28
29
30

1 <Day 1.
2 Monday, 2nd October 2000.
3 LORD JUSTICE CLARKE: As everyone here today knows, this is the
4 first day of a formal investigation into the collision
5 between the BOWBELLE and the MARCHIONESS which took place
6 on the River Thames at about 0146 on 20th August 1989,
7 over eleven years ago, with the tragic loss of 51 lives.
8 On 14th February of this year, the Secretary of
9 State for the Environment, Transport and the Regions, the
10 Deputy Prime Minister, Mr John Prescott, directed that a
11 formal investigation be held into the collision and the
12 subsequent search and rescue operations. I was ed
13 appoint to conduct the formal investigation as Wreck
14 Commissioner.
15 The essential purposes of a formal investigation
16 are to ascertain in a public forum the cause of the
17 collision and of the loss of life which followed and to
18 consider what lessons can be learned in order to avoid a
19 similar casualty in the future.
20 I set out my view of the purpose of a Public
21 Inquiry in section 5 of my final report in the Thames
22 Safety Inquiry published in February of this year.
23 I shall not repeat now what I said then, save to
24 say that I intend that this should, in the words of
25 Lord Bingham, be a full, fair and fearless investigation
26 which will involve the exposure of the relevant facts to
27 public scrutiny.
28 I have held two preliminary hearings on
29 21st March and 21st June when I have gave detailed
30 directions for the preparation of the Inquiry. I am very

1 pleased to say that all parties have cooperated fully, and
2 I would like to thank everyone for their co-operation to
3 date, because an Inquiry of this kind cannot sensibly
4 proceed without goodwill on all sides.
5 I would also like to urge all parties and their
6 solicitors and counsel to continue to co-operate, in order
7 to ensure, on the one hand, that the Inquiry is full and
8 fair, but, on the other, that it focuses only on the facts
9 which can properly be said to be causative of the
10 collision or loss of life and is conducted with reasonable
11 expedition.
12 I would like to return briefly to the future
13 conduct of the Inquiry after each party has had an
14 opportunity to make a short opening statement. I have
15 every reason to think that those opening statements will
16 be completed in the course of today, and that we should
17 begin to hear the evidence tomorrow.
18 I propose to sit today until 1 o'clock and then
19 from 2 o'clock to 4.30, or until the opening statements
20 are concluded, whichever is the earlier. Before I ask the
21 Attorney-General to outline the facts, I would like to
22 mention three further points:
23 The first is that, as you can see, I am assisted
24 by two Assessors, Commodore Squire on my left and
25 Captain Bailey on my right, who, I hope, will keep me on
26 the right lines.
27 The second is that I have also been asked to
28 conduct a non-statutory Inquiry into the identification of
29 victims following major traffic accidents. I propose to
30 conduct that Inquiry after the conclusion of the formal

1 investigation. Its terms of reference are in these
2 terms:
3 (1) to consider and to report on the procedures
4 followed to establish the identity of the victims of the
5 collision between the BOWBELLE and the MARCHIONESS;
6 (2) to review and to report on the procedures
7 currently followed when establishing the identity of
8 victims following similar accidents;
9 (3) in the interests of minimising distress to
10 the families of victims, (1) to advise on what additional
11 procedures should be followed, if any, when the need to
12 identify victims arises following similar accidents, and
13 (2) to consider and advise on procedures for the
14 notification and involvement of the next of kin in cases
15 when it is necessary to establish the identity of such
16 victims.
17 I have already received a considerable number of
18 submissions, but if anyone who has not already done so
19 would like to contribute in any way to that Inquiry,
20 please would he or she contact Mr Sandal at MARCHIONESS
21 Inquiries, Westminster Central Hall, Storeys Gate,
22 Westminster, London SW1H 9NH.
23 The third point is that, as everyone can see,
24 the television cameras are here to record the opening of
25 the proceedings. It seemed to me that it would be
26 appropriate for them to cover the opening statements made
27 by each party, but not the evidence, which can, of course,
28 be reported in the ordinary way.
29 The evidence will be available on the Inquiry's
30 website to which I shall refer further before the evidence

1 begins.
2 Finally, two administrative matters of very
3 little importance: first, the microphones have, I think,
4 been set up on the basis that counsel will sit and not
5 stand when addressing the Inquiry or examining witnesses,
6 but any counsel is free to sit on stand as he or she
7 wishes.
8 Second, although we have done so this morning,
9 we shall not in the future process in and out.
10 I will now ask the Attorney-General to open the
11 formal investigation.
12 THE ATTORNEY-GENERAL: Sir, you have a list of parties and of
13 legal representation. I am here, as Attorney-General, to
14 show a decent respect for those who died and an
15 appropriate regard for those who still mourn, believing,
16 as they do, perhaps, that they have been let down by the
17 past process of inquiry and redress.
18 In the early hours of Sunday, 20th August 1989,
19 the dredger, BOWBELLE, collided with the MARCHIONESS. 51
20 people lost their lives. The collision was the worst on
21 the Thames since 3rd September 1878 when the paddle
22 steamer PRINCESS ALICE collided with the steamer, BYWELL
23 CASTLE, at Gallions Reach and over 600 lost their lives.
24 On 9th June 1983 there was a collision on the
25 Thames between a dredger and a passenger launch, the PRIDE
26 OF GREENWICH. The name of that dredger was BOWBELLE.
27 Nobody was hurt as a result of that collision.
28 There was an investigation into it by the Department of
29 Transport. A surveyor in the Department at the time,
30 Captain McGaw, wrote a minute about that collision.

1 I quote from the part of it:
2 "The cause of this incident can only be put
3 down to grossly inadequate visibility from the respective
4 steering positions, that of the BOWBELLE ahead and that of
5 PRIDE OF GREENWICH ASTERN. If adequate visibility from
6 these positions had been achieved the incident would not
7 have occurred ... Until such time of a requirement for
8 excellent all round visibility is made and enforced for
9 all vessels using those or similar waterways accidents of
10 this nature will continue to occur - possibly with fatal
11 results".
12 Captain McGaw's was note a lone voice. Ten
13 years earlier in 1973, Chief Inspector Turner of the
14 Metropolitan Police had written to the Department of
15 Transport about the safety of passenger launches on the
16 Thames. By the early 1980s and following a series of
17 collisions, including the one I mentioned, there was much
18 concern at the prospect of a serious accident between a
19 passenger launch and the dredger.
20 At a meeting in 1983, Mr Creber, the Chief
21 Marine Surveyor in the London Marine Office of the
22 Department of Transport, said that in his view: "As things
23 stood, it was not a case of if a serious incident occurred
24 but when".
25 Such concerns were felt not only of Department
26 of Transport but also at the Port of London Authority and,
27 indeed, by the owners of BOWBELLE, British Dredging, which
28 became East Coast Aggregates in 1983.
29 On 14th February this year, as you indicated,
30 sir, the Deputy Prime Minister ordered a formal

1 investigation into the collision. The reasons why a
2 Public Inquiry was not ordered earlier were considered by
3 you in the Thames Safety Inquiry. It is not necessary for
4 me to rehearse those reasons. The purpose of this Inquiry
5 is to investigate in public why the collision and its
6 tragic consequences occurred.
7 The immediate circumstances raise many
8 questions: What exactly happened? Was BOWBELLE
9 travelling too fast? Did MARCHIONESS make a late turn to
10 port across her path? Was MARCHIONESS unexpectedly
11 affected by interaction or tidal eddies? How could it be
12 that nobody on the bridge or the fo'c'sle of BOWBELLE saw
13 MARCHIONESS until the last moment? Were they distracted
14 by HURLINGHAM? How could it be that nobody on MARCHIONESS
15 saw BOWBELLE until a few seconds before the collision?
16 Why had the mate of MARCHIONESS not been instructed to
17 keep a lookout? Were any of the crewmen on duty that
18 night affected by alcohol?
19 Those are important matters for consideration.
20 But against a background of concern, going back more than
21 15 years before the collision, there is another issue that
22 requires attention. How is it that if so many people had
23 known for so long of the risk of serious collision on the
24 Thames, such a thing could, nevertheless, still occur?
25 What steps had been taken in the light of known risks?
26 Why did those steps prove to be so inadequate? There may
27 be lessons to be learned here, but are no less important
28 than the lessons to be learned from the collision itself.
29 I turn in a moment to some of the principal
30 issues that will confront you. But may I, before doing

1 so, mention that, in accordance with your directions, all
2 parties have served provisional answers to the questions
3 posed in the Notice of Investigation as well as
4 provisional criticisms. The service of those provisional
5 answers has enabled the issues to be identified at the
6 outset rather than as the Inquiry proceeds.
7 The service of those criticisms has enabled
8 those who face such criticism to know the charges against
9 them. I believe this has been of particular importance to
10 three individuals who face personal criticism, but, who,
11 nevertheless, have agreed to give oral evidence before
12 you, namely Captain Henderson, Mr Blayney and Mr McGowan.
13 It is against the background of those provisional answers
14 and criticisms that I continue.
15 It might be thought that with a collision
16 involving so many people in the middle of London on a
17 clear night in the late summer, one could at least be sure
18 about where it happened, but, in fact, for many years
19 there has been controversy about this.
20 The BOWBELLE was a suction dredger. She would
21 extract sand and gravel from the seabed outside the Thames
22 Estuary using specialised dredging gear. She would then
23 take it upriver to her berth at Nine Elms. The sand and
24 gravel would then be used in the building industry.
25 Could we have, please, document No. 1 Admiralty
26 Chart 3319?
27 On Friday, 18th August, BOWBELLE left her berth
28 nine hours heading for her dredging grounds at sea. She
29 finished dredging and returned to London the next day. On
30 Saturday afternoon, at about 1340, she was secured

1 alongside the Metro Greenham Aggregates wharf at Nine
2 Elms. The aggregate was discharged that afternoon and the
3 job was finished at about 2230.
4 At 0102, in the early morning of Sunday,
5 20th August, Captain Henderson, the Master of BOWBELLE,
6 reported by VHF to the Port of London Authority's
7 navigation control centre at Woolwich that BOWBELLE was
8 singling up. Her impending departure was broadcast by
9 Woolwich on channel 14 to all ships.
10 At 0112, the last of BOWBELLE's lines was cast
11 off and she set off again downriver back towards the
12 dredging grounds. At 0120 she passed under Vauxhall
13 Bridge. Again she reported to Woolwich. Ten minutes
14 later, at about 0130, BOWBELLE passed under Westminster
15 Bridge. A few minutes earlier, MARCHIONESS had left
16 Charing Cross Pier with 132 people on board, including the
17 crew, Mr Faldo and Mr McGowan. She had been booked for
18 the night for a private party. She set off a few minutes
19 ahead of BOWBELLE in the same direction.
20 Ahead of MARCHIONESS was another passenger
21 launch, the HURLINGHAM, which had left Westminster Pier
22 sometime between 10 past and quarter past 1. By
23 coincidence, HURLINGHAM was owned by Tidal Cruises, who
24 were also the owners of the MARCHIONESS.
25 Could we have document 2, the Port of London
26 Authority's chart 317, please?
27 The chart shows the stretch of river from just
28 west of Waterloo Bridge to just east of Tower bridge off
29 the chart on the right-hand side.
30 It is not in dispute that the collision occurred

1 somewhere to the west of Cannon Street bridge, that is, to
2 the left of it, looking at the chart. There can, I think,
3 be no dispute that the collision occurred no further west
4 than a position on the river in front of the Globe
5 Theatre. Mr Phang, a survivor, who helped to organize the
6 party on board MARCHIONESS recalls passing the Globe
7 Theatre before the collision took place. The question is,
8 where within those limits did the collision actually
9 occur?
10 One version is that the collision occurred on
11 the approach to Southwark Bridge, that is to the left of
12 Southwark bridge looking at the chart. That is marked
13 with a "1". The other possibility is that it occurred
14 sometime after Southwark bridge, probably closer to Cannon
15 Street bridge than Southwark Bridge. We have marked that
16 with a "2".
17 Version 1 is substantially based on the evidence
18 of some of those on board HURLINGHAM. She had been
19 overtaken by MARCHIONESS some time between Blackfriars and
20 Southwark bridges. We shall be calling Mr George Williams
21 to give evidence. He was the Skipper of HURLINGHAM. He
22 recalls the collision occurring before Southwark Bridge.
23 Some of the passengers who were standing on the foredeck
24 of HURLINGHAM also recall that the collision occurred
25 before Southwark bridge AND you will hear evidence from
26 one of them.
27 Version 2 draws upon the evidence of many more
28 witnesses (indeed the large majority) who put the
29 collision between Southwark and Cannon Street bridges.
30 They include the crew of BOWBELLE and two bystanders, who

1 were standing immediately outside the Anchor public house
2 at the time. We shall be calling them to give evidence.
3 They say they watched the collision happen in front of
4 them.
5 There is also evidence as to the location of the
6 wreck of MARCHIONESS. It is marked on the chart. There
7 was a strong flood tide in excess of three knots at the
8 time. The tide would have tended to carry the wreck
9 upstream before it settled on the riverbed. The location
10 of the wreck is, therefore, difficult to reconcile with a
11 collision on the approach to Southwark Bridge.
12 You, sir, will have to decide which evidence you
13 prefer on the evidence, but in my opening I shall
14 concentrate, if I may, on version 2.
15 There is less controversy regarding the time of
16 the collision. The navigation control centre at Woolwich
17 has a tape-recording of a broadcast to all ships beginning
18 at 01.44 and 39 seconds. During that broadcast they gave
19 the height of tide at Woolwich: 4.1 metres above chart
20 datum. That information was written down by Captain
21 Henderson in the log of BOWBELLE. The entry is timed at
22 0145 at Southwark bridge. Captain Henderson recalls
23 making that entry at the time. So the collision could not
24 have happened before then, though it is possible that it
25 may have happened as he was writing the entry.
26 We also know from the same tape recording that
27 at 0146 and 11 seconds Mr George Williams (the Skipper of
28 HURLINGHAM) raised the alarm over channel 14. So by then
29 the collision had already occurred.
30 The nature of the collision is also, I believe,

1 largely a matter of common ground. Captain Beetham has
2 prepared a report for us. He saw the wreck of MARCHIONESS
3 after it was raised. His view is that the angle of first
4 contact between the two vessels was between 5 and 25
5 degrees and probably towards the upper end of that range
6 between 15 and 20 degrees. We have had no indication that
7 any party disagrees with the way Captain Beetham puts it.
8 He also believes that the first contact was
9 between the starboard bow of BOWBELLE and the port quarter
10 of MARCHIONESS. Again, nobody so far has suggested that
11 he is wrong about that. It seems that this initial
12 contact caused the heading of MARCHIONESS to swing to
13 port. Moments later there was a more substantial contact
14 between the stem of BOWBELLE and the port side of
15 MARCHIONESS.
16 MARCHIONESS quickly heeled over to starboard as
17 her head was turned further to port and BOWBELLE continued
18 bearing down on her. She rapidly flooded through open
19 doors and windows. She may have been rolled over on to
20 her side and she probably then passed down the port side
21 of BOWBELLE. She remained afloat briefly and then sank.
22 The whole thing must have been over in no more than about
23 a minute, perhaps less. At some early stage in the
24 collision the roof of the bar deck became detached. That
25 was fortunate. If it had not happened, the death toll
26 would almost certainly have been greater. All these
27 matters are probably not controversial though, of course,
28 fine detail will need to be filled in.
29 Speed: BOWBELLE's engines were set to half
30 ahead in the minutes leading up to the collision. They

1 had been put to half ahead after passing Westminster
2 Bridge. Such an engine setting would produce a speed of 8
3 to 8.5 knots through the water. By reference to the times
4 at which BOWBELLE passed various points in her passage
5 downriver her speed over the ground was about 5 to 5.5
6 knots. This is as would be expected because there was a
7 flood current of about 3 knots flowing at the time.
8 For MARCHIONESS, matters are not quite so
9 simple. She was found with her throttle in the full ahead
10 position, but this was probably the result of action taken
11 by her Skipper, Mr Faldo, very shortly before the
12 collision. So we cannot be sure what the engine setting
13 was before then. However, Captain Beetham concludes that
14 the relative speed between the two vessels was two to 3
15 knots based on the pattern of damage. So if BOWBELLE was
16 making between 5 and 5.5 knots, MARCHIONESS was probably
17 making between 2 and 3.5 knots. In fact, so far as we are
18 aware, nobody puts her speed at more than 3 knots.
19 There is also the evidence of when she left
20 Charing Cross Pier. We do not know her exact time of
21 departure. Nobody has been able to say, "I looked at my
22 watch as we left, so I am quite sure what the time was".
23 The evidence suggests that it was probably between 0120
24 and 0125. The distance from Charing Cross Pier to
25 Southwark is one nautical mile and to Cannon Street
26 another tenth of a mile. So if MARCHIONESS left Charing
27 Cross Pier between 0120 and 0125, she was doing an average
28 of between two and a half and three knots over the ground.
29 As both vessels were proceeding towards
30 Southwark bridge, BOWBELLE was, therefore, coming up from

1 astern of MARCHIONESS at a speed that would cause her to
2 overtake MARCHIONESS between Southwark and Cannon Street
3 bridges.
4 You will have seen, sir, that in our provisional
5 answer to question 1 in the Notice of Investigation, we
6 originally gave a speed for MARCHIONESS of 2 to 2.5 knots
7 over the ground. We think we are wrong about that.
8 Certainly, our present view (and it may be the view of
9 most of the parties) is 2.5 to 3 knots is a more likely
10 figure.
11 I may add that although the speed of HURLINGHAM
12 is not one of the matters raised in the Notice of
13 Investigation, the evidence will suggest that she was
14 proceeding probably only about half a knot more slowly
15 than MARCHIONESS. That, therefore, means that the two
16 vessels must have been almost side by side for quite a
17 while.
18 The speed of BOWBELLE:
19 Paragraph 1 of the Notice of Investigation
20 raises the question of whether the speed of BOWBELLE was
21 excessive "in all the circumstances". That phrase "in all
22 the circumstances" perhaps is unfortunate. If one
23 includes the circumstances that MARCHIONESS was ahead of
24 BOWBELLE, then there undoubtedly came a time when the
25 speed of BOWBELLE was excessive, plainly because she was
26 about to collide with the MARCHIONESS. But, of course,
27 that is not really what the question is concerned with.
28 The question is really directed at whether half ahead, or
29 5 to 5.5 knots over the ground was a safe speed for this
30 stretch of river at night.

1 BOWBELLE was not exceeding the speed limit
2 because there was no speed limit, nor is there now for
3 this stretch of the river. Nevertheless, it was night.
4 Captain Henderson knew of the visibility restrictions on
5 his vessel. I return to those in a moment. He also knew
6 that passenger launches would be out and about. Indeed,
7 he saw HURLINGHAM between Blackfriars and Southwark
8 bridges. It will be suggested by some that in those
9 circumstances half ahead or 5 to 5.5 knots over the ground
10 was far too fast for safety. On the other hand, it might
11 be said that even at half ahead or 5 to 5.5 knots over the
12 ground there was ample time for BOWBELLE to take avoiding
13 action by reducing speed and the use of sound signals and
14 the problem was not one of speed, it was one of lookout.
15 Doubtless, sir, you will consult your Assessors on this
16 question after all the evidence is to hand.
17 Could we have document 3, please?
18 This is the chart that we looked at earlier, but
19 giving our estimate of the courses of BOWBELLE,
20 MARCHIONESS and HURLINGHAM marked on it. It is based upon
21 plots that have already been circulated among the experts,
22 but I do make it clear that this is not an agreed plot.
23 The track of MARCHIONESS is only shown as far as
24 Southwark Bridge. What happened thereafter is a matter of
25 some controversy and the evidence will need to be heard on
26 that.
27 We have a good idea of the course of BOWBELLE
28 because we know she was proceeding through the centre
29 arches of the bridges along the navigation channel. There
30 is also evidence, some in statement form, some you will

1 hear, as to the usual course taken by BOWBELLE outbound
2 through the bridges. There is nothing to suggest that on
3 the night in question there was anything unusual about the
4 course taken by BOWBELLE.
5 The dashed line on the chart marked B shows what
6 we believe her most likely course to have been. As I have
7 said, this is our estimate, and it is not agreed. There
8 may be some debate as to whether her actual course was a
9 few metres north or south of that line.
10 Mr Faldo cannot tell us what course MARCHIONESS
11 was taking because he did not survive, nor can the mate,
12 Mr McGowan, because he was attending to the passengers
13 during the passage down river.
14 Nevertheless, some of her passengers recall she
15 took a course along the centre of the river. Certainly
16 there is not much doubt that Mr Faldo was intending to
17 take MARCHIONESS through the centre arches of Southwark
18 and Cannon Street Bridges. This was, of course, the same
19 route that BOWBELLE was taking, but whereas BOWBELLE was
20 shaping to pass through the middle of the centre arches,
21 it is likely that MARCHIONESS was shaping to pass through
22 the southern side of those arches.
23 It seems to us that the likely courses of both
24 vessels prior to Southwark Bridge raise a most important
25 point. If both vessels were heading for the centre arches
26 of Southwark Bridge and Cannon Street bridge, then even if
27 nothing had caused their paths to converge, the likely
28 passing distance between them would not have been more
29 than about 15 to 20 feet, having regard to the distance
30 between the bridge piers of the centre arches of Southwark

1 and Cannon Street bridges (140 and 136 feet respectively)
2 and the breadth of the vessels (44.4 feet and 15.5 feet).
3 The question, therefore, which needs to be asked
4 is this: Did the very fact that both vessels were heading
5 for the same arch of Southwark Bridge, separated by less
6 than a minute in time, in itself create a potentially
7 hazard situation? Even if the two Masters had been aware
8 of the presence of each other's vessel, and even if they
9 had been on parallel courses, was the passing distance
10 between them sufficient for safety?
11 We shall be suggesting that a situation in which
12 both vessels were heading for the same arches of Southwark
13 and Cannon Street bridges was a dangerous one that, in
14 itself, gave rise to a risk of collision. The danger
15 arose from the simple fact that both were taking similar
16 courses and, therefore, until one or other took avoiding
17 action, there was a risk of them passing much too close to
18 each for safety. We shall suggest that this danger should
19 have been evident well before either vessel passed under
20 Southwark Bridge.
21 Events immediately before the collision:
22 I turn to the sequence of events between
23 Southwark and Cannon Street bridges. It spans a very
24 short time; from the time the bows of BOWBELLE emerged
25 from under the bridge until collision must have been well
26 under a minute. There is a dispute as to whether
27 MARCHIONESS altered course to port across the bows of
28 BOWBELLE or whether BOWBELLE simply ran into the port
29 quarter of MARCHIONESS. You will hear oral evidence from
30 survivors and others as to their recollection of events

1 during those last few moments.
2 You will also hear evidence from Mr Blayney and
3 Mr Quantrill who were on the fo'c'sle of BOWBELLE.
4 Mr Blayney recalls seeing MARCHIONESS between two and
5 three points to starboard and some distance away. He then
6 recalls MARCHIONESS altering course across the bows of
7 BOWBELLE.
8 This evidence raises a number of questions. Is
9 it possible? Is it credible? If Mr Faldo had altered
10 course so as to turn a passing into a collision, where his
11 vessel at the time of that alteration of course? How had
12 it got there? And why did he alter course (if he did) in
13 this way? If Mr Faldo did apply port helm, was it
14 anything more than a small adjustment of heading to keep
15 MARCHIONESS on course for the central arch of
16 Cannon Street?
17 To assist the Inquiry, we have produced a series
18 of plots. I do not trouble you, sir, with the details
19 now, although I should say at present it does appear to us
20 that Mr Blayney's account cannot be dismissed as either
21 impossible or implausible.
22 In considering whether his account is correct,
23 one needs to take into account the possible effects of the
24 tide, the local currents and hydrodynamic interaction and
25 you will be assisted by expert evidence on these matters.
26 However, whatever the precise sequence of events
27 after Southwark Bridge in those last moments, can it
28 really explain the collision? If the ordinary navigation
29 of BOWBELLE and MARCHIONESS, perhaps combined with the
30 affects of tide, the local currents and hydrodynamic

1 interaction, was sufficient to result in a collision, does
2 this not suggest that there was something seriously wrong
3 with the navigation of both vessels before
4 Southwark Bridge? I repeat the point which I made
5 earlier: Just how safe was it for both vessels to have
6 been proceeding for the same arches of Southwark and
7 Cannon Street bridges in the first place?
8 Visibility of MARCHIONESS from BOWBELLE:
9 I turn to the questions of visibility raised by
10 questions 2 and 3 of the Notice of Investigation.
11 By "visibility" is meant the extent to which
12 each vessel could have been seen by the other if there had
13 been someone watching. This, in the main, is a question
14 of three dimensional geometry. If you know the size and
15 position of the obstructions (whether they are bridge
16 arches or dredging gear) it is a matter of calculation to
17 work out what could have been seen at what distance and
18 from where.
19 I begin with BOWBELLE and what could have been
20 seen of MARCHIONESS by Mr Blayney on the fo'c'sle of
21 BOWBELLE. The stern light on MARCHIONESS should have been
22 sufficiently bright to be seen from a distance of two
23 miles. For the entire period with which we are concerned,
24 that is from when BOWBELLE passed under Waterloo Bridge,
25 the distance between BOWBELLE and MARCHIONESS was well
26 under a mile.
27 There is evidence from one witness, who is a
28 retired river constable, that on the previous night he had
29 seen MARCHIONESS proceeding with no illuminated stern
30 light. You will wish to consider whether that might have

1 been the position on the following night. But, subject to
2 that, there should have been no difficulty about seeing
3 her stern light from the BOWBELLE, assuming, of course,
4 uninterrupted line of sight.
5 It is likely to be common ground that there was
6 just such an uninterrupted line of sight from the fo'c'sle
7 of BOWBELLE, save possibly for a brief period when
8 MARCHIONESS and BOWBELLE were on different sides of
9 Blackfriars Bridges. This means that whatever the reason
10 why Mr Blayney did not see MARCHIONESS until after
11 Southwark Bridge, it was not because his view was
12 obstructed. There would have been shore lights and
13 reflections on the water. However, they would not have
14 prevented the stern light on MARCHIONESS from being seen.
15 So the position is that MARCHIONESS was there to be seen,
16 but Mr Blayney, for some reason, did not notice her. What
17 was that reason?
18 You will wish to hear Mr Blayney's evidence on
19 this, but we shall be inviting you to have in mind that
20 Mr Blayney was an able seaman, not an officer. He was
21 experienced but he was not qualified to assess
22 navigational risks and he had no instructions or guidance
23 as to what to watch out for or what to report.
24 In those circumstances, while it is surprising
25 Mr Blayney did not notice the presence of MARCHIONESS
26 ahead as BOWBELLE was approaching Southwark Bridge, his
27 omission must be put in the context of the system of
28 lookout that was being operated on BOWBELLE to which
29 I shall return in a moment.
30 Could we have, please, document 4 which is a

1 photograph showing the deck of BOWBELLE as seen from her
2 bridge?
3 Captain Henderson's view, unlike that of
4 Mr Blayney, was impaired by the various items of dredging
5 gear on the foredeck of BOWBELLE. The component parts of
6 the gear have been labelled. The impairment to visibility
7 by the dredging gear was made worse by the low wheelhouse
8 of BOWBELLE which was necessary to enable her to pass
9 under the bridges. It was particularly acute when
10 BOWBELLE was in ballast and when she was trimmed by the
11 stern as she was at the time of collision. The degree of
12 that impairment has been calculated in a most helpful
13 report prepared by Captain Noble for the Port of London
14 Authority. It is shown graphically in a sequence of video
15 clips prepared by HR Wallingford for the Treasury
16 Solicitor's Department on our behalf.
17 For much of the time those impairments of vision
18 would have prevented MARCHIONESS from being seen at all
19 from the bridge of BOWBELLE. However, there are two
20 periods during which MARCHIONESS may well have been
21 visible from the bridge of BOWBELLE in the minutes leading
22 up to the collision.
23 First of all, the impairments of vision ought
24 not to have prevented MARCHIONESS from being seen for a
25 minute or two as BOWBELLE emerged from Waterloo Bridge.
26 During that time, MARCHIONESS would have been visible from
27 the bridge of BOWBELLE because of the bend in the river
28 between Waterloo and Blackfriars Bridges. This bend means
29 that MARCHIONESS would have been bearing sufficiently to
30 starboard to have been clear of the obstructions caused by

1 the dredging gear on the deck of BOWBELLE.
2 Should Captain Henderson have noticed
3 MARCHIONESS at that stage? MARCHIONESS would have been
4 some distance ahead and, indeed, shortly about to pass
5 under Blackfriars Bridge. It might be said that at that
6 time Captain Henderson was entitled and, indeed, bound to
7 focus his attention on vessels that might affect the
8 passage of his ship in the stretch of water immediately in
9 front of him; that is between Waterloo and Blackfriars
10 bridges. It might be said that he had no reason to be
11 concerned or even to notice MARCHIONESS at that time
12 because she would already have been about to pass under
13 Blackfriars bridge. You will have seen our provisional
14 answer on this question. We take the view that it cannot
15 be said to be a substantial criticism of Captain Henderson
16 that he did not then see MARCHIONESS.
17 Others may take a different view. It will be
18 suggested, I am sure, that even at this relatively early
19 stage, Captain Henderson should have made it his business
20 to be aware of the presence of any passenger vessel ahead
21 of him, especially one that appeared to be taking a course
22 through the centre arches of the bridges. You will have
23 to decide between those two views. You will have the
24 benefit of evidence from Captain Henderson and, of course,
25 advice from your Assessors.
26 Secondly, the calculations which have been done
27 for us by our experts suggest that there was probably a
28 future period, perhaps 30 or so seconds, during which
29 MARCHIONESS could again have been seen from the bridge of
30 BOWBELLE by Captain Henderson, some three to four minutes

1 before the collision. If, as I have suggested, a
2 potentially dangerous situation was by then in the making
3 (because MARCHIONESS was shaping to pass through the same
4 arch of Southwark Bridge as BOWBELLE), that was the time
5 for Captain Henderson to consider either reducing his
6 speed or making sound signals or both.
7 As matters stand at the moment, it seems to us
8 there are grounds for criticising Captain Henderson for
9 failing to observe MARCHIONESS at that stage. On the
10 other hand, you may feel that the time period during which
11 Captain Henderson could have seen MARCHIONESS was so short
12 that it would be wrong to criticise him for not having
13 taken that opportunity.
14 Of course, if the position is that Captain
15 Henderson did not have any real opportunity to see
16 MARCHIONESS after his vessel had passed under Blackfriars
17 bridge, it might be suggested that this made it all the
18 more important that there should be an effective system of
19 lookout from the fo'c'sle.
20 Visibility of BOWBELLE from the MARCHIONESS:
21 BOWBELLE had a forward steaming light that would
22 have been visible from six miles. She had side navigation
23 lights. From where MARCHIONESS would have been in the ten
24 minutes before the collision, that is a distance of less
25 than a mile ahead, there should have been no particular
26 difficulty seeing BOWBELLE's forward steaming light and
27 her green starboard navigation light.
28 Some of the passengers on MARCHIONESS have
29 described how they only saw the dark hull of BOWBELLE
30 looming over MARCHIONESS and did not see any lights. The

1 explanation for this is that it would not have been
2 possible to see the steaming light of BOWBELLE from low
3 down and close at hand; the steaming light was set back on
4 the fo'c'sle. But it certainly would have been possible
5 to see it from a distance.
6 Could we have document 5 now, please?
7 This is a photograph of MARCHIONESS from before
8 the accident. We have marked on it the wheelhouse, the
9 raised bar deck and the position of the hatch in the roof
10 of the wheelhouse where the hatch cannot actually be seen
11 in the photograph.
12 Because of the presence of the raised bar deck,
13 the view when looking aft from the wheelhouse was
14 obstructed. Nevertheless, there were two ways in which
15 the Skipper or crew of MARCHIONESS could have overcome
16 this restriction and observed BOWBELLE. The first was by
17 using the hatch in the wheelhouse roof.
18 To an observer looking through that hatch, it
19 would have been possible to see BOWBELLE's navigation
20 lights for substantially the whole of BOWBELLE's passage
21 from Waterloo to Southwark Bridge.
22 It would also have been possible to see BOWBELLE
23 for much of the time by looking back over the rails on the
24 port and starboard sides of MARCHIONESS.
25 There was only one dredger on the river.
26 Mr Faldo would or should have known that BOWBELLE was
27 underway both because of his general knowledge of the
28 movements of dredgers and because of the broadcasts that
29 had been made by Woolwich. He should have been all the
30 more careful because he was navigating his vessel along

1 the middle of the river at night at a time when BOWBELLE
2 would also be passing along the middle of the river.
3 It is not, of course, possible to enquire of
4 Mr Faldo why he did not, apparently, see BOWBELLE. Was it
5 because he was in inattentive? Was it because the
6 construction of his vessel made it difficult or impossible
7 for him to keep a proper lookout astern on his own?
8 What steps should have been taken to avoid
9 collision?
10 Paragraph 4.7 of the Notice of Investigation
11 poses that question.
12 Obviously, both vessels ought to have kept a
13 good lookout. The precise steps that each vessel ought to
14 have taken, had they done so, will probably be debated
15 before you, sir, in this Inquiry. But, in essence, the
16 steps seem clear. MARCHIONESS ought to have kept to the
17 starboard side of the river, and so avoided impeding the
18 passage of BOWBELLE. And BOWBELLE, had she observed
19 MARCHIONESS heading for the centre arch of Southwark
20 Bridge, ought to have reduced her speed and sought to
21 alert MARCHIONESS to her presence by sound signals. It is
22 difficult indeed to imagine that the collision could have
23 occurred had both vessels kept a good lookout.
24 There is one aspect of this question that I need
25 to draw to your attention at this stage, and it is this.
26 Rule 13 of the International Collision
27 Regulations requires an overtaking vessel to keep out of
28 the way of the vessel that it is overtaking. The vessel
29 that is being overtaken is required to maintain its course
30 and speed. This means that once BOWBELLE started to

1 overtake MARCHIONESS, MARCHIONESS was required under
2 Rule 13 to maintain her course and speed. So if she was
3 keeping a course in the middle of the river, she was
4 required to keep that course.
5 But one of the measures introduced by the Port
6 of London Authority to address the risk of collision was
7 an amendment to By-law 19 of the River By-laws. The point
8 of the amendment was to ensure that passenger vessels kept
9 out of the way of larger vessels such as the dredgers.
10 That amendment required vessels such as MARCHIONESS not to
11 impede vessels the size of BOWBELLE. So if MARCHIONESS
12 was taking the centre of the channel in front of BOWBELLE
13 and BOWBELLE wished to overtake MARCHIONESS, then unless
14 MARCHIONESS got out of the way, she would be impeding
15 BOWBELLE. By-law 19 thus required her to move over to the
16 starboard side of the channel. Indeed, that is where she
17 should have been anyway. See Rule 9 of the Collision
18 Regulations.
19 The problem is that MARCHIONESS could not at the
20 same time maintain her course and speed as required by
21 Rule 13 and get out of the way as required by By-law 19.
22 It may be that this apparent conflict between
23 Rule 13 and By-law 19 is more theoretical than real and
24 ought not to have caused any difficulty in practice.
25 Nevertheless, sir, you may need to consider how those two
26 provisions are to be reconciled, if indeed they can be.
27 I may add that it appears to us that the same problem
28 arises even now under the current by-laws and this is a
29 matter upon which you, sir, might wish to make
30 recommendation for the future.

1 The system of lookout on BOWBELLE:
2 On BOWBELLE the forward lookout was being kept
3 by Mr Blayney. Mr Quantrill was also the on fo'c'sle with
4 Mr Blayney, but it was not his duty to keep a lookout.
5 Mr Blayney had received no particular instructions from
6 Captain Henderson or, indeed, anyone else as to what he
7 was to look out for or what to report.
8 It seems that at most he regarded his lookout
9 duty as being confined to warning Captain Henderson of
10 vessels that he, Mr Blayney, regarded as posing a danger
11 to the navigation of BOWBELLE. The system also relied on
12 shouting from the man on the fo'c'sle. There were three
13 portable VHF sets on BOWBELLE at the time of the
14 collision, but they were not being used.
15 The Inquiry will need to consider whether this
16 was an adequate system. Mr Blayney was an able seaman,
17 not an officer. He was not qualified to navigate
18 BOWBELLE. We suggest he was in no position to make an
19 assessment of navigational risks. Nor he had he received
20 any instructions about what to look for or report; yet he
21 was being required to exercise judgment and discretion in
22 a difficult stretch of water at night.
23 The Inquiry will hear that there had been a
24 practice in earlier years to post an officer forward with
25 an able seaman to keep a lookout. The officer was
26 equipped with a portable VHF set to enable him to
27 communicate with the wheelhouse. However, it seems that
28 the previous practice was deliberately discontinued on
29 BOWBELLE from about 1987. Why was that? Was the previous
30 system a better system? We suggest that it was.

1 It might be said, does any of this matter? If
2 MARCHIONESS was not seen by anyone on BOWBELLE until about
3 30 seconds before collision, what difference does it make
4 who was posted forward, what were their instructions and
5 whether they had a portable VHF set or not? It would have
6 been too late for Captain Henderson to take avoiding
7 action.
8 Sir, we suggest it does matter, because if there
9 had been a qualified officer posted forward with a
10 convenient means of communication between fo'c'sle and
11 bridge, it is more likely that the risk posed by the fact
12 that both vessels were heading for the same arch of
13 Southwark Bridge would have been appreciated and reported
14 to the Master.
15 To assist in the resolution of these questions,
16 you will hear evidence not only from Captain Henderson but
17 also from former Masters of BOWBELLE about the systems
18 they had operated and how satisfactory those systems
19 were. They do not all speak with one voice. However,
20 since they are men with experience of the same vessel as
21 Captain Henderson, their evidence is plainly relevant and
22 will need to be weighed.
23 If you take, sir, the view that the system of
24 lookout operated on BOWBELLE was inadequate, as I suggest
25 it was, it is necessary to consider where the
26 responsibility lay for that state of affairs. As Master
27 of his vessel, the Inquiry will obviously need to consider
28 the extent to which Captain Henderson should have
29 appreciated that his system was unsafe. But what of the
30 managers? What of the owners of BOWBELLE?

1 At the time of the collision and for some 14
2 months before, BOWBELLE was owned by East Coast Aggregates
3 and managed by South Coast Shipping. Both companies were
4 part of the Ready Mix Concrete group of companies. At the
5 time South Coast Shipping managed a fleet of vessels,
6 including the three "BOW" vessels that regularly traded to
7 Nine Elms.
8 Prior to June 1988, those vessels were owned and
9 managed by East Coast Aggregates. In June 1988, Ready
10 Mixed Concrete decided that the fleet and the vessels
11 owned by South Coast Shipping should all be managed by
12 South Coast Shipping. In this operational sense,
13 therefore, there was a merger between the operations of
14 East Coast Aggregates and South Coast Shipping. Sir, at
15 the time of the collision, and indeed for more than a year
16 before, responsibility for the safe operation of BOWBELLE
17 and the other BOW vessels had rested with South Coast
18 Shipping.
19 You will hear evidence from some of the managers
20 and directors of South Coast Shipping, including the
21 marine officer, Mr Darwell, and the general manager,
22 Mr Samuel. The Inquiry will need to consider whether the
23 standing orders that were in place were adequate. If they
24 were not, why was that?
25 It seems that Mr Darwell was asked to update the
26 standing orders after the merger, but did he have the
27 knowledge that would enable him to tailor standing orders
28 to the needs of the vessels that traded beneath the
29 bridges? What steps were being taken to monitor the
30 system of lookout on BOWBELLE? Did anyone among the

1 management at South Coast Shipping even know what the
2 system was? If not, why was that? Was it because,
3 contrary to good ship management practice, there was not a
4 designated person ashore responsible for monitoring the
5 safety aspects of the operation of the South Coast
6 Shipping fleet, including BOWBELLE?
7 Since the risk of a collision between a dredger
8 and a passenger vessel causing loss of life had been
9 foreseen years earlier, it will also be necessary to
10 examine what steps East Coast Aggregates took before
11 June 1988 to eliminate that risk.
12 The Inquiry labours under the handicap that
13 Captain Butcher and Mr Bason, two of the key men at East
14 Coast Aggregates, died some years earlier. But there is a
15 body of documentary evidence to suggest that, particularly
16 in the early 1980s, they, particularly Captain Butcher,
17 were deeply concerned about the possibility of a serious
18 accident involving one of their vessels and a passenger
19 vessel. They took steps to address the problems as they
20 saw them.
21 Captain Butcher amended the standing orders to
22 draw particular attention to the problems of navigation
23 above the bridges. It was he, Captain Butcher, who
24 introduced the system of portable VHF sets and he,
25 Captain Butcher, was active in many meetings and
26 discussions that were held in the early 1980s to try to
27 address the problems.
28 Why then was the amendment to the standing
29 orders effectively withdrawn in 1987? Why did the use of
30 portable VHF sets fall into abeyance even though

1 Captain Butcher was still working at East Coast
2 Aggregates? Did East Coast Aggregates have an effective
3 system for monitoring shipboard practices? All of these
4 matters will need to be considered by this Inquiry.
5 The evidence presently available suggests that
6 East Coast Aggregates did not have a proper system for
7 monitoring shipboard practices and that the management did
8 not know that the practice of posting an officer on the
9 fo'c'sle equipped with a portable VHF set which had been
10 introduced in the early 1980s, in order to provide
11 effective lookout and good communications between bridge
12 and fo'c'sle, had fallen into disuse on BOWBELLE well
13 before the collision of MARCHIONESS. Nor, it appears, did
14 the management of South Coast Shipping discover this. In
15 1989, and for two years before, the standing orders from
16 BOWBELLE's owners and managers did not draw attention
17 either to the need for a lookout on the fo'c'sle when
18 navigating above the bridges or for an effective means of
19 communication between the bridge and the fo'c'sle.
20 You will know, sir, that it has been suggested
21 by the family groups represented before you that
22 Ready Mixed Concrete, which owned both East Coast
23 Aggregates and South Coast Shipping, must bear
24 responsibility for any failure on the part of subsidiary
25 companies to have adequate safety standards and policies.
26 You will have to consider whether that suggestion is
27 well-founded in circumstances where the requisite
28 knowledge and expertise concerning ship management was to
29 be found within the subsidiary companies.
30 To assist in deciding this issue, you have the

1 benefit of documentation provided by Ready Mixed Concrete
2 bearing on matters of safety policy. You will hear from a
3 former director of East Coast Aggregates and South Coast
4 Shipping, Mr John Ornsby, and from Mr Julius Stephens.
5 Mr Ornsby was the Southern Regional Director for Ready Mix
6 Concrete (UK) Limited from 1974 until 1995, and he was the
7 man to whom the General Managers of East Coast Aggregates
8 and South Coast Shipping reported. Mr Stephens was the
9 manager of Ready Mixed Concrete Group Safety Department.
10 I touch on the question of alcohol.
11 This is a sensitive matter, and it would be
12 wrong of me to anticipate the evidence in any detail.
13 I limit my remarks at this stage, therefore, to the
14 factual question as to whether the ability of either
15 Captain Henderson or Mr Blayney to perform their duties
16 was affected by alcohol at the time of the collision.
17 There is no doubt that both men had consumed some alcohol
18 during the previous day. They both gave detailed accounts
19 to the police about what they had drunk.
20 Based on those accounts and other information
21 provided to this Inquiry, calculations have been carried
22 out to try to establish blood alcohol concentrations for
23 Captain Henderson and Mr Blayney at the time of
24 collision. The experts have calculated that if the two
25 men eliminated alcohol from their bodies at an average
26 rate, Captain Henderson would have had no alcohol in his
27 blood at the time of the collision and Mr Blayney 35
28 milligrams per 100 millimetre of blood. That is just
29 under half the legal limit for driving on the road.
30 Of course, the accuracy of those calculations

1 depends upon the accuracy of the information provided by
2 Captain Henderson and Mr Blayney to the toxicologists.
3 This is a matter which, doubtless, the Inquiry will wish
4 to investigate.
5 However, if (and I must stress that) the
6 assumptions upon which the experts have worked are
7 correct, it seems most unhighly that Captain Henderson was
8 at all affected by alcohol and unlikely that Mr Blayney
9 was affected to any significant degree.
10 The system of lookout on MARCHIONESS:
11 She was carrying 132 passengers at night in a
12 crowded and potentially hazardous stretch of river. Those
13 passengers were dependent for their safety upon the
14 quality of the lookout kept on the vessel upon which they
15 were travelling. MARCHIONESS had only two crew.
16 Mr McGowan, the mate, had no instructions to keep a
17 lookout and did not regard it as his duty to do so. Any
18 lookout being kept on MARCHIONESS was kept solely by
19 Mr Faldo. Was this a safe system? In order to keep
20 lookout astern, Mr Faldo either had to leave the wheel,
21 step up, open the hatch in the roof of the wheelhouse and
22 look back, or he had to cant his vessel to port or
23 starboard, or he had to leave the wheelhouse altogether
24 and look over the ship's side. It may be thought that
25 such a system could not possibly be regarded as safe. On
26 the other hand, it may be said that it was possible to
27 keep a good lookout, notwithstanding the limitations
28 I have described. We shall be suggesting the former,
29 namely, such a system could not possibly be regarded as
30 safe.

1 If the Inquiry concludes that the system was
2 indeed unsafe, then why was that? Why had no instructions
3 been given by Mr Faldo to Mr McGowan to keep a lookout
4 astern? Why had no instructions been given by the owners
5 of MARCHIONESS to Mr Faldo to ensure that his mate kept a
6 lookout astern?
7 The Inquiry will hear evidence that in 1984
8 Tidal Cruises, the owners and managers of MARCHIONESS, had
9 been required by the Department of Transport to have a man
10 other than the man at the helm keeping a lookout. At
11 about the same time, when Tidal Cruises sought and
12 obtained from the Department of Transport permission to
13 reduce the crew of VISCOUNTESS and HURLINGHAM from three
14 to two, they were again required to have a man other than
15 the man at the helm on lookout. Why did this practice not
16 obtain in MARCHIONESS in 1989? Did Tidal Cruises take any
17 steps to give effect to the requirements of the Department
18 of Transport?
19 At present, the evidence does not reveal that
20 any such steps were taken. Even if that practice had
21 obtained, how effective would it have been? How precisely
22 could Mr McGowan have kept a lookout astern on
23 MARCHIONESS, bearing in mind the small size of the
24 wheelhouse and the fact that the passengers had access to
25 the deck on either side of it?
26 Was it, in fact, the case that this vessel,
27 MARCHIONESS, could not be safely operated with a crew of
28 only two when one of them was required to attend to
29 passengers from time to time? You will hear evidence on
30 these matters from, among others, Mr McGowan and the

1 directors of Tidal Cruises, Mr Ludgrove and Mr Dwan.
2 The Department:
3 This brings me to the role played by the
4 Department of Transport. MARCHIONESS was a Class V
5 passenger vessel. She was, therefore, subject to a system
6 of annual survey by the Department. The surveyor was
7 required to certify that the vessel was fit to ply the
8 Thames. Was she in 1989?
9 Could we have document 6, please?
10 Document 6 is a plan of MARCHIONESS showing her
11 after she was built in 1923. At that time she bore little
12 resemblance to the vessel that sank in 1989. She had only
13 one saloon; she had an open steering position. From the
14 steering position, the helmsman would have had an
15 unobstructed 360 degree view, but in 1979 she was bought
16 by Tidal Cruises. They modified her substantially.
17 Document 7, please.
18 The profile at the top of the page shows
19 MARCHIONESS as she was by the end of the conversion in
20 1982. Her wheelhouse was further forward. It was
21 covered. The view astern was obstructed by a raised
22 saloon. Nor was there anywhere for a man to keep a
23 lookout at the stern of the vessel because the after deck
24 had been covered over as well.
25 The Inquiry will need to consider why these
26 modifications were permitted if the effect was to prevent
27 the helmsman from having an all round view. Is it because
28 the Department had insufficient power to prevent such
29 modification? Is it that those responsible for the
30 approval process did not appreciate the problems? If the

1 latter, why was that? Was it because the problems posed
2 by limited visibility from the wheelhouse of passenger
3 vessels were not appreciated at the time when MARCHIONESS
4 was converted or was there some other reason? Our present
5 view is that the Department should have appreciated the
6 visibility problem at the time of the conversion, having
7 regard to the consideration given to the problem generally
8 in 1973 and 1974 and, therefore, that the conversion ought
9 not to have been permitted.
10 Having approved the modifications to
11 MARCHIONESS, should the Department then have taken other
12 steps to mitigate the adverse effects on visibility?
13 MARCHIONESS, as I said earlier, and other vessels in the
14 same ownership, had in 1984 been required by the
15 Department of Transport to have a man other than the man
16 at the helm keeping a lookout. The Inquiry will need to
17 examine closely the circumstances in which those
18 requirements were imposed. Why was the requirement not
19 repeated annually when the passenger vessel certificate
20 came up for renewal? Should it have been?
21 The Inquiry will have evidence from surveyors
22 who worked at the Department of Transport in the late
23 1970s and 1980s, in particular, from Mr Creber, who was
24 the Chief Marine Surveyor at the London Marine Office
25 between 1973 and 1985 when he retired. He was among the
26 most active in seeking to promote the safety of navigation
27 on the Thames during his period in office. You will also
28 hear from a number of other surveyors, senior and junior,
29 who played a part in the events under consideration.
30 It has also been suggested by some parties that

1 the Department should have taken steps in relation to
2 BOWBELLE and indeed perhaps should not have permitted
3 BOWBELLE to operate at all on the Thames. You will have
4 to consider whether that is a fair criticism and, indeed,
5 upon what basis it is said The Department could have taken
6 such steps. We, plainly, shall have to see how the case
7 is put, but I ought to make it clear at present we do not
8 suggest the Department should or could have taken any such
9 steps.
10 I turn to the Port of London Authority:
11 The Inquiry will hear evidence from those at the
12 Port of London Authority who were involved with events in
13 the 1980s. The Authority was and is responsible for the
14 safety of navigation on the Thames. They, as with the
15 Department, were active in seeking to improve matters in
16 the 1980s when it had become clear that all was not well
17 on the river.
18 It was they who were responsible for promoting
19 the amendment to By-law 19 that I mentioned earlier. They
20 introduced the new VHF reporting requirements. They took
21 steps to enforce Rule 9 of the Collision Regulations by
22 which vessels like MARCHIONESS were to keep as far over to
23 the starboard side of the channel as practicable.
24 But the Inquiry will need to consider whether
25 there is more they ought to have done. Should the PLA
26 have taken steps to enforce the keeping of a good lookout
27 astern by passenger launches as some have suggested?
28 Should they, as we say, have required vessels such as
29 BOWBELLE to station a lookout forward in VHF communication
30 with the wheelhouse? Could they and should they have

1 taken even more radical steps? Should they have banned
2 BOWBELLE altogether? Or are some or all of those
3 suggestions only made with the benefit of hindsight?
4 Rendering of assistance by BOWBELLE:
5 One of the matters which has been controversial
6 almost since the day of the collision is the question of
7 whether something could or should have been done by
8 Captain Henderson to assist those from MARCHIONESS who
9 were in the water. This is the first time that there has
10 been an opportunity for this question to be examined in a
11 public forum.
12 It is an emotive issue; the notion that a vessel
13 that has just been involved in a collision with a
14 passenger launch should simply proceed on its way without
15 rendering assistance, is objectionable. It is precisely
16 because the issue is so emotive (and understandably so)
17 that it needs to be considered dispassionately. The
18 Inquiry will need to look at the practical constraints
19 under which Captain Henderson was operating. His own
20 vessel was set off course by the collision. It collided
21 with Cannon Street bridge. If he had lost control of
22 BOWBELLE, the consequences could have been disastrous. He
23 could not safely have anchored, and if any steps were to
24 be taken by him, they would have to be taken almost
25 immediately because the survivors from MARCHIONESS were
26 being rapidly swept upstream. Yet it may be said there
27 was something he could have done immediately. His vessel
28 had life buoys. Some of them could have been released
29 from within the wheelhouse where Captain Henderson himself
30 was standing. Why did he not release them straightaway?

1 Was it because in the agony of the moment he overlooked
2 that simple step? Was it because his attention was
3 directed at getting his own vessel safely through
4 Cannon Street bridge? If so, are there any grounds for
5 criticism or was he doing really what any ship's Master
6 would have done in that situation?
7 You will hear the evidence from Captain
8 Henderson on this question. He is the person best placed
9 to defend himself against the allegation that he could
10 have helped but did not.
11 The means of escape from MARCHIONESS:
12 51 people were brought to their deaths. 27
13 bodies were recovered from the river. The probability is
14 that they escaped from MARCHIONESS but drowned
15 thereafter. Their fate is linked with the search and
16 rescue operation that I will mention soon. 24 people had
17 no opportunity to be rescued because they could not escape
18 from the wreck. Why was this? This is subject of
19 question 15 of the Notice of Investigation.
20 The Inquiry will have to consider whether the
21 means of escape and the life saving appliances on board
22 MARCHIONESS were adequate. "Adequate" for what purpose?
23 For the purpose of a catastrophic collision such as
24 occurred or for some other purpose? MARCHIONESS was
25 simply not designed with such a disaster in mind. This
26 was not an accident in which there was time for an orderly
27 escape. The lights went out. The vessel flooded in
28 seconds and within a minute or less MARCHIONESS sank.
29 It may be unlikely that additional means of
30 escape or signs would have made any real difference, but

1 it is, of course, sir, a matter for you to consider having
2 heard the evidence.
3 It will be necessary further to consider whether
4 the means of escape and life saving appliances on
5 MARCHIONESS complied with the regulations in force at the
6 time. Did she have sufficient open deck space? It may
7 well be that in this and other respects MARCHIONESS did
8 not comply strictly with the regulations in force at the
9 time. Whether any such noncompliance made any difference
10 to loss of life is a different matter about which there
11 will be different views.
12 Stability and survivability:
13 Another matter which the Inquiry will consider
14 is the stability of MARCHIONESS and her standards of
15 subdivision. This is a matter which has been recently
16 raised and I do not, therefore, address you in any detail
17 about it. I simply need to say that on the evidence as it
18 currently stands (and I do emphasise that qualification)
19 it does not appear to us that there are any grounds for
20 saying that the MARCHIONESS sank or she sank more quickly
21 because of a want of stability or subdivision. We shall
22 need to see whether my other party contends otherwise and,
23 if so, on what grounds.
24 The search and rescue operation:
25 The search and rescue operation that immediately
26 followed the sinking was a huge operation involving
27 hundreds of police officers, other members o the emergency
28 services and many vessels. The Inquiry will hear evidence
29 from a number of police officers responsible for the
30 co-ordination of that operation. No one has suggested

1 that the efforts they made on the night of the casualty
2 are susceptible to substantial criticism. Indeed, very
3 many of the 81 survivors were picked up by the boats that
4 attended the scene of the casualty.
5 It has, however, been suggested by some parties
6 that the Metropolitan Police were not adequately prepared
7 for the role they had to fulfil on the night of the
8 casualty. We shall need to see how that case is put and
9 you, sir, will need to consider whether it is a fair
10 criticism.
11 Given the nature of this casualty, in particular
12 the fact that a large number of passengers were thrown in
13 the water so quickly, it was important that such crafts as
14 were available for search and rescue were informed of the
15 casualty as soon as possible. One such craft was the Fire
16 Brigade's boat, LONDON PHOENIX. It had rescue equipment
17 and search lights.
18 The Inquiry will need to consider when the Port
19 of London Authority should have telephoned the Fire
20 Brigade. It seems their own procedures required them to
21 do so at an early stage, but the evidence does suggest
22 that they did not do so until 13 minutes after the
23 collision, and some nine minutes after they had clarified
24 the location of the casualty. But for that delay, LONDON
25 PHOENIX might have arrived on the scene earlier. If there
26 was a mistake, why was this? What can be done to prevent
27 a similar mistake being made in the future?
28 The Inquiry will hear evidence on this question
29 from the duty officer at the Port of London Authority.
30 The initial mishearing of the location of collision is

1 perhaps not a ground for criticism. It can very easily
2 happen and was soon corrected. But an apparent failure to
3 apply existing procedures may well be a ground for
4 criticism.
5 Captain Henderson's certificate:
6 The main purpose of this Inquiry, of course, is
7 to try to find out what happened and why, and to make all
8 appropriate recommendations. But the Inquiry also serves
9 a disciplinary function. Captain Henderson is a
10 certificated officer. Indeed, he is a serving officer.
11 If you find that he was guilty of serious negligence that
12 caused or contributed to the accident, you have the power
13 to remove his certificate and with that his livelihood.
14 It seems to us that the question of penalty is entirely a
15 matter for you, having regard to any submissions made on
16 behalf of Captain Henderson and by the Department as the
17 certifying authority.
18 In accordance with your earlier direction, sir,
19 a chronology has been circulated. No one, as far as I am
20 aware, suggests any material errors or omissions. We
21 shall try to ensure that the chronology is updated on a
22 regular basis to reflect any additional materials which
23 come to attention during the course of the hearing.
24 Sir, may I say just a word about my own position
25 and that of my team which assists me?
26 We are not here to present any particular case.
27 This is not adversarial litigation. Our work is to put
28 the relevant evidence before the Inquiry so that you may
29 come to your informed conclusions as to where the truth
30 lies. That does not mean we have to be silent on the

1 issues. We already given advanced notice of criticisms
2 that we may make at the end of evidence. If we consider
3 that certain findings of fact are not supported by the
4 evidence, we shall make submissions accordingly.
5 During the course of this relatively short
6 opening, I have tried to make it plain that I am simply
7 describing the case as it presently appears and presently
8 appears to us. Of necessity, this has involved my putting
9 forward an account of events which may well differ from
10 that which other parties wish to put forward.
11 I stress again that the views I have tried to
12 express are inevitably provisional and should be so. They
13 will remain provisional until the end of the evidence.
14 Those who assist me will not hesitate in withdrawing
15 criticism if evidence which comes to light suggests that
16 any criticism is unfounded. We believe that to be our
17 duty. If it subsequently appears that we have overlooked
18 matters that should be brought to your attention, it is
19 plainly our duty to do that at once.
20 Sir, that is all I wish to say at this stage.
21 LORD JUSTICE CLARKE: Thank you very much. As everyone knows,
22 the rules permit what are described as brief speeches on
23 behalf of any other party.
24 The schedule of witnesses includes a proposed
25 batting order to which I understand no one has objected,
26 so it seems sensible to follow it. On that basis, I think
27 it falls to Mr Haddon-Cave to make such submissions as he
28 wishes.
29 MR HADDON-CAVE: Thank you, sir. May it please you, sir, I
30 appear together with my learned friend, Mr Nigel Jacobs,

1 on behalf of the Marchioness Action Group.
2 Sir, may I begin by thanking the Attorney
3 General, Lord Williams, for being here today and for
4 delivering the opening speech in this Inquiry?
5 The families and survivors in the Marchioness
6 Action Group are grateful to him for recognizing and
7 marking the importance of this Inquiry in this way,
8 particularly when he has so many other calls on his time.
9 May I secondly pay attribute to the hard work
10 that Mr Sandal and the Attorney-General's team have put in
11 preparing for this hearing and for the unfailingly helpful
12 and courteous way in which they have dealt with
13 inquiries. We are also grateful for the excellent
14 facilities that have been set up and provided for all of
15 us in this building.
16 Sir, the MAG are delighted and relieved the day
17 has finally come when the facts of this tragedy which has
18 deeply and irrecoverably affected so many lives begin to
19 be fully examined in public.
20 It has been a long, difficult and often
21 disheartening 11 years for those campaigning for this
22 Public Inquiry. The fact that we are here today is due in
23 no small measure to the dedication and determination of a
24 small number of people, most of whom I am pleased to see
25 are present here this morning in the front row. It is due
26 to the laudable decision of the Deputy Prime Minister to
27 set up the Thames Safety Inquiry and, of course, sir, to
28 your rigorous analysis and decision in Part 2. For these
29 decisions the MAG are very grateful.
30 Whatever the outcome and recommendations of your

1 inquiry, sir, the very fact that it is being held in
2 public after such a long struggle is perhaps a fitting
3 tribute to those who died. It is perhaps also fitting
4 that today is the auspicious day on which the European
5 Convention on Human Rights is incorporated into English
6 domestic law.
7 The grief of the families and survivors remains
8 just as real and painful today as it did in August 1989.
9 However, the MAG approach this formal Inquiry in a
10 positive manner. They are anxious finally to know what
11 happened to their loved ones, why and who was responsible,
12 but they are also intent on looking forward and hope that
13 this formal Inquiry helps ensure that inland waterways in
14 particular are safer places for the public in the future.
15 The events last week in Greece have only served to
16 highlight that these sorts of inquiries have an importance
17 for maritime safety generally.
18 Sir, in Part 2 of your final report in the
19 Thames Safety Inquiry, you analyse carefully the case for
20 a Public Inquiry into the MARCHIONESS disaster, and
21 recommended that one should be held. You said that there
22 remained unanswered questions in a number of areas,
23 principally as regards the primary facts, as to what
24 happened in the final moments before the collision, where
25 the collision took place, etc., the role of alcohol and
26 the position of the owners of the BOWBELLE.
27 You also pointed out that any formal Inquiry
28 would have to have considered the Department of
29 Transport's role in connection with the earlier similar
30 collisions that have taken place and its approach to the

1 structural alterations to the MARCHIONESS. The evidence
2 that has so far emerged in this formal Inquiry process has
3 already more than justified your conclusion that there was
4 a case for a Public Inquiry into this disaster.
5 Sir, the provisional notice of substantial
6 criticism served on behalf of the Attorney-General sets
7 out a large number of serious criticisms of six parties:
8 (1) the owners of the MARCHIONESS, Tidal Cruises;
9 (2) British Dredging and South Coast Shipping, the owners
10 and managers of the owners of the BOWBELLE;
11 (3) the Department:
12 (4) the PLA;
13 (5) Captain Henderson; and
14 (6) Mr Blayney.
15 Broadly, the MAG agrees with and endorses the
16 vast bulk and thrust of the Attorney-General's provisional
17 criticisms and much of his provisional answers to the
18 notice of the formal Inquiry. The evidence that we have
19 so far seen is striking and he case against those named is
20 a stark and formidable one.
21 In the MAG's provisional answers to the notice
22 of substantial criticisms, we have sought to indicate in
23 as much detail as is possible at the moment and in a
24 format which we hope is helpful in what particular
25 respects we presently either differ from or go somewhat
26 further than the Attorney-General.
27 For instance, we believe that in so far as
28 British Dredging and South Coast Shipping were seriously
29 at fault in respect of the measures to ensure the safe
30 operation of the BOWBELLE, their parent company, Ready Mix

1 Concrete, were also seriously at fault in failing to take
2 any or any adequate steps to implement their group safety
3 policy regarding safety of the public.
4 Since our written answers and provisional
5 criticisms are detailed, I do not intend to cover every
6 area and finding which the MAG hopes and expects the
7 Inquiry to investigate and make. Instead, I wish in
8 opening simply to highlight two areas which the MAG are
9 deeply concerned about and which the MAG feel the Inquiry
10 should pay particularly rigorous attention to.
11 The first is the question of alcohol
12 consumption. The second is the role of the Department and
13 the PLA.
14 Sir, a central aspect of this Inquiry will be to
15 investigate the state of mind and condition of Captain
16 Henderson, the Master of the BOWBELLE, and Terence
17 Blayney, the forward lookout, on the BOWBELLE's fo'c'sle,
18 particularly in the 10 minutes before the collision.
19 The experts on visibility have met and agreed
20 that the MARCHIONESS was capable of being seen by someone
21 standing in the centre of the bridge of the BOWBELLE for
22 approximately three and a half minutes of the five and
23 quarter minutes' passage between Waterloo Bridge and
24 Blackfriars Bridges, and for up to one and a half minutes
25 of the four and three quarter minute passage between the
26 Blackfriars Bridges and Southwark Bridge, depending on the
27 precise standing position in the wheelhouse and the track
28 of the vessel.
29 The experts have, in any event, agreed that the
30 view from the fo'c'sle was entirely unobstructed, and the

1 MARCHIONESS was capable of being seen by someone standing
2 on the fo'c'sle of the BOWBELLE for the full 10 minutes
3 prior to the collision, i.e. throughout BOWBELLE's passage
4 from Waterloo Bridge to Southwark Bridge, except for brief
5 periods due to obstruction by the bridge piers.
6 Visibility conditions that night could not have
7 been more perfect. It was clear and moonlit. We believe
8 that you will conclude, when you have seen all the
9 evidence and heard the experts, that the MARCHIONESS was
10 not just capable of being seen from the BOWBELLE, but
11 plainly visible because of her navigation lights, the
12 lune from her 16 windows either side and the reflection of
13 her hull on the bright water.
14 Thus, perhaps the most troubling feature of the
15 whole case, and one of the major questions which the
16 Inquiry will have to answer, is why did neither
17 Captain Henderson nor Mr Blayney see the MARCHIONESS at
18 all during the 10 minute passage between Waterloo and
19 Southwark Bridge? What on earth were they doing during
20 those vital 10 minutes?
21 Both Captain Henderson and Mr Blayney admitted
22 to the police that they had been drinking before
23 reboarding the BOWBELLE on 19th August. Captain
24 Henderson's statement to the police said that he had drunk
25 six pints of beer whilst ashore that afternoon when he
26 visited no less than five different pubs, the Prince of
27 Wales and the Builders Arms in Vauxhall and the Battersea
28 Arms, the Red House and Duchess of York in Battersea.
29 Mr Blayney's statement said he had drunk four
30 large cans of Abbott ale at home that afternoon and four

1 pints of Fosters lager at the Pavilion pub that evening, a
2 pub very close to where the BOWBELLE was moored.
3 Many members of the public will feel shock and
4 considerable disquiet that such large quantities of
5 alcohol were consumed by two men who were about to board a
6 ship and navigate it down the Thames. The public will
7 also be surprised to learn that there was no legislation
8 in force at the time specifying the maximum allowable
9 blood/alcohol level for mariners and there still appears
10 to be no such general legislation, only some PLA By-laws.
11 It is perhaps surprising that a director of
12 British Dredging, Mr Butcher, was first to board the
13 vessel and discuss the accident with the crew before the
14 police. The public will also be surprised that when the
15 police did board the vessel in the early hours of
16 20th August, Captain Henderson and Mr Blayney were not
17 immediately taken back to the police station and blood
18 samples taken from them. Unfortunately, blood samples
19 were not, in fact, taken until over seven and 14 hours
20 after the collision respectively. This has caused
21 difficulties for the toxicological experts whose evidence
22 about the precise level of ethynyl in their blood at 0146
23 hours that morning, the moment of collision, may
24 ultimately prove to be inconclusive.
25 However, sir, irrespective of this, we submit
26 that the amounts which Captain Henderson and Mr Blayney
27 admit to having drunk that day were (a) on any view
28 excessive and irresponsible, and (b) bound to have
29 affected their abilities to perform their respective
30 duties that night as Captain and forward lookout.

1 We make three main points at this stage. First,
2 to most right-minded people, for a Master and a crew
3 member to drink such large quantities of alcohol in the
4 hours before navigating the equivalent of a juggernaut
5 down the most difficult part of the Thames in the dark
6 when there were bound to be passenger vessels around with
7 hundreds of people on board was utterly irresponsible,
8 particularly when they both knew that they would have to
9 be awake and alert late into the night.
10 Secondly, as to causation, the toxicological
11 experts have agreed that alcohol can produce a hang over
12 effect which can result in impairment of an individual's
13 ability to concentrate. Dr Furner believes that it is
14 important in this case also to look at the combined effect
15 of alcohol and fatigue, and permission to research this
16 aspect further was kindly given last week. You should
17 note, sir, that Mr Blayney, in particular, may have had
18 very little sleep between going on the 3.00 a.m. shift on
19 19th August, and the collision over 22 hours later.
20 Thirdly, Captain Henderson's and Mr Blayney's
21 behaviour took place against the backdrop of a culture of
22 drinking, which appears to have pervaded not only the BOW
23 ships but many of the commercial and pleasure craft plying
24 the Thames at that time. This was a culture which British
25 Dredging, South Coast Shipping, Ready Mixed Concrete and
26 the Department and the PLA must have been aware of but
27 failed to deal with adequately. South Coast Shipping, in
28 particular, appeared to have tolerated or at least allowed
29 a situation to develop whereby crew members had regular
30 opportunity to go ashore and drink during their three week

1 shift and some crew members were, apparently, unaware of
2 any company prohibition against continuing to drink on
3 board.
4 You will note that Captain Henderson's history
5 of employment shows that he had been dismissed before for
6 drinking whilst on duty.
7 The evidence as to the pervading culture of
8 drinking, you will see, sir, includes, in particular,
9 CHR_00396, a letter from Mr Belinda John of Meridian Lines
10 Cruises to Mr Creber of the Department, dated 4th October
11 193, in which he said:
12 "I believe there is a very real drinking problem
13 amongst the crew of the boats. Thee should be tighter
14 enforcement of the appropriate by-laws, but no man should
15 be intoxicated with a vessel in his charge. The governing
16 authorities should lead the way".
17 Secondly, you will see instances of drunkenness
18 on board the BOWPRINCE and the BOWTRADER in 1986 and
19 1988.
20 Thirdly, a letter dated 2nd July 1988 from a
21 source on the river -- the original reference is 03270200
22 -- which formed part of a consultation process by Jeremy
23 Handley, MP, who subsequently wrote to the then Minister
24 for Shipping, Lord Brabazon, about boatman on the river.
25 The letter said:
26 "The most dangerous problem on the river is the
27 amount of alcohol which most of them seem to consume and
28 also the long hours which they work".
29 Fourthly, T0820004, the statement of Mrs Faldo
30 regarding the dismissal of her late husband in April or

1 May 1988 of a mate on the MARCHIONESS for drunkenness, and
2 the subsequent reaction of other watermen who went on
3 strike and sent Mr Faldo to Coventry for several weeks.
4 Fifthly, WIT_5133, notes of an interview with
5 Mr Peter Nicholls of the Department, a principal surveyor
6 who will be called to give evidence, who said: "It was
7 known that some crew members were drinking", but in his
8 time at the marine office no one ever went out to examine
9 the vessels at night.
10 Finally, SCS_02066. One of the reasons for
11 Captain Henderson's subsequent dismissal by South Coast
12 Shipping in March 1992 was "There was no control regarding
13 alcohol being taken on board the vessel BOWBELLE".
14 For these reasons, sir, we believe that the
15 question of alcohol consumption by Captain Henderson and
16 Mr Blayney and its effects should be a very important part
17 of this Inquiry.
18 The problem of alcohol abuse by Masters and crew
19 members of British ships is all too prevalent and
20 recurrent a problem, it seems, as witnessed by the recent
21 Disciplinary Inquiry on the south coast reported in the
22 press last week.
23 I should mention in passing that we have an
24 outstanding application for disclosure of Captain
25 Henderson's and Mr Blayney's medical records which you
26 have indicated that, if necessary, you will hear later
27 today after speeches.
28 At this stage, I simply express surprise at
29 Captain Henderson's solicitors' reluctance to disclose
30 Captain Henderson's pre1986 medical records even to his

1 own toxicological expert.
2 Sir, the Department and the PLA:
3 I turn to highlight the second area which is of
4 particular concern to the MAG, namely, the role of the
5 Department and the PLA. For 51 young people to die during
6 a pleasure cruise on a clear, moonlit summer night on the
7 Thames in the heart of London within sight of St Paul's
8 was unthinkable to most people. But that is precisely
9 what happened in the early hours of 20th August 1989.
10 It appears not to have been unthinkable to the
11 Department of Transport or the PLA. The dusty, if not
12 dark, secret which a careful study of the files of the
13 Department of Transport and he PLA for the 1970s and 1980s
14 has revealed, is that the possibility, indeed probability,
15 of a collision between one of the BOW ships and a
16 passenger vessel on the Thames leading to serious loss of
17 life was at various times anticipated by numerous officers
18 in the Department and the PLA.
19 What is all the more disturbing is that, first,
20 the fundamental problems of lack of visibility aft and
21 disco noise interfering with the hearing of radio messages
22 in the wheelhouse were first drawn to the Department's
23 attention, as you have heard, and subsequently to the
24 PLA's attention, no less than 16 years before the
25 MARCHIONESS disaster.
26 In his letter of 6th December 1973 to the
27 Principal Officer of the Marine Survey Office,
28 Chief Inspector Turner referred to the increase in
29 passenger steamers on the Thames and made a number of
30 recommendations which he felt were "matters of importance

1 with respect to public safety and common sense".
2 They included:
3 (1) all new vessels and any such older vessels
4 that can be modified must have all round unobstructed
5 vision from the wheelhouse;
6 (2) all wheel boxes to be sound insulated from
7 the main entertainment area.
8 Secondly at a meeting in 1974 attended by
9 representatives of the Department, the PLA, the River
10 Police and Thames launch operators, it appears to have
11 been decided that pleasure craft without all round
12 visibility would be allowed to ply during daylight and
13 craft wishing to ply after dark would have to be
14 satisfactorily modified. That meeting was on 18th April
15 1974.
16 Third, it was extraordinarily, therefore, that
17 in 1981 the Department retrospectively approved
18 modifications made by the owners of MARCHIONESS to her in
19 1980 whereby, as you have seen, they totally enclosed her
20 top deck with a solid structure which had the effect of
21 removing such visibility aft as she had hitherto had and
22 which Chief Inspector Turner had said was so important as
23 a matter of public safety and common sense. The
24 MARCHIONESS had had, as you have heard from
25 Attorney-General, 360 degree all round visibility before.
26 In approving such modifications to the
27 MARCHIONESS and, it appears, other similar craft, the
28 Department were violating their own written instructions
29 to their surveyors about such matters.
30 Fourth, the principal surveyor, Mr Hughes, who

1 approved the modifications, wrote the following, frankly
2 incredible, minute about the MARCHIONESS on 30th September
3 1981:
4 "There is an unrestricted view aft and access to
5 shipside. No objection from visibility aspect."
6 It is difficult to see how anyone could have
7 come to such a conclusion even on the most cursory
8 examination o the vessel or the plans. More puzzling,
9 "JH Hughes", as he appears in the chronology, seems from
10 the handwriting to have been the very same surveyor who
11 appears both earlier and later in the chronology as
12 "D Hughes, Senior Nautical Surveyor", and who on
13 26th March 1974 wrote about the new buildings, FATHER
14 THAMES and the MAYFLOWER THAMES, that:
15 "The bridge or control position should be
16 provided with all round visibility above the canopy and
17 must not rely on visibility through the upper saloon."
18 This requirement was considered necessary for this type of
19 craft "whether it is a new building or an existing open
20 vessel being closed in for passenger comfort". CHR_00081.
21 The same D Hughes wrote on 27th October
22 regarding the VISCOUNTESS:
23 "The aim is to apply a similar treatment to all
24 vessels having small wheelhouses which do not have
25 immediate access to either side and to require the
26 wheelhouse top to be raised to give the helmsman and
27 unrestricted view aft". CHR_00412.
28 Fifthly, the Department and the PLA were well
29 aware of the problems of limited forward visibility from
30 the bridge of the BOW ships and the real dangers posed by

1 this and their large size and their limited
2 manoeuvreability.
3 Sixthly, many people will be shocked to learn of
4 the fact that in the early 1980s there were three very
5 similar, if not identical, collisions which occurred on
6 the Thames. The dangers highlighted by the collisions
7 were obvious and serious. Large BOW ships with limited
8 bridge visibility forward and limited ability to maneouvre
9 and stop could easily mow down small pleasure craft with
10 limited or nil visibility aft causing serious loss of
11 life. The documents show starkly that the Department and
12 the PLA were fully aware that, unless properly addressed,
13 this situation represented an obvious and serious danger
14 to the public.
15 Indeed, there are endless rounds of minutes and
16 meetings warning of and discussing the implications and
17 potential for serious loss of life unless something was
18 done.
19 I quote, by way of illustration, from one such
20 minute dated 6th July 193 written after the first two of
21 those collisions, CHR_00352:
22 "The principal common factors in the two cases
23 are lack of all round visibility in the passenger vessels
24 and the dredger evasion and inadequate communication. At
25 present there is a real danger of a very serious accident
26 involving these craft. They are not small boats and when
27 they are full in many cases some 200 or 300 people are at
28 risk.
29 "Having said that, the problem can be much
30 reduced if the launch skippers realise the danger and,

1 accordingly, take precautions by maintaining an efficient
2 VHF watch and thus monitoring traffic movements and always
3 checking aft, if necessary by sending a man to the stern
4 before swinging in the river.
5 "I do not think that we need take the extreme
6 step of requiring modification of the vessels now or
7 restricting their movements, with the high season just
8 beginning. Nonetheless, bearing in mind the inevitable
9 fact that the salutary effect of these two incidents will
10 wear off in time, I am sure that in the longer term
11 positive steps to improve the visibility from the
12 wheelhouse and allow the watch-keeper to keep an efficient
13 lookout are needed."
14 Sixthly, however, despite all the meetings and
15 discussions and minutes, the authorities still somehow
16 allowed a seriously dangerous situation to continue to
17 exist on the Thames, such that the BOWBELLE/MARCHIONESS
18 disaster was one day inevitable.
19 The major issue which will you have to
20 investigate, sir, is why? Why did the Department and the
21 PLA allow such a seriously dangerous situation to
22 continue? What was their response individually and
23 collectively to this situation? Were the steps that they
24 took to address the problem reasonable, competent and
25 adequate in all the circumstances?
26 The MAG submit that the evidence suggests that
27 the response of the Department and the PLA to the clear
28 alarm bells which these three collisions rang was,
29 frankly, lamentable, both generally and, in particular, as
30 regards the MARCHIONESS.

1 A general review of a list of 30 passenger
2 vessels with poor visibility, including the MARCHIONESS,
3 was undertaken by the Department at the end of 1993.
4 Incidentally, the list comprises 30 craft, not 20, as
5 referred to in the chronology at 22.7.83.
6 However, from what we have so far seen and had
7 the chance to read, there appears to have been no common
8 or objective standard devised or applied across the board,
9 no similarity of treatment between vessels with similarly
10 defective visibility, and nobody seems to have taken an
11 overall grip of the problem.
12 By way of illustration, it appears from
13 CHR_00128 and some of the photographs that the
14 MARCHIONESS, the HURLINGHAM and the ROYALTY were of a
15 similar type and had had similar conversions. You will
16 note that in his memo of 11th November 1981 Captain
17 de Coverly had referred to the visibility from the
18 HURLINGHAM as thoroughly unsatisfactory, CHR_00224.
19 On 13th November 1981, Mr Shone, a Chief
20 Nautical Surveyor, said that keeping a lookout aft from
21 the HURLINGHAM would be "extremely difficult during
22 daylight hours and virtually impossible at night".
23 However, whereas the ROYALTY was required in
24 1993 to raise its wheelhouse deck head 18 inches as a
25 permanent structure "to enable a proper all round lookout
26 to be kept over the passenger accommodation deck head
27 aft", CHR_00428, the HURLINGHAM was inspected for
28 visibility in January 1984 and passed as "not ideal but
29 satisfactory", CHR_00442.
30 It was only subsequently in June 1984 that the

1 HURLINGHAM was also required to raise her wheelhouse deck
2 head like the ROYALTY, but only, it appears, following a
3 request for permission from the owners to reduce her crew
4 from three to two.
5 At no time was MARCHIONESS required to raise her
6 wheelhouse deck head, even though she all along had only
7 ever had a crew of two. I will turn in a moment to the
8 particular requirements for her.
9 As far as we can tell from the documents, sir,
10 again so far as we have had a chance to read them, the
11 general approach by the authorities to the problems can
12 best be described as ad hoc and at worst shambolic. Only
13 four of the 30 vessels listed and two others not in the
14 original list were required to raise or partly raise their
15 wheelhouse deck heads, ELEANOR ROSE, KINGSTON ROYAL,
16 NEW SOUTHERN BELL and the VISCOUNTESS, query, and the
17 ROYALTY.
18 Two of the 30 were required to install hatches
19 in the wheelhouse, COCKNEY SPARROW and MARCHIONESS. Only
20 the MARCHIONESS was required to have side platforms,
21 apparently for a crew member to hang over each side of the
22 vessel to look aft.
23 Only six of the 30 and four other vessels not on
24 the original list were expressly required by the
25 authorities to have a permanent dedicated lookout other
26 than the helmsman, EMPRESS OF INDIA, MARCHIONESS,
27 NEW WINDSOR CASTLE, PRIDE OF GREENWICH, SYDNEY HULL and
28 the SILVER MARLIN, the CHEVENING, the NAUTICA, the ROYALTY
29 and the SUERITA.
30 In three of the 30 cases listed, recommendations

1 were made, but it is not clear what, in fact, was done,
2 RICHMOND ROYAL, QUEEN ELIZABETH and SILVER MARLIN.
3 In 16 of the 30 ways cases there is no evidence
4 of inspections having been carried out or any
5 recommendations being made, at least in the chronological
6 bundles.
7 Turning to the particular treatment of the
8 MARCHIONESS, the Department's Nautical Surveyor,
9 Mr Clifford, imposed three requirements on Tidal Cruises
10 in 1984 in relation to the MARCHIONESS. On
11 10th February 1984, he required the fitting of viewing
12 platforms with hand rails either side of the wheelhouse
13 and on 20th February 1984 that the passenger doors either
14 side should be kept shut, CHR_00445 and CHR_00450.
15 On 10th February he also wrote:
16 "Under all circumstances, it will be necessary
17 to detail one crew member in addition to the person at the
18 control position to maintain an all round lookout",
19 CHR_00445.
20 Subsequently, on 16th October, he wrote:
21 "In addition, the After Section of the
22 Wheelhouse Top to be modified to provide a hinged flap and
23 two steps to be fitted up to it", CHR_00501.
24 We submit that the modifications required were
25 hopeless, a hopeless and an absurd response to the
26 MARCHIONESS's aft visibility problem and placed a wholly
27 unrealistic reliance on the willingness, let alone the
28 ability, of the crew to use them. The side platforms were
29 obviously hopeless. It was unrealistic to think that a
30 crew member would be jumping up on to these platforms,

1 which were no more than steps, and then leaning out
2 awkwardly and looking aft, and then running around the
3 wheelhouse and doing the same on the other side, let alone
4 for sustained periods and on a permanent basis, which is
5 what a proper night lookout requires.
6 The wheelhouse flap idea was also absurd. It
7 was absurd to suppose that the man at the wheel would let
8 go the wheel, turn round, climb up two steps, open the
9 hatch and poke his head out and look aft. For a start, he
10 might have hit a bridge pier ahead of him.
11 Canting the vessel side to side was, obviously,
12 an unworkable method too.
13 There was no logical reason or excuse for the
14 authorities not having insisted on exactly the same
15 modifications to the MARCHIONESS as had been carried out
16 to the ROYALTY and the HURLINGHAM, though, query, were
17 these enough?
18 Moreover, at no stage does it appear that the
19 Department or the PLA ever checked to ensure that
20 designated lookouts were being used on any of the
21 vessels. It is clear that Tidal Cruises never detailed a
22 second member of the crew as a permanent lookout.
23 Mr McGowan seems blissfully unaware of this
24 duty. He seems to have spent his time helping the bar
25 staff who were, in fact, supplied by himself and
26 Mr Faldo.
27 Tidal Cruises' excuse set out in paragraph
28 9.2(4) of their answers served recently, that they
29 "understood the requirement for a dedicated lookout to
30 have been discontinued by the Department" when the flap

1 idea was introduced is both feeble and untenable. It is
2 clear from the language of Mr Clifford's letters which I
3 have quoted, CHR_0045 and CHR_00501, that the requirement
4 for an additional permanent lookout was permanent and not
5 optional.
6 There was no excuse for Tidal Cruises ignoring
7 this clear requirement by the Department which, moreover,
8 applied to the HURLINGHAM and the VISCOUNTESS. The need
9 for a second person to keep permanent lookout other than
10 the helmsman, should have been blindingly obvious to Tidal
11 Cruises, as experienced Thames River people who were aware
12 of all the previous problems. Indeed, Mr Dwan, a director
13 of Tidal Cruises, was the Skipper of the HURLINGHAM when
14 it was strike by the BOWTRADER in the early 80s.
15 Sir, the response of the Department and the PLA
16 to the mirror problem of visibility forward from the
17 BOWBELLE was no less poor, though perhaps the owners, the
18 managers, the parent company, bear an even greater share
19 of responsibility. If, despite the three collisions in
20 the early 80s, BOW ships were to continue to be allowed to
21 steam up and down the Thames, despite their limited
22 visibility forward, despite their relative size to most
23 other vessels on the Thames and despite their limited
24 ability to manoeuvre and stop quickly, it was incumbent,
25 surely, on the authorities and the operators to ensure, as
26 a minimum, that, firstly, there was in place the most
27 rigorous system of forward lookout possible with properly
28 qualified and instructed people as lookouts on the
29 fo'c'sle, with proper methods of instantaneous
30 communication between the bridge and the fo'c'sle and the

1 bridge and the engine room and regular spot checks by the
2 authorities and the owners to ensure that the system of
3 lookout was being maintained to the highest standard.
4 Secondly, they should have ensured, as a
5 minimum, that there were the most rigorous separation
6 rules on the river. For instance, taking the simple step
7 of reserving centre arches for use by the large ships
8 only. It beggars belief that:
9 (1) The lookout on the fo'c'sle was an able
10 seaman with little or no instruction on when and what to
11 report and who considered his job as lookout, as best,
12 secondary to being on stand-by to dropping the anchor.
13 (2) There was no method of communication between
14 fo'c'sle and bridge except for running back and waiving
15 and shouting. If there were any walkie-talkies on board,
16 they were not working and had probably never been used for
17 this purpose. It did not help that the helmsman,
18 Mr Noble, wore a hearing, wore thick glasses and had
19 serious health problems, having retired on health grounds
20 two years earlier.
21 (3) Communication between the bridge and the
22 engine room remained archaic with a bell and telegraph
23 system.
24 In our submissions, sir, the lack of any proper
25 system of communication between the bridge and the
26 fo'c'sle of the BOWBELLE helped engender an atmosphere of
27 sloth on the fo'c'sle of the BOWBELLE, such that it
28 appears Mr Blayney could not ever recall having reported
29 anything in over 100 trips as lookout.
30 As regards By-law 19, the PLA amendment of

1 By-law 19 in 1987, approved by the Department in 1988, was
2 a nonsensical approach to the problem of poor visibility
3 aft on passenger vessels and poor visibility forward on
4 BOW vessels. It was little good requiring vessels less
5 than 40 metres in length not to impede passage of vessels
6 more then 40 metres in length when the real problem was
7 that the big vessels sometimes had difficulty seeing the
8 small vessels ahead and the small vessels could not see
9 the big vessels coming up behind at all.
10 Sir, this formal Inquiry is, of course, in no
11 sense an inquiry into the MAIB report, though reference
12 may be made from time to time to the MAIB findings and
13 conclusions. For this reason, I am bound to record our
14 very considerable surprise at finding a substantial number
15 of departmental minutes during the period 1981 to 1988
16 dealing with these collisions and the problem of aft
17 visibility on passenger vessels, bearing the name of
18 Captain de Coverly, who was an important figure in the
19 Department throughout the time.
20 It is clear that Captain de Coverly was aware
21 and deeply concerned about the situation highlighted by
22 these collisions and that he was influential in
23 formulating policy as to the Department's response to the
24 problem. He was, for instance, the author of the minute
25 of CHR_00224 which I quoted at length earlier.
26 In these circumstances, it was wholly
27 inappropriate for Captain de Coverly to be placed in
28 charge of the subsequent MAIB investigations into the
29 MARCHIONESS disaster since this would necessarily have
30 involved him, in effect, in investigating his own actions

1 and the actions of his colleagues in the Department
2 between 1981 and 1989.
3 This was not something that he should have been
4 asked to do. It was putting him in an impossible position
5 of apparent conflict of interest, in the sense outlined in
6 R v. Goff, Pinochet and, most recently, in Lockerbie.
7 I should make it quite clear that I make
8 absolutely no criticism of Captain de Coverly personally
9 in this regard. It is easy to see the historical reasons
10 as to how this unfortunate situation came about. Since
11 the only MAIB had only recently been set up and staffed
12 naturally from the Department. However, it was, it must
13 be said, most regrettable and can only add to the
14 instinctive sense of unease felt all these years by the
15 families.
16 Sir, I turn finally to deal briefly with the
17 means of escape and search and rescue questions. Our
18 provisional case is again set out in some detail in our
19 draft answers and criticisms. The MAG will be submitting
20 that the means of escape on the MARCHIONESS were woefully
21 inadequate. The only practical means of getting out, if
22 the one vessel began sinking, was through the two forward
23 doors of the disco area.
24 For the large number of passengers which the
25 MARCHIONESS was certificated to carry, two workable exits
26 were wholly insufficient. It was sheer luck that the
27 BOWBELLE anchor ripped open the roof of the bar thereby
28 allowing more to escape. Had this not occurred, it is
29 likely that many more would have died.
30 We believe that the means of escape on many

1 passenger vessels on the Thames are similarly inadequate.
2 At DEP_02408, you will find an instructive memo dated 20th
3 October 1988 from the then Minister for Shipping,
4 Lord Brabazon of Tara, who was constrained to write after
5 a private trip on board a Thames pleasure boat the
6 following memo:
7 "I assume that we are responsible for surveying
8 and inspecting this type of boat, but I must admit I was a
9 little concerned about the apparent lack of emergency
10 exits and signs to tell one what to do in the case of an
11 emergency."
12 I mention in passing also that we believe that
13 the extraordinary speed at which the MARCHIONESS sank was
14 the cause of the loss of many lives and is an important
15 issue to be investigated. We are grateful to see that the
16 AG has agreed to include our questions relating to this
17 issue.
18 As to such a rescue, you will have seen that the
19 MAG believe that more could and should have been done by
20 the BOWBELLE by way of offering practical assistance
21 following the collision in terms of dropping life saving
22 appliances immediately. Those on the bridge of the
23 BOWBELLE were well aware that they collided with a
24 pleasure boat full of people and, indeed, could hear the
25 cries from the water.
26 Whilst many owe their lives to the heroic
27 actions and quick thinking and skill of others, both on
28 the HURLINGHAM and the rescue services, there are three
29 matters which particularly concern us.
30 First, why were both Police boats, Thames 3 and

1 Thames 4, moored at Wapping at the time of the collision
2 and not on patrol on the river?
3 Second, why was the arrival of the Fire Service
4 boat, LONDON PHOENIX, on the scene delayed for so long?
5 Third, were the police sufficiently trained in
6 handling a MAYDAY or major disaster situation on the
7 river? The coordination of the rescue effort,
8 particularly in the early stages, seems to have left
9 something to be desired. It may be that better training
10 and practice is required. Who should have been in overall
11 charge at that stage?
12 You, sir, have rightly set a brisk, some of us
13 less fit might say, breath taking pace for both the
14 preparations for this Inquiry and a tight timetable for
15 the hearing itself. However, we trust that you will keep
16 an eye on the balance to be drawn between, on the one
17 hand, ensuring that the Inquiry is conducted swiftly and
18 as efficiently as possible and, on the other hand,
19 ensuring that all aspects of this tragic and complex
20 matter are as carefully and thoroughly investigated as
21 possible, and that the parties are given proper
22 opportunity to consider and test all the evidence.
23 In short, the Inquiry should dictate the
24 timetable and the timetable should not dictate the scope
25 of the Inquiry. I mention this at this stage, firstly,
26 because I think we are not alone in having received a very
27 large number of bundle only very recently and it has so
28 far physically not been possible to read them all.
29 Secondly, because the present timetable does not
30 appear to leave much scope for flexibility if some

1 witnesses require a little longer. We shall, of course,
2 do our best to work around the clock and we would hope
3 that you will be sensitive to ensuring any alteration or
4 attenuation of the timetable which may from time to time
5 be necessary, expedient or fair.
6 After eleven years of waiting for this Inquiry,
7 sir, an extra week or two seems less important.
8 Sir, unless I can assist you any further, those
9 are my opening submissions for the MAG.
10 LORD JUSTICE CLARKE: Thank you very much. Mr Mansfield?
11 MR MANSFIELD: Sir, I appear together with my learned friend
12 Nigel Meeson for the Marchioness Contact Group who
13 comprise presently 87 individuals, some survivors and
14 obviously some who are related to those who died, eleven
15 years ago.
16 Sir, I am conscious that a number of points that
17 the Contact Group would wish to make have already been
18 very eloquently adumbrated both by the Attorney-General
19 and by my learned friend on behalf of the Marchioness
20 Action Group. I will attempt not to repeat the points
21 that have been made, but perhaps to condense into smaller
22 propositions, but there are some matters which bear
23 repetition.
24 The first is that those I represent are equally
25 grateful for the opportunity that has finally been
26 provided for the truth of what happened all those years
27 ago to be exposed, indeed, the worst river disaster since
28 1878.
29 It is necessary, this opportunity, because no
30 government before this one was prepared to order a proper

1 full, fair, fearless Inquiry, and because the earlier
2 Inquiry, which was conducted by the Marine Accident and
3 Investigation Bureau, with its report in 1991, not only
4 was not conducted in public, but it was seriously flawed
5 and singularly failed to elicit the truth which is still
6 sought.
7 The sad but undoubted fact is that if it had not
8 been for the undying efforts and, as has already been
9 described, effectively, determination and dedication of
10 all the families, no one would be here today. Throughout
11 that period of eleven years there have been various legal
12 processes wherein the families have attempted to obtain
13 what I am going to categorize from the beginning and
14 throughout as "straightforward answers to basic and
15 obvious questions".
16 Most notably, their attempts were conducted at
17 inquest hearings and it was, may I mention, in the course
18 of one of those hearings in the High Court about the need
19 to resume the adjourned inquest about these matters, that
20 the court itself found the most persuasive argument in
21 favour of a resumed inquest expressed in a letter sent by
22 Mr and Mr S Garland, whom I represent, to the Coroner at
23 the time. I do not ask for it to be put on the screen,
24 but the letter is, in fact reproduced in volume 4 of the
25 proceedings bundle recently assembled. The reference is
26 01663. The case is reported under the names of two of the
27 family, Dallaglio and Lockwood Croft. Simon Brown LJ,
28 during the course of his judgment, read out the letter
29 which he found so persuasive. It reads:
30 "Personally," meaning Mr & Mrs Garnham, "we

1 would want this inquest to continue, hoping at least some
2 of questions not yet answered can be. The main question
3 being, how was it possible for 51 young and healthy people
4 to die in the middle of London on a Saturday on a very
5 busy river even at that time of night? What happened to
6 rescue and emergency services that so many had to lose
7 their lives? Much of this rescue remains a mystery,
8 perhaps you", meaning the Coroner, "can find the answer
9 for us".
10 These sentiments already alluded to in another
11 context moments ago were echoed by the Master of the
12 Rolls, as he then was, Sir Thomas Bingham -- the page
13 reference, if needed, is 01679 -- when he remarked that
14 the Coroner was understandably concerned at the death of
15 over 50 young adults in the heart of London on a fine
16 August night, and that it had not been thought to merit a
17 full Public Inquiry, contrary to the almost invariable
18 practice when such catastrophes occur.
19 At the resumed inquest in the spring of 1995,
20 the jury returned a verdict of unlawful killing. It was
21 that jury that began the process which should have begun
22 before of unraveling the truth. Although I do not set
23 them out here, they provided a raft of detailed
24 suggestions and observations, 15 in all, perhaps some of
25 the most detail of any jury in any inquest in the United
26 Kingdom has ever provided.
27 Five of them dealt with the regulation of river
28 traffic. Three of them dealt with the deficiencies on the
29 vessels and six of them dealt with the crew and their
30 abilities.

1 The inquest, of course, was limited in its
2 remit. It was no surprise, therefore, to discover that
3 the same questions that Mr & Mrs Garnham had asked and the
4 same letter also impressed the present Lord Chancellor
5 when writing to the Deputy Prime Minister, Mr John
6 Prescott, in April 1989 about the desirability of a formal
7 investigation. Those basic questions of how that could
8 have come about on a fine August night remain on the table
9 and deserve long overdue straightforward answers.
10 In one sense, the answers are not those that
11 necessarily arise out of nautical expertise, because we
12 say they are common sense. From the materials that have
13 so carefully been gathered and assembled over the past
14 months in preparation for this Inquiry, it is clear that
15 there are at least three propositions to be distilled.
16 May I indicate what the three propositions are which
17 summarize, we submit, the criticisms that have been
18 already laid in detail?
19 The first one is this, that neither of the two
20 vessels concerned, the BOWBELLE and the MARCHIONESS,
21 should have been on the river that night at all. It is a
22 simple proposition, and I will elaborate slightly in a
23 moment.
24 Secondly, even allowing for all the shortcomings
25 and difficulties, some of which have already been
26 outlined, there is one central and unequivocal situation.
27 There were overwhelming opportunities for the BOWBELLE, by
28 which I mean the crew, to have spotted the MARCHIONESS and
29 taken action to avoid this collision. Again, I will
30 elaborate in a moment.

1 Thirdly, the safety and rescue provision, both
2 on the river (and, of course, that includes the riparian
3 sides of the river and the authorities in relation to
4 that) and on the passenger vessels, was seriously
5 deficient.
6 Those are the three propositions and we set it
7 in this context, that it has been said time and again over
8 the years, and even one of the crew members of the
9 BOWBELLE has recognized it, and it has been mentioned yet
10 again by the Attorney-General this morning, that what
11 happened was, in fact, a disaster waiting to happen. How
12 often has that refrain been heard in many contexts of
13 disasters of this kind? The Attorney-General this morning
14 said it was not if, but when.
15 Therefore, the magnitude and the gravity of the
16 questions that have just been posed straightforward as
17 they are, and of course the documents that show the
18 awareness by authorities specified, the Department and the
19 PLA as well as the owners of the vessels, this was a
20 situation which did not come out of the blue. It was
21 foreseen and there can be very little or no excuse as to
22 why provision was not made in advance, let alone why
23 action was not taken on the night.
24 May I elaborate one further contextual matter,
25 that it is not just a question of assessment by Assessors,
26 whether they come from the Department or the PLA, everyone
27 had full warning by what was actually happening on the
28 river over the years preceding 1989. Some of the
29 incidents which I am going to mention now are in the
30 chronology, some are not, but may I highlight those

1 incidents over the years before which have the greatest
2 bearing on what you have to examine and a back cloth
3 against which all these other questions have to be seen?
4 On 3rd July 1981, the BOWTRADER collided with
5 the PRIDE OF GREENWICH near Cannon Street bridge. On
6 18th October 1981, the BOWTRADER once again collided with
7 the stern of a pleasure launch which happened to be the
8 HURLINGHAM in the vicinity of Tower bridge in an
9 overtaking situation.
10 On 26th May 1982, the BOWBELLE collided with the
11 scaffolding at bridge pier on south side of Cannon Street
12 railway bridge, the very bridge we are talking about.
13 On 5th June 1982, the BOWBELLE had a near
14 collision with a passenger launch called ELTHAM near
15 Southwark Bridge. On 8th June 1983, Shell Distributor
16 collided with a passenger vessel, the NEW SOUTHERN BELLE
17 in Lambeth, near Lambeth bridge.
18 On 9th June 1993, the BOWBELLE (and this is the
19 one of particular significance because it is a mirror
20 image of what actually happened on this occasion) was
21 outward bound from Nine Elms, as it was on this occasion.
22 It collided with the port quarter of a pleasure craft, as
23 it did on this occasion, only that pleasure vessel was
24 called the PRIDE OF GREENWICH in the vicinity of
25 Hungerford bridge, not far from this collision.
26 On 5th November 1987, the BOWSPRITE and the
27 BOWBELLE collided with each other in the upper pool of the
28 Thames.
29 Therefore, over a nine-year period vessels
30 belonging to the BOW fleet in a stretch of river from Nine

1 Elms down to Tower Bridge were involved in six incidents
2 of gravity; four of the six concerned passenger pleasure
3 vessels.
4 However, there is one further incident which is
5 of concern. Captain Henderson took over as Master of the
6 BOWBELLE towards the beginning of May in 1989. In just
7 over a month, about a month later, on 25th June 1989, the
8 BOWBELLE itself with him as Master was, in fact, involved
9 in a collision. We are now a month or so away, two
10 months, to be precise, from the fatal collision. This was
11 25th June 1989, in Newhaven Harbour, not on the river, it
12 is fair to say, with another vessel, the ARCO SCHELDT.
13 Could I for these purposes please ask that a
14 particular photograph -- it is only one I am going to ask
15 to call up -- it is in the experts' bundle, 01598, is put
16 on the screen, please? I do not know whether that is
17 possible? I will just pause. Thank you very much.
18 The damage caused on that occasion is marked
19 with a black arrow, and this is contained in Captain
20 Beetham's report this year, although it is a photograph
21 taken much nearer the time. You will see that the damage
22 caused out of the Newhaven collision was still evident on
23 the starboard bow of the BOWBELLE on this occasion of the
24 photograph. If we could just return to the full image,
25 please, for a moment? White spots indicate damage that
26 arises out of the collision with the MARCHIONESS. Of
27 course, the anchor that is seen in the middle of the
28 photograph is the very anchor that ripped through the
29 superstructure of the MARCHIONESS.
30 Therefore, we say, two months before an area of

1 this vessel was concerned in a collision, albeit in
2 slightly different circumstances, where the Captain was
3 also in charge. The explanation for that is of again some
4 significance because it is said the reason it occurred was
5 during berthing because there was a lack of liaison
6 between the engine room and the bridge with the orders, as
7 it were, effectively being reversed.
8 Whether that is the true explanation or not, if
9 it is, it merely reflects the inability of either the
10 company or the crew, for that matter, to ensure that there
11 was a proper means of communication, not only with the
12 engine room, but, as you have already heard, a means of
13 communication with other parts of the vessel which, of
14 course, more relevant even than with the engine room,
15 although that will be relevant in this instance in view of
16 what was happening between the two bridges and the
17 communication between the bridge and the engine room in
18 that short space of time between the two bridges
19 concerned, namely Southwark and Cannon Street.
20 What is more staggering is that when
21 Captain Henderson was later questioned, not only about the
22 MARCHIONESS, but about this previous incident -- on
23 21st August he was questioned and the reference is, should
24 it be required, 00495 -- his only observation was that he
25 found the collision quite an interesting experience.
26 We say, in the light of these previous incidents
27 both on the river and elsewhere, it was blatantly and
28 abundantly clear to all concerned, therefore, first of
29 all, and I return to the propositions, that neither
30 vessel, for that matter, should have been on the river

1 that night. The factors that you have already heard that
2 bear upon why neither should have been is, undoubtedly,
3 the size of the BOWBELLE and, putting it in the
4 vernacular, it is nearly the size of a football pitch in
5 length. Its visibility ahead is severely restricted by
6 its size and by all the equipment on deck. You will hear
7 in detail about it, but it would appear that the
8 invisibility, that is the shadow area in front of that
9 vessel, ballasted incorrectly as it was, was three times
10 what it should have been on the night. In other words,
11 anyone standing on the bridge was going to have a whole
12 area in front of the bow more than twice length of the
13 football pitch invisible to anyone standing on the bridge,
14 never mind what was happening beyond that area of
15 invisibility.
16 Plainly, given its size, and given its design in
17 the sense of the invisibility that arises therefrom, there
18 is plainly a lack of manoeuvre. The word juggernaut has
19 been used on many occasions and, given its speed and lack
20 of manoeuvre and also impossibility of sight, it means,
21 therefore, the combination of those alone provides a
22 serious basis for suggesting it should have been taken off
23 the river. Fortunately, as you may know, it no longer
24 plies the river.
25 But if you combine that with no provision for
26 alternative systems of not only communication but of
27 actual lookout, no competent system being provided, and
28 then you combine that with what has been regarded as a
29 potentially hazardous stretch of river, whether it has
30 other traffic or not -- Captain Henderson described in his

1 interviews on more then one occasion how the manoeuvre
2 between those these two bridges, Southwark and
3 Cannon Street, was a very difficult manoeuvre, and,
4 essentially, he was doing that blind; he could not see,
5 according to his interviews, through Southwark Bridge to
6 which was on the other side -- then you add to that the
7 obvious presence of other traffic on the river, pleasure
8 craft, in particular, and the known increase in pleasure
9 craft over these years, competing with commercial traffic,
10 of course, finally it all happening at night, the
11 combination of these factors, we say, are unbeatable to
12 the extent that there can be no question, we say, that
13 these vessels should not have been on the river that
14 night.
15 The responsibility for allowing these vessels to
16 be on the river that night cannot be dodged and we do not
17 accept the Attorney-General's suggestion this morning that
18 perhaps it was not for the Department of Transport. We
19 say it certainly was for the Department of Transport, as
20 the licensing authority, to insure that such vessels in
21 such conditions should not have been plying the river.
22 The Port of London Authority, secondly,
23 obviously, as a regulatory authority, plays a part in
24 this; so do the owners, managers and operators of both
25 vessels and, in particular, so that it is clear whom we
26 mean by that, Ready Mix Concrete, British Dredging, South
27 Coast Shipping and Tidal Cruises.
28 The second proposition in the context of the
29 history I have outlined: it was clear here, even without
30 consideration of by-laws, even without consideration of

1 legislation, this was a simple matter of five people on
2 the BOWBELLE all looking ahead failing to spot, and I put
3 it in ordinary terms, on a calm, fine summer evening with
4 good visibility what was ahead, 10 minutes window of
5 opportunity with good lines of sight on passages between
6 Waterloo Bridge and Southwark.
7 This needs to be explained and there are only,
8 we say, a limited number of explanations for this, what we
9 have categorized as straightforward answers. Some of them
10 are as follows. First of all, it demonstrates, we say, a
11 complete disregard by the five, or any one of them, on the
12 night and a view which we say must have been taken, that
13 as the BOWBELLE was a large vessel and as, in their view,
14 it took precedence on the river, they rode the river as if
15 no one else was on it on the basis of an assumption that
16 everyone else would get out of the way.
17 Secondly, and I do not elaborate upon it as it
18 already has been, there was a culture of drinking.
19 Undoubtedly, four members of the nine strong crew had been
20 consuming alcohol, and we wait to see whether this was the
21 normal routine, whilst the dredger was unloading at
22 Greenham, but two of the four are of importance because it
23 was the Captain and the lookout, Mr Blayney.
24 Thirdly, again it has been mentioned, so I do no
25 more than to repeat it at this stage, one has to reflect
26 upon the helmsman having had his early retirement on
27 27th April 1985 accepted by East Coast Aggregates on the
28 basis of medical evidence which had been provided to
29 them. The question remains, was he of impaired sight and
30 hearing?

1 Mr Blayney, the lookout, enough has already been
2 said about the inadequacy of either his training or his
3 guidelines or anything in writing, and so forth. However,
4 this does not require training and guidance. All
5 Mr Blayney had to do was to stand on the fo'c'sle and look
6 ahead, because if it is said that he is an able seaman
7 with experience, he would know that it was necessary to
8 alert the Captain, not of every single buoy that they
9 passed, but certainly of other craft, particularly if the
10 craft was ahead using the same channel, by which I mean
11 channel in the river.
12 However, he again came out with, we say, a
13 staggering and remarkable observation when he was
14 interviewed on 23rd August by the operators of the
15 BOWBELLE. He said this: "I am not much good at judging
16 distances." Who knew that? Did the Captain know that?
17 Did the owners and operators know that the able seaman
18 whose job it was, although he did not think it was the
19 prime job, as lookout, was not much good at judging
20 distances?
21 There are no other reasons other than a
22 combination of complete disregard, alcohol and
23 incompetence as well as just not doing the job that
24 explains why none of the five people, that was three on
25 the bridge and two on the fo'c'sle, failed to spot the
26 MARCHIONESS.
27 The only other contextual matter that may have a
28 bearing in this context is, undoubtedly, a climate,
29 besides the culture of drinking, which provided for profit
30 before safety. They were running a tight schedule to get

1 from the grounds, up the river, discharge their load and
2 back out again. Was the company, the operator and the
3 managers imposing an unnecessarily heavy schedule in
4 order, as it were, to meet market demands at that time?
5 Because the question that remains, if profit was not the
6 main reason for getting that vessel in and out quickly, of
7 course, was there a way in which the vessel could have
8 negotiated the river in daylight hours instead of night,
9 or would that have meant too much delay and too much loss
10 of money?
11 Sir, I see the time. Would that be a convenient
12 moment?
13 LORD JUSTICE CLARKE: I think we will adjourn now, if we may,
14 until 2 o'clock, but we will not process out. Thank you
15 very much.
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1 (Luncheon adjournment)
2 LORD JUSTICE CLARKE: Could I make two other requests? One is
3 I have been asked to ask everyone, other than the person
4 who is actually speaking, to turn off their microphone
5 since I understand leaving the microphone on may cause
6 difficulties for the Shorthand Writers.
7 The second is could I make a plea for everybody
8 to turn off their mobile phone during these sessions?
9 Thank you very much. Yes, Mr Mansfield?
10 MR MANSFIELD: Sir, I come finally to the third proposition,
11 namely the serious deficiency that existed on the river in
12 relation to what I would classify as safety and rescue
13 resources, particularly in the light of the incidents
14 I outlined this morning, and the documentation that has
15 also been mentioned showing that there was a clear
16 anticipation of the risk that a pleasure craft with
17 hundreds on board may sink or be caused serious damage in
18 this stretch of river.
19 The areas, clearly, you will and have already
20 look at in relation to the Thames Safety Inquiry is
21 provision on the bank side which again has been
22 highlighted on various occasions, for example, chains on
23 the bank to enable people in the river to get out, the
24 provision of steps or ladders on the river bank, the
25 provision of life buoys and life belts which are vandal
26 proof but on the river bank, because again many of those
27 on the bank were quite helpless in the sense that they
28 were only able to watch and were not able to provide real
29 assistance.
30 Beyond the river bank itself, of course, one

1 looks at the vessels on the river, either purpose built or
2 adapted for rescue, and there was, putting it shortly, a
3 dearth of such vessels and the ones that were available,
4 as has already been pointed out, were too far away.
5 Clearly, and we would include and we have made
6 it clear in our Notice, the Police as well, there was a
7 need for those who patrol the river and had the
8 responsibility of patrolling the river to have given
9 thought and provision for a number of purpose-built craft
10 to be available, and clearly not just one or two because
11 of the numbers that were anticipated who might require
12 rescue in the event of a tragedy.
13 In addition to purpose-built or adapted vessels
14 are the passenger vessels themselves. They have already
15 been mentioned extensively and I only list the areas that
16 will clearly be of prime concern, emergency exits;
17 emergency lighting; furniture that is not capable of
18 trapping people, as was the case in the MARCHIONESS, in
19 other words, that it should be fixed furniture; the
20 availability of life boats and life rafts; the
21 availability of life jackets and, of course, that the crew
22 of any such passenger vessel is knowledgeable about the
23 presence of such items, and a matter which has arisen
24 before, whether it is necessary and should be on passenger
25 vessels (as it is on aircraft) to ensure that passengers
26 who get on are given a safety talk about the resources
27 before the vessels sets sail.
28 However, despite these deficiencies, and I come
29 back to the BOWBELLE, there were some resources
30 immediately available on the river within yards of the

1 tragedy, and by which I mean on the BOWBELLE itself. As
2 the Attorney-General mentioned this morning, although this
3 is an emotive issue, emotion one way or the other should
4 not cloud the reality of a situation in which professional
5 navigators, although under pressure, must, one can assume
6 and one ought to be able to assume, be prepared for such
7 emergencies and have guidelines and protocols about how to
8 deal with such emergencies as well as handling the welfare
9 of their own crew and their own vessel.
10 So far as the BOWBELLE is concerned, may I ask
11 for Attorney-General document No. 4 to come up, please,
12 that you saw this morning? It is a view from the
13 wheelhouse. Attorney-General document No. 4, please?
14 It is worth noting that the BOWBELLE had on
15 board at the time, first of all, two life boats which
16 could hold 16 people. They were on davits of the kind
17 that you see in the photograph on the right-hand side,
18 only that was not the position of the two life boats. So
19 far as one can tell from diagrams, the two life boats were
20 either side of the wheelhouse on the poop deck, but
21 retained by similar davit arms. They would require,
22 clearly, two men to lower the life boats, and a further
23 two to crew the life boats.
24 The suggestion that we make, the clear
25 suggestion, on behalf of the families, is that at least
26 one of those life boats could have been lowered when one
27 recalls that the BOWBELLE had nine crew. It may well be
28 one of them was out for the count, namely the cook,
29 Mr Westcott, because he had been drinking and had a
30 headache. However, that still leaves enough to at least

1 launch one of these life boats. I come back to how this
2 could have occurred.
3 In addition to the two life boats, there was one
4 self-inflatable, in the sense that it automatically
5 inflated, life raft which could hold 12 people. It is not
6 entirely clear where it was lodged on the BOWBELLE, but,
7 according to plans, it seems to be again on the poop deck
8 somewhere behind the wheelhouse, not far from the two
9 life boats. This would not require manning and merely had
10 to be hauled to the side and thrown overboard when it
11 would inflate and then could obviously float towards
12 people in need of help.
13 In addition to the life raft, there were 10 life
14 buoys or rings. So it will be seen in this photograph
15 that two of them are visible. They are attached to the
16 aft of the fo'c'sle in the middle of the photograph, one
17 just below the swivel housing and the other near the
18 fo'c'sle arrow.
19 They would have been easy, we suggest, to
20 release. There were two men on the fo'c'sle, and there
21 were two life buoys at hand. There were two more at the
22 forward end of the poop deck. There were two more with
23 ropes attached on the forward bulkhead of the wheelhouse.
24 There were two more with a quick release system from the
25 bridge which had light and smoke attachments, and they
26 were near to the life boats again. There were two on the
27 engine casing at the aft part of the deck house. So there
28 was there a range of materials and resources that could
29 have been used.
30 The first point we make is that no consideration

1 was given by Captain Henderson to using any of this. It
2 does not appear that this was a case of Captain Henderson
3 wrestling with his conscience as to whether it is his
4 vessel or the other vessel. It would appear from
5 everything he said the prime and only consideration was
6 the BOWBELLE.
7 We say that, of course, he had to ensure the
8 safety of the BOWBELLE and ensure that it did not in any
9 way endanger anyone, but that is very different from,
10 effectively, as the Attorney-General said this morning,
11 leaving the scene and eventually anchoring many miles from
12 the scene itself.
13 The suggestion here, clearly, is this, that, of
14 course, get beyond the bridge which seemed to be causing
15 the problem for the BOWBELLE, namely Cannon Street, and we
16 say, given the tide and given the fact that one of the
17 jobs, certainly, of those on the fo'c'sle, particularly
18 Mr Blayney, as he seemed to interpret it, was anchor man,
19 we submit that the BOWBELLE could have anchored perfectly
20 safely in the sense that it would have preserved its own
21 integrity and the welfare of its crew, and allowed it the
22 opportunity to use at least some of its life saving
23 equipment had it anchored beyond Cannon Street bridge and
24 before it got to London bridge or Tower Bridge, for that
25 matter.
26 Because there was time, despite a rising tide,
27 because these boats, for example, only take minutes to get
28 into the water, for it to have provided that help before
29 it, obviously, had to move on, lest it either could not
30 get under the bridges or became grounded if it stayed too

1 long in one place. We are dealing with possibly 10 to 15
2 minutes of anchorage in between those two bridges in order
3 to use those materials I have mentioned.
4 But, we say, the approach that Captain Henderson
5 took to this is very much the same as the approach to the
6 bridge and this disaster, namely that there was a blatant
7 disregard by him. Of course, the question that also
8 arises and will arise, the questions to be asked of him
9 and the crew, is how many of the crew knew where the life
10 saving equipment was? How often were they trained or
11 drilled in the use of the life saving equipment, even if
12 he had thought of using it? To what extent, again, was
13 the company who owned, managed and operated this vessel
14 concerned with the provision and the use and the drills in
15 relation to all of those resources?
16 We say, therefore, in relation to the three
17 propositions that we have put before you, namely that
18 neither vessel should have been on the river, secondly,
19 that it is perfectly clear there was an overwhelming
20 opportunity to spot the MARCHIONESS and, finally, the
21 serious deficiency and also the serious disregard by the
22 BOWBELLE in relation to a collision in which it was
23 involved, that there are obvious and straightforward
24 answers. As a result, we would ask that, certainly
25 towards the end of the Inquiry when there may be further
26 opportunities to address you, there should be at long last
27 a sense of accountability and responsibility by those who,
28 undoubtedly, contributed to this disaster.
29 LORD JUSTICE CLARKE: Thank you very much, Mr Mansfield. Is
30 Mr Philpott here? Does he wish to say anything at the

1 moment? No, very well. Mr Purnell is the next.
2 MR PURNELL: May it please you, sir, I appear together with my
3 learned friend Mr Simon Gault on behalf of South Coast
4 Shipping and British Dredging.
5 As has been remarked by a number of counsel who
6 precede me, this is, of course, not only an Inquiry which
7 has been appointed by the decision of the Secretary of
8 State on 14th February, but it is, in fact, the third
9 formal investigation of one type or another which has been
10 appointed by Secretaries of State for the Department of
11 Transport in its various forms. South Coast Shipping has
12 co-operated fully with each of the earlier Inquiries.
13 It accepts fully the decision of the Secretary
14 of State to order this formal investigation, and the
15 company appreciates both the public interest in a detailed
16 and objective examination and an analysis under public
17 scrutiny into the causes of the collision and the
18 subsequent tragic loss of life, but also the intensity of
19 the private grief and the concern of the families of the
20 deceased and the survivors which has driven and led the
21 impetus to hold this formal investigation.
22 The company has made available to the formal
23 investigation, not only the tens of thousands of pages of
24 surviving contemporaneous material in the possession of
25 the company, but also that material which was generated by
26 the company in its own internal investigation which was
27 conducted in the immediate aftermath of the tragedy.
28 In addition, the company has facilitated the
29 interview by the investigation team of many of the
30 employees and former employees of the company, and the

1 company will, of course, continue to assist to the best of
2 its ability.
3 Many lessons have been learned and changes made
4 by all those who have an interest in vessels which
5 navigate the Thames. The process of introducing
6 management changes into the operation of the South Coast
7 Shipping fleet had begun from the point when the merger to
8 which the Attorney-General referred this morning of East
9 Coast Aggregates and South Coast Shipping took place in
10 June 1988. The review which has been undertaken as a
11 consequence of the terrible events of August 19th and 20th
12 1989 provided a new dimension to that process.
13 We submit that the immediate cause of the
14 collision was the failure of lookout aboard both vessels.
15 In October 1989, joint liability for the collision was
16 formally admitted by South Coast Shipping and Tidal Cruise
17 Limited.
18 Irrespective of what might be the eventual
19 findings of the internal and official investigations,
20 which were then put in progress, steps were taken to
21 introduce measures or to make formal the requirement to
22 deploy existing measures which might serve to promote
23 safety on the River Thames. The evidence which is to be
24 submitted to this formal investigation will, we submit,
25 prove that this collision was brought about by the fatal
26 coincidence of critical contributory factors in a single
27 incident.
28 Criticism has and will be levelled at those who
29 were in direct command of the two vessels at the time of
30 the collision. The Marine Accident and Investigation

1 branch did so in its 1991 report. It also criticised the
2 authorities who accepted and authorized vessels of such
3 design to navigate in the Thames. Criticism was directed
4 at the failure to amend the Collision Regulations and the
5 PLA By-laws in the face of the growing traffic in
6 passenger carrying disco party boats.
7 But in the catalogue of 26 recommendations which
8 were made in the report of the Marine Accident and
9 Investigation branch, only one of those recommendations
10 was directed at South Coast Shipping. The company
11 accepted the criticism made of it in that report and did
12 so perhaps in contrast to the response which was
13 forthcoming from both the Department of Transport and
14 Tidal Cruises Limited, both of whom sought alternative
15 drafts for the report.
16 As the Attorney-General pointed out this morning
17 with some emphasis, it is a matter of regret to the
18 company that the examination which is now to take place 11
19 years after the event, and which will involve, among other
20 matters, an investigation into the management of the BOW
21 vessels, necessarily does so after the death of two
22 important potential witnesses. Mr Dennis Bayson was a
23 Director and the General Manager of British Dredging,
24 formerly East Coast Aggregates, until the merger with
25 South Coast Shipping took place in June 1988. Captain
26 Peter Butcher was the Operations Manager of South Coast
27 Shipping at the time of the casualty and he had held a
28 similar position in British Dredging for several years
29 prior to the merger.
30 South Coast Shipping, on its own initiative and

1 in response to necessity to take any practical step to
2 guard against the recurrence of such a tragedy, took
3 immediate steps to review operating methods and standing
4 orders and, in the context of the disaster which had taken
5 place, put in to place additional safeguards.
6 Documentary material before this formal
7 investigation includes evidence that a new operations
8 manual and new standing orders had been commissioned in
9 March 1989 by the new management team. These were in
10 preparation at the time the collision occurred. The new
11 standing orders require, among other matters, a signature
12 to establish they have been read by every member of a
13 ship's crew. They require the Master to confirm that the
14 fixed link telecommunications system on each ship and the
15 hand-held VHF radios are in full working order before the
16 ship sails. They require the Master to detail an officer
17 who is equipped with a VHF radio and a weighting as
18 lookouts on the bow of all the vessels navigating the
19 Thames bridges.
20 The operations manual of South Coast Shipping
21 which has been put in place and which has undergone
22 amendment as time has gone by meets the highest industry
23 standards.
24 The company has been accredited under ISO 9002
25 by Lloyds. The vessels in the fleet are in a process of
26 achieving accreditation under the International ISM Code,
27 even though this is not a legal requirement for vessels of
28 this type.
29 The distinction, we submit, must be drawn,
30 however, between changes and new measures which are

1 prudent and desirable with the benefit of hindsight and
2 those factors which are shown to have been causative of
3 the collision with which this formal investigation is
4 concerned.
5 By reference to the standards which were current
6 in 1989 and the requirements of national and international
7 regulatory authorities, and in accordance with the custom
8 and usage of experienced Master mariners, an experienced
9 and properly certificated able seaman should, we submit,
10 be fully capable of carrying out lookout duties in any
11 waters.
12 The inspector for the Marine Accident and
13 Investigation branch, however he may be criticised with
14 regard to his former departmental duties, has not and
15 could not be criticised on navigational matters and he
16 pointed this out in his report.
17 An adequate number of working hand-held VHF
18 radios had been supplied by the company to enable direct
19 communication to take place between the lookout on the bow
20 and the Master on the bridge of the BOWBELLE. Factual
21 evidence and the expert evidence to be called on behalf of
22 the Attorney-General will, we submit, establish the facts
23 that, firstly, there was a failure of lookout on both
24 vessels; secondly, by reason of the failure of lookout,
25 each vessel, unaware of the presence of the other, adopted
26 a course taking the centre arch of Southwark Bridge and
27 lining up for the centre arch of Cannon Street bridge and,
28 by reason of those specific facts, this collision was then
29 inevitable.
30 Any suggested inadequacies of training of

1 systems of communication or of deficiencies of standing
2 orders were not in the event causative factors towards the
3 casualty, notwithstanding that a measure of criticism may
4 be directed at the company in those areas. The fact that
5 the company has since this tragedy introduced other and
6 improved measures is itself indicative that such
7 improvements are not only possible but desirable.
8 South Coast Shipping accepts that there were not
9 at the material time standing orders which required an
10 officer to keep a lookout at the bow equipped a VHF
11 hand-held radio. There was no system in place to check
12 that such a lookout was maintained.
13 South Coast Shipping accepts that there was not
14 a system in place to ensure that the lookout of the bow
15 was equipped with a hand-held VHF radio. The company's
16 belief that the provision of a suitable number of
17 competent, certificated and experienced crew and a
18 sufficient number of working and suitable hand-held VHF
19 radios was the appropriate and standard manner in which to
20 ensure that an experienced Master was able to deploy his
21 crew and equipment in the best manner to ensure the safety
22 of the ship and the public was, we submit, a reasonable,
23 if imperfect, belief.
24 The company accepts the criticism that no single
25 person ashore was designated with responsibility for
26 monitoring the technical and safety aspects of the
27 operation of the ships. At the same time, as it
28 acknowledged the overall strength of the well-qualified
29 shore based management, the Marine Accident and
30 Investigation branch in its report was the first to make

1 that criticism, and that criticism was immediately
2 remedied by the company.
3 In reality, until that time, safety matters had
4 been the overall responsibility of Captain Darwell, but
5 Captain Butcher was designated in the company manual as
6 having responsibility for navigational safety. The
7 company rejects, however, propositions which, whilst they
8 are not the subject of criticisms advanced by the
9 Attorney-General, are, apparently, to be levelled by other
10 parties (as, sir, you have heard already this morning and
11 earlier this afternoon) namely, that the company failed to
12 have adequate systems to ensure that their vessels
13 proceeded at safe speed, or that speed contributed in any
14 way to this collision.
15 The company similarly rejects wholly the
16 suggestion that it failed to take effective steps to
17 prevent a culture of drinking among crew on board its
18 vessels. The standing orders and the demonstrable
19 disciplinary stance which was taken by the company when
20 made aware of any infringements of its alcohol code are,
21 we submit, evidence of best practice.
22 South Coast Shipping accepts the responsibility
23 upon management to cultivate, foster and monitor a safety
24 culture among its workforce. The extent to which it
25 achieved that aim will be among the aspects to be examined
26 in this formal investigation. But the steps which were
27 taken after the merger of the East Coast Aggregate's fleet
28 of BOW revels with the sand vessels of South Coast
29 Shipping and the efforts which were made to bring the
30 standard of the BOW vessels up to the standards of the

1 sand vessels were real and were effective.
2 With hindsight, those measures, worthwhile in
3 themselves, may have contributed to a preoccupation with
4 specific regulatory requirements and the physical
5 condition of the vessels and may have masked an earlier
6 appreciation of the human elements involved; in
7 particular, that Masters in command of the BOWBELLE had
8 permitted a degree of relaxation and elements of departure
9 from the established systems, whereby different methods of
10 lookout and communications were adopted on that vessel
11 from those employed by Masters on other vessels in the
12 fleet at different times.
13 South Coast Shipping acknowledges there should
14 have been greater consistency of approach, even though
15 professional opinion genuinely varies as to what is or is
16 not appropriate. The evidence now collected for this
17 formal investigation will show that even with the history
18 of this tragedy in mind, as the Attorney-General foresaw
19 this morning, experience navigators continue to debate
20 whether the systems operated by Captain Henderson were
21 preferable to the requirements which were instigated and
22 enforced by the company after the loss of the MARCHIONESS.
23 The conclusion that was reached in the MAIB
24 report, we submit, nevertheless, underlines the human
25 element that lies at the core of this, as so many tragic
26 accidents. As Captain de Coverly wrote:
27 "Despite the difficulties, it was possible in
28 each vessel for lookout to be maintained if sufficient
29 positive steps were taken. Some steps were taken, but
30 they were not sufficient to provide for a fully adequate

1 lookout in either vessel".
2 So we see the part to be played by this company
3 in this formal investigation is one in which we must
4 continue to assist in every way possible and to discipline
5 ourselves not to elongate the proceedings by repetition of
6 cross-examination or of argument.
7 I had not in this opening statement sought to
8 repeat or identify criticisms which the company may in due
9 course make of other parties. That aspect of this
10 investigation has already been dealt with in detail in the
11 written provisional criticisms which we provided in
12 accordance, sir, with the order that you made. But we
13 submit that the mechanism of the process by which a formal
14 investigation identifies the facts is bound to involve
15 some critical elements. But, that is, as you pointed out
16 in your introductory remarks this morning, not the purpose
17 of the investigation itself, and we reserve that until
18 after the evidence is before you.
19 LORD JUSTICE CLARKE: Thank you very much, Mr Purnell. Could
20 I just ask two things? First of all, it would be
21 assistance to me if I could have a reference to the new
22 standing orders in the documentation if it is there, not
23 at this very moment but at some convenient moment.
24 MR PURNELL: Of course.
25 LORD JUSTICE CLARKE: The second point, if I could just revert
26 to the position of RMC, for this reason, that it appears
27 from some of the criticisms that have been made by other
28 parties that they wish to criticise RMC or advance what
29 they say are substantial criticisms of RMC. It follows,
30 therefore, that RMC's conduct is in issue within the

1 meaning of Rule 5.4, and it may be that the
2 Attorney-General will give them a notice under that rule,
3 if it has not already, although I dare say RMC are fully
4 aware of the nature of the criticism.
5 So far as I am aware, RMC have not sought to be
6 directly represented at this Inquiry or, indeed, to become
7 a party to it. Am I right in thinking that you, as
8 counsel at least, do not represent RMC?
9 MR PURNELL: Sir, I do not represent RMC, but I have, in the
10 light of the criticisms that were noted in the provisional
11 criticisms that were made, sought inquiries to be made of
12 RMC. No notice has been given to RMC of any intention by
13 counsel to the Inquiry to seek to make them parties.
14 However, a number of witnesses from RMC identified by the
15 Attorney-General this morning are to be called, and
16 further witnesses from RMC are to be interviewed.
17 Sir, we would submit that the sensible course is
18 to postpone the question of whether or not RMC should
19 become a party until, effectively, the material evidence
20 has been considered by the formal investigation, but there
21 is no mystery about the position. RMC had more than 100
22 subsidiary companies. Operational control of those
23 subsidiary companies was delegated to the relevant general
24 manager who, in turn, reported to a Regional Director.
25 The Regional Director in question is one of the witnesses
26 to be called.
27 Sir, we are conscious that the position has been
28 flagged by those who go before me. If RMC would wish to
29 become a party in due course or if the formal
30 investigation considers, when the relevant evidence has

1 been heard, that it would assist to have RMC specifically
2 a party to the investigation, then I would invite the
3 investigation to arrange for that.
4 LORD JUSTICE CLARKE: Thank you very much. Then I think
5 Mr Reeder is the next?
6 MR REEDER: May it please you, sir. I appear with my learned
7 friend Mr Neville Philips on behalf of Tidal Cruises
8 Limited. Sir, the loss of 51 lives in the collision
9 between the MARCHIONESS and the BOWBELLE 11 years ago was
10 a terrible tragedy which always required public scrutiny.
11 May I at once extend my sympathy and that of my
12 clients to all those who have been bereaved. Their grief,
13 in the absence of thorough public investigation, must
14 still be keenly felt. For those who died and those who
15 survived, the experience on that night must have been
16 truly terrifying.
17 The decision of the Secretary of State to order
18 this formal investigation is, therefore, to be welcomed.
19 Those who lost their loved ones and friends and those who
20 survived are entitled to know how and why this collision
21 could happen in modern times on the Capital's river. The
22 public need to know what steps have been taken, or may
23 need to be taken, to prevent, so far as humanly possible,
24 such an occurrence in the future.
25 Sir, as you observed in your final report in the
26 Thames Safety Inquiry, it is often the case that parties
27 to Inquiries such as this have at least half an eye on the
28 consequences of the evidence for civil litigation which
29 almost always arises as a consequence of such a serious
30 casualty. As my learned friend Mr Purnell has already

1 pointed out, however, that does not arise in this case
2 because civil litigation issues have been disposed of.
3 The primary facts, however, in this case, once
4 established, may give rise to differences of opinion on a
5 variety of issues, but it is to be hoped that those views
6 will be honestly expressed even if, at the end of the day,
7 a particular opinion is found to be flawed.
8 My clients have co-operated and wish to continue
9 to co-operate fully with this Inquiry to ensure its
10 principal purposes are fulfilled, namely proper
11 ascertainment of the facts and the lessons learned or to
12 be learned.
13 There is, of course, the subsidiary question of
14 fault or blame. However, this is not a collision or
15 limitation action of the old style in some other guise.
16 Allocation of precise divisions of blame is not at the
17 heart of this aspect of the Inquiry, in our submission,
18 but the nature of a particular fault may be of importance
19 in making recommendations to avoid a future disaster.
20 My clients now recognize that the system of
21 lookout which they thought was being operated on the
22 MARCHIONESS and included the mate acting as a lookout was,
23 in fact, flawed, although at the time it was considered
24 adequate.
25 Bad lookout on the part of each vessel was a
26 principal cause of the collision on the evidence we have
27 seen so far. Partly this arose as a result of the design
28 and build of both vessels, though each vessel was properly
29 certificated by the responsible authorities. However,
30 sir, a good lookout is essential to maritime safety and,

1 thus, my clients now accept that intermittent lookout kept
2 through a wheelhouse hatch, perhaps by the man at the
3 steering position, is not consistent with good practice in
4 a river where passenger vessels ply along with larger
5 commercial ships.
6 Neither is it good practice for the helmsman to
7 leave the wheelhouse to ascend steps to look aft or peer
8 around the side of the vessel. They also recognize that,
9 in the absence of a clear all round view from the
10 wheelhouse, a proper lookout aft as required could only be
11 maintained by the mate acting as lookout with proper means
12 of communication with the wheelhouse if you are aft of the
13 vessel. They acknowledge that a system of lookout needs
14 to be reinforced by standing orders to which the crew
15 should be referred and their observance properly
16 emphasised.
17 Sir, the exact nature, the causative potency and
18 the gravity of these shortcomings in all the circumstances
19 is a matter for submission when the evidence has been
20 heard and tested in cross-examination. I will, therefore,
21 say no more about them at this stage.
22 Further, my clients adopt the provisional
23 position of the Attorney-General as regards the means of
24 escape and life saving appliances. Any deficiencies which
25 may be proved were not, on the evidence as it stands,
26 separately causative of loss of life because of the speed
27 with which the MARCHIONESS was overwhelmed and sunk.
28 Finally, sir, I say nothing about the criticisms
29 that others made of Tidal Cruise Limited. They reflect,
30 in large measure, those of the Attorney-General or others

1 and they have already been raised.
2 LORD JUSTICE CLARKE: Thank you very much. Mr MacDonald?
3 MR MacDONALD: May it please you, sir. In this matter I appear
4 with my learned friend Mr Nigel Cooper on behalf of the
5 Department of the Environment, Transport and the Regions.
6 I have not very much to say in opening on behalf
7 of the Department. The Department is anxious to help this
8 Inquiry in every way possible to arrive at the causes of
9 this terrible tragedy. The Department has already
10 co-operated fully with three previous major investigations
11 into the collision or related issues by the Chief
12 Inspector of Marine Accidents, the Hayes Inquiry and your
13 own Thames Safety Inquiry. Each of those investigations,
14 as well as the inquest jury, put forward recommendations
15 to improve the safety of United Kingdom waterways and the
16 ships that ply on them. As you will know, the Department
17 has carefully considered those recommendations and
18 responded substantively to them.
19 The Department will continue its positive and
20 open approach, an approach that it has taken throughout
21 this investigation. Thus, the Department has already
22 undertaken a huge exercise in disclosure. It has assisted
23 the Attorney-General to locate and interview many former
24 employees of the Department or its predecessors. The
25 Attorney-General will call a significant number of these
26 witnesses to give evidence before you.
27 Further to assist you, the Department will
28 present expert evidence as to the life saving appliances
29 and means of escape in the MARCHIONESS from Dr Howard
30 Oakley, the Head of Survival and Thermal Medicine, at the

1 Royal Navy Institute of Naval Medicine, who is one of the
2 United Kingdom's foremost authorities on ship wreck escape
3 and survival.
4 A word about criticisms: the Attorney-General
5 and other parties make a number of criticisms of the
6 Department or its predecessors. I am not going to address
7 those in detail now. You will have seen the Department's
8 provisional answers to the questions as currently
9 formulated.
10 A few points, however, do need to be briefly
11 addressed. The criticisms made of the Department are
12 wide-ranging, but in several cases they are based on a
13 misunderstanding of the Department's role and powers.
14 Notably, the Department had, in my submission, no power to
15 prohibit the trading on the River Thames by vessels such
16 as the BOWBELLE. Even had such a step been justified or
17 realistic, one might ask rhetorically why any authority
18 should have been concerned to ban a vessel which had
19 "overwhelming opportunities to avoid this collision by
20 ordinary good lookout".
21 We say also that the criticisms made of the
22 Department are heavily tinged with hindsight. The
23 Department will say that it took all steps realistically
24 open to it as a regulator at the time to ensure the safety
25 of those travelling on the Thames. I emphasise the
26 words "realistically open to it" and "at the time". The
27 Department does not accept that it had any causative role
28 in the loss of the MARCHIONESS.
29 One party has described the Department's
30 response as "ad hoc". There is no dispute that the

1 Department was aware of the potential for a casualty
2 involving a passenger launch and a commercial ship at
3 times prior to 1989. But there was a response both in the
4 1970s and, more importantly, in 1980s that was a
5 considered, thoughtful and vigorous response which is
6 described in summary form in the Department's provisional
7 answer to 12.2.
8 In brief, many important meetings were convened
9 amongst interested parties, and a thorough review was
10 undertaken of Class V passenger vessels plying on the
11 Thames which were subsequently inspected by Departmental
12 nautical surveyors and, where necessary, structural
13 modifications were required to be made -- a step which was
14 taken in relation to a number of ships.
15 The steps pertaining to individual vessels may
16 have differed because of differences in those vessels, but
17 that was evaluated pursuant to a policy. To you it falls
18 to evaluate the quality of that response in due course
19 after you have heard all the evidence. But I remind you
20 that in the incidents listed by other parties before you
21 today after the steps taken in the 1980s by the Department
22 to address the potential risk, only one occurred, the
23 collision between the BEAUSPRITE and the BOWBELLE in 1987,
24 an incident involving commercial ships only. There was no
25 significant incident involving a passenger vessel, or any
26 danger to life or limb between the Departmental review of
27 1983/4 and the collision which you are investigating
28 today, and in the coming days.
29 We have heard for the first time today a
30 suggestion from a party that the Department must have been

1 aware of and failed to act in regard to a culture of
2 drinking on commercial and pleasure craft. I have four
3 short observations on that. First, it has not been
4 notified in writing as a criticism of the Department, and
5 it is raised for the first time today.
6 Secondly, it is very thinly supported in
7 evidence.
8 Thirdly, there is nothing to suggest that it was
9 a factor in any previous incident relied upon by a party
10 as a warning factor.
11 Fourthly, the Department will have to consider
12 whether any further response to it is required in the
13 light of what has been said today.
14 Last on criticisms, a word about
15 Captain de Coverly and the MAIB. You will be aware, sir,
16 that the Marine Accident Investigation report is an
17 independent arm of the Department. It is not a party to
18 this Inquiry and it is not represented. However, in its
19 capacity as a party the Department reminds those present
20 through me that the staffing and execution of the MAIB
21 investigation is not one of the questions that this formal
22 investigation is addressing. It may bear mentioning in
23 passing that the MAIB report was critical of the
24 Department. Indeed, the Department offered an alternative
25 test which was turned down.
26 Sir, the Department does not criticise others in
27 the sense of seeking to apportion blame or fault because
28 the Department does not believe that to apportion blame is
29 part of its role before this investigation. The
30 Department does, however, have a case or a position as to

1 the errors on board each vessel and ashore, primarily
2 relating to lookout, which in fact and alone caused the
3 collision. This case is clearly set out in the
4 Department's provisional answers and is relied upon to
5 support its position.
6 That concludes what I wish to say about the
7 Department's position in relation to the formal
8 investigation.
9 I would, however, like to say a brief word about
10 two other matters. First of all, the position of those
11 witnesses who are or were employed by the Department and
12 about the proposal for further questions relating to the
13 stability of the MARCHIONESS.
14 The witnesses: of the 10 Department witnesses
15 currently scheduled to be called, eight are elderly,
16 retired and former employees of the Department. They have
17 not worked for the Department for some considerable time.
18 At least two of them are not in good health. They give
19 and have given their time and co-operation to the
20 investigation because they think that those affected by
21 this disaster have the right to know all the facts.
22 It is regrettable, therefore, that recent
23 correspondence from some parties has adopted a noticeably
24 hostile tone towards them and suggested either that
25 certain of them should be publicly accountable as
26 individuals or that they are somehow personally answerable
27 for alleged shortcomings of the Department. It is plainly
28 right that criticisms of the Department should be fully
29 and vigorously explored.
30 Witnesses now or formerly employed by the

1 Department are, of course, expecting searching questions
2 from the Attorney-General and others. But it would not,
3 I suggest, be right or just for it to be suggested to you
4 or indeed the witness concerned that any individual
5 witness was personally accountable for the alleged
6 failures of the whole Department as a regulatory body.
7 You will have in mind, I am sure, that no former
8 employee of the Department has been subjected to a notice
9 of substantial criticism, nor are any of them parties nor
10 are any of them represented. We have no doubt that you
11 will protect all witnesses, if necessary, from questions
12 which are hectoring, repetitious, irrelevant or otherwise
13 improper. I will remind all parties, if need be, that the
14 purpose of this investigation is to establish the facts,
15 otherwise there is a danger, I suggest, that the progress
16 of the Inquiry will be disrupted if a position is reached
17 where it is only just that individual witnesses should be
18 made parties to the investigation, should be formally
19 notified of any criticisms made of them, should be
20 entitled to legal representation and, indeed, to a
21 sufficient adjournment to enable that legal representation
22 to be effective.
23 Finally, a word about stability: I have said on
24 previous occasions that the Department is in no way
25 concerned to restrict the scope of this investigation.
26 Therefore, although it is extremely unlikely, given the
27 circumstances of the collision, that any deficiency in the
28 MARCHIONESS' in tact stability had any causative effect on
29 the sinking or the subsequent loss of life. It is, of
30 course, a matter for you to decide whether any and if so

1 what further questions should be added on this subject.
2 Both the Attorney-General and the Marchioness
3 Action Group questions have been tabled in
4 correspondence. I have seen one of those some days ago
5 and the other only today. They appear to be deficient
6 alike in one respect, that they fail clearly to address
7 the issue of causation.
8 I would invite you to order, sir, that the
9 question or questions include something to this effect,
10 that if there was any breach of standards or regulations
11 in relation to any of in tact stability, standard of
12 subdivision or free board, did that failure cause or
13 contribute to the loss of the MARCHIONESS and/or to the
14 loss of life or personal injury on this occasion?
15 If stability becomes a subject of investigation,
16 as it seems that it probably will, my client is likely to
17 wish to call, or at any rate will wish to consider
18 calling, expert evidence. The approach adopted by the
19 Attorney-General, as I understand it, is that the Action
20 Group and Contact Group should present expert evidence
21 first, and that other parties should have an opportunity
22 to respond to that.
23 I would respectfully support that as an approach
24 and ask you in due course to direct, sir, that those other
25 parties have an adequate opportunity to serve reports of
26 their own, should they so wish. That is all I wish to say
27 at this stage.
28 LORD JUSTICE CLARKE: Thank you, Mr MacDonald. Could I
29 just make three observations? The first relates to the
30 action taken upon various recommendations that have been

1 made in the past and so is relevant to the future.
2 I think quite recently the Department has made available,
3 at least to me -- I am not sure if to everybody else -- an
4 update upon the latest position. It is, I think, likely
5 that I would wish, unless there is any real good reason
6 why I should not, to include in my report an appendix, at
7 least, containing a summary of what will then be the
8 latest position. I would ask you to ask the Department if
9 they could at a later stage in the Inquiry produce the
10 latest up-to-date position as it then will be.
11 MR MacDONALD: The document to which you refer, sir, has been
12 distributed to all parties, but it may well be, depending
13 on the speed with which the Inquiry progresses, there will
14 be an opportunity to amend it further and we will review
15 it towards the end of the evidence and make sure that it
16 is fully up-to-date.
17 LORD JUSTICE CLARKE: Thank you very much. I notice that some
18 of the steps are currently being taken.
19 The second point is that I shall wish to say a
20 word about the position of individuals between the end of
21 counsels' opening statements and the beginning of the
22 evidence just very shortly.
23 The third point arises out of the last topic you
24 mentioned. I have not so far seen a proposed question
25 asking whether any deficiency in the statical stability,
26 for example, of the vessel was causative of the collision
27 or loss of life, I should say. No one, so far as I am
28 aware, has so far suggested that it is, that the position
29 is, indeed, left as you have indicated, as I understand
30 it, and that it seems to me to be sensible to wait and see

1 what others might wish to say before deciding precisely
2 what question it would be appropriate to ask. If
3 necessary, I could give some directions in relation to
4 that, but whether directions are really necessary remains
5 to be seen.
6 MR MacDONALD: Sir, thank you for the second and third points
7 which we have duly noted.
8 LORD JUSTICE CLARKE: Thank you very much. Miss Cameron?
9 MS CAMERON: Sir, I appear with Mr Andrew Newcombe on behalf of
10 the Port of London Authority which I shall refer to in the
11 usual way as the "PLA".
12 Sir, there is a poignancy today at the opening
13 of this formal investigation, or what will be called a
14 Public Inquiry in ordinary language. During the 11 years
15 that have elapsed since the tragic loss of 51 lives on
16 20th August 1989, there have been other human disasters
17 which have occurred on the road, on rail, at sea and in
18 the air. Each time a disaster is reported, we are
19 reminded not only of our own mortality, but of the effect
20 upon the bereaved and those who have to be involved in the
21 aftermath of the particular disaster. For all those
22 people, the sudden tragic deaths have a lasting impact.
23 So it has been since the MARCHIONESS disaster.
24 We are particularly conscious, sir, the emotions
25 that will be brought to the surface in the coming weeks in
26 the case of the relatives of the young people who died
27 that night and the survivors whose loved ones died. We
28 sincerely hope that this investigation being held on your
29 recommendation will in the end be cathartic for them and
30 that the emotional distress caused by revisiting the

1 events of that night will be outweighed by the comfort of
2 knowing that the facts have at last been fully and
3 carefully examined in public.
4 I turn briefly to the purpose of this
5 investigation. In your final report, sir, on the Thames
6 Safety Inquiry, you identified the two purposes of a
7 Public Inquiry as ascertaining the facts and learning
8 lessons for the future. You went on to point out that the
9 chances of a further investigation enabling lessons to be
10 learned for the future which have not been learned in the
11 last 10 years are small.
12 You referred to the many improvements introduced
13 by the Department and the PLA over the last 10 years. It
14 follows that the primary purpose of this investigation is
15 the ascertainment of facts, that is those facts relevant
16 and available in evidence, oral or documentary, in
17 connection with the collision on the night of 20th August
18 1989.
19 You are, I know, sir, well versed in the process
20 of evaluating evidence, but I would like to refer to four
21 general points at this stage. They are, first,
22 microscopic examination of the facts; second, the passage
23 of time; third, the giving of evidence and, fourth,
24 hindsight.
25 Taking them in order, microscopic examination of
26 facts: we fully recognize that it is necessary to look at
27 many facts in detail, and the Attorney-General has
28 collated a great deal of material for you already and has
29 summarized some of it today. We ask you to examine the
30 facts in your evaluation process in the context of

1 conditions on the River Thames at the time. I need not,
2 I believe, remind you of the partial picture which can
3 result from a microscopic examination without looking at a
4 wider perspective.
5 Secondly, the passage of time: the passage of
6 11 years since the collision has meant that some of those
7 who were in post at the time, certainly so far as the PLA
8 is concerned, and we had the same point made on behalf of
9 the Department, have long since retired, and,
10 understandably, put matters relating to their time with
11 the PLA at the back of their minds. They have voluntarily
12 agreed to do what they can to assist your investigation.
13 The PLA is most anxious that you should recognize this
14 from the outset.
15 In the same context, really, I turn to giving
16 evidence. For those who have never given evidence as
17 witnesses before, the prospect of attending a major Public
18 Inquiry, which this investigation is, is a fairly daunting
19 one. I am sure that you will have this in mind, sir, as
20 they come forward and I hope so will others who are tasked
21 with asking them questions.
22 Fourthly, hindsight, and that word has appeared
23 already several times on your screen today. If this
24 Inquiry had been held shortly after the collision, a
25 judgment could have been made on the basis of knowledge of
26 circumstances prevailing at the time. Eleven years later,
27 when many changes in lifestyle and perception have taken
28 place, there is a danger of judging by hindsight or after
29 the event, although Latin is unpopular now, ex post facto
30 rationalization, it would have been called a few years

1 ago.
2 This hindsight can be very dangerous, because it
3 is then judgment by present day standards and not by those
4 prevailing at the relevant date in the past. I am sure,
5 sir, you will be well aware of this and be guarding
6 against falling into this trap.
7 I say a few words about the river in 1989.
8 Quite apart from the fact that it has historically been a
9 busy port, the tidal navigable River Thames has always
10 been London's aquatic highway. There has always been a
11 wide variety of vessel traffic, both commercial and
12 recreational using it. You were given details of these as
13 at 1999 in the course of the Thames Safety Inquiry.
14 For many years, colliers made their way through
15 the bridges up and down the river, to and from the coal
16 fired power stations. As these disappeared from the
17 scene, the Aggregate vessels, such as the BOW class,
18 designed to operate under the bridges upstream of
19 Tower Bridge became a common sight on the river. Since
20 the BOW vessels ceased to use the river in 1992, the site
21 now is of refuse barges and building/spoil barges as well
22 as smaller Aggregate vessels navigating on the river every
23 day.
24 So, in 1989 the picture was one of mixed use of
25 the river, as it was in earlier days and as has continued
26 to be the case up to the present day. There had, of
27 course, been growth in one section of what was commercial
28 use of the river with the extended use of large passenger
29 vessels. They represented one type of business
30 enterprise, just as did the Aggregate company's vessels.

1 Both were able to use this aquatic highway together.
2 Around them there were also the various motor boats,
3 smaller passenger vessels, work boats, etc.
4 I remind you of this, sir, in order to set the
5 scene because there could be a tendency to lose sight of
6 the overall picture on the river and of the nature of the
7 river within the PLA's responsibility as minds concentrate
8 particularly on the two vessels involved in the fatal
9 collision on 20th August 1989. Then, as now, the extent
10 of the river within the PLA's jurisdiction extended
11 downriver from Teddington well out into the Thames
12 Estuary.
13 I turn now to the subject of the framework for
14 navigation. Because it is a tidal river as well as an
15 aquatic highway, the River Thames has inherent
16 characteristics attributable, among other things, to the
17 ebb and flow of the tide, the geographical features and
18 the presence of bridges. Like any waterway or the open
19 sea, the river has its own dangers. Consequently,
20 navigation needs to be subject to rules. As you well
21 know, sir, these include the International Collision
22 Regulations and detailed PLA by-laws dealing with
23 navigational matters. These provide the framework within
24 which those navigating on the river are expected to
25 operate.
26 But I do stress that the management and conduct
27 of the vessels within that framework has to be left to
28 those in charge of the vessels. For the benefit of others
29 perhaps, rather than yourself, sir, with your wide
30 knowledge of these matters, I suggest that there is a

1 simple analogy between a road as a highway and a river as
2 an aquatic highway, in that the Highway Code can provide
3 for so much on the road but thereafter the driver is
4 responsible. So it is in respect of by-laws, directions,
5 notice to mariners and such like on the river.
6 I am not at this stage, sir, responding in
7 detail to the suggestion that the PLA should have
8 amplified its direction in respect of lookouts -- you will
9 recall there is a clear rule about lookouts -- the
10 suggestion that we should have amplified the direction in
11 respect of lookouts at the time of the collision in August
12 1989. I am simple setting the scene as to our general
13 response that it was not considered appropriate.
14 I turn then to a few comments on the sequence of
15 events on the night. Reconstruction of the sequence of
16 events both immediately before and after the collision is
17 obviously a major task for the investigation. You have
18 made it clear, sir, and there has been reference by others
19 addressing you today, that an investigation of this kind
20 is, essentially, concerned with facts.
21 However, in accordance with your directions,
22 criticisms have been formulated by the Attorney-General
23 and the parties. The advantage, of course, is that
24 everyone knows at the outset what is presently being
25 asserted. But it inevitably also means that it has
26 introduced an element of contention and defensiveness
27 amongst parties. Yet, as the Attorney-General pointed
28 out, he has provisional views at the moment, it will not
29 be possible until the end of these hearings after the
30 facts as disclosed in evidence have been examined for any

1 final view to be formed as to the validity of those
2 criticisms.
3 As the pieces of the jigsaw are fitted together,
4 it might, I suggest, be found that some of the picture is
5 quite different from that which is has been presented
6 prior to or even at the opening of this investigation
7 today. It has, for example, been suggested that PLA,
8 having been in direct contact with the Police, did not
9 contact the Fire Brigade as promptly as it should have
10 done after the collision. But analysis of the various
11 records show that the Fire Brigade was in direct
12 communication with the PLA. It is the sequence of events
13 afterwards, so far as the Fire Brigade is concerned, which
14 is still not entirely clear.
15 I do not believe that it is appropriate at this
16 stage, sir, that I go into further detail. I simply
17 wanted to make it clear that the PLA refutes the criticism
18 levied against it. However, the question of the time of
19 attendance of the LONDON PHOENIX is relevant in the light
20 of the comments made by the Attorney-General this
21 morning. This is, of course, a matter for the London Fire
22 Brigade.
23 The question in relation to attendance by the
24 LONDON PHOENIX has arisen at a late stage in preparation
25 for this investigation. But in order that the London Fire
26 Brigade should have a full and fair opportunity to hear
27 evidence and to make representations to you, if it sees
28 fit, then I ask you, sir, whether the London Fire Brigade
29 should not be made a party. It is a point we have already
30 raised in very recent correspondence with Mr Sandal about

1 the chronology in relation to the London Fire Brigade.
2 Evidence will be given in due course in relation to this
3 sequence of events on the night and I shall, undoubtedly,
4 be addressing you on it at the conclusion of the
5 investigation.
6 In the circumstances, it, therefore, seems
7 highly desirably that you, sir, should be invited to give
8 a ruling on the question of whether the London Fire
9 Brigade should be made a party now at the beginning of the
10 investigation rather than at any later stage.
11 Whether, sir, it is appropriate to use Rule 9 or
12 Rule 5.4, to which you have already drawn attention this
13 afternoon, will be a matter for your consideration and
14 direction.
15 Finally, sir, I say that if as a result of the
16 investigation you do conclude that there are further
17 lessons to be learned, then I can assure you that the PLA
18 will do its utmost to ensure that any recommendations you
19 make are put into effect.
20 LORD JUSTICE CLARKE: Thank you very much. Mr Thwaites?
21 MR THWAITES: Sir, I appear on behalf of the Metropolitan
22 Police Commissioner together with my learned friend
23 Mr John Beggs.
24 The full story of the search for survivors and
25 the central role played by the Thames Division Officers of
26 the Metropolitan Police in the rescue operation has yet to
27 be told. This is the first opportunity the Police have
28 had to put the record straight. There are no mysteries.
29 Officers of the Metropolitan Police did
30 everything humanly possible to save lives and reduce

1 fatalities caused by this disaster. That was the top
2 priority of Thames Division Officers themselves who were
3 on river duty that night, and the many hundreds of regular
4 Officers who supported them by responding to the call and
5 came from the streets of London and the scores who came
6 from their homes in order to help.
7 The Metropolitan Police are a highly trained and
8 disciplined body of men and women for whom service to and
9 protection of the public is the highest ideal. Only men
10 and women motivated by a desire to contribute positively
11 to society apply to join the Police Force. Those who have
12 the character, integrity and personality to rise to the
13 formidable challenges with which they are daily faced are
14 accepted as Police Officers.
15 The actions of the Police as a fully accountable
16 body must be open to public scrutiny. The Commissioner
17 has directed that every co-operation be extended to this
18 Inquiry by the Metropolitan Police who are willing
19 participants in this forum. The modern culture of the
20 Metropolitan Police involves continuous critical
21 assessment of its performance, underpinned by a
22 determination to learn from experience and implement
23 improvements at every level of its operations.
24 From midnight on Saturday, 19th August 1989,
25 there was a flood tide on the River Thames. Therefore,
26 the water was flowing upstream east to west at a rate of
27 three knots which is just over three miles an hour or the
28 pace of a brisk walk. No one who found himself or herself
29 in the river could have remained in the same place for
30 long for the tide carried everything, including people,

1 along at a rate of at least five feet or 1.5 metres per
2 second.
3 If after the MARCHIONESS sank, anyone who had
4 remained floating free in the water for 10 minutes, he or
5 she would have travelled half a mile in the direction of
6 Waterloo Bridge. Anyone in the water who, for whatever
7 reason, could not swim continuously, could not survive for
8 long. The passengers and crew who did survive the sinking
9 of the MARCHIONESS either swam immediately to safety or
10 pulled aboard the HURLINGHAM or were rescued by the four
11 Police boats, two from Wapping and two from Waterloo, that
12 quickly got to the scene. It is thought that about half
13 of the people saved were rescued by Police Officers in
14 Police boats. If there had been more survivors visible in
15 the water between Southwark Bridge and Waterloo Bridge,
16 the Police could probably have saved many more.
17 This was a major tragedy that on 20th August
18 1989, without prompt and efficient actions of the Officers
19 of the Thames Division, the number of fatalities would
20 almost certainly have been much higher.
21 The contingent of Thames Division Officers who
22 began the night-shift at 10.00 p.m. on 19th August 1989
23 consisted of one inspector, three sergeants and 10
24 constables, making a total of 14 Officers. They were
25 posted to Wapping, Waterloo and Barnes. They had four
26 designated police boats with which to patrol the Thames
27 that night, each with a crew of three Officers, except at
28 Barnes where they had two. The Officers were given
29 staggered meal breaks so that two boats were available to
30 be on patrol at any time.

1 Their main duty were patrolling the river which
2 on a Saturday night included the monitoring the activities
3 of the occupants of party pleasure boats. According to
4 the latest figures available -- these are for 1999 --
5 between the hours of 2.00 a.m. and 6.00 a.m. the Thames
6 Division only received one call for assistance every five
7 days. Between the hours of 10.00 p.m. and 2.00 a.m. they
8 received less than one call a day, approximately five a
9 week.
10 At the time of the MARCHIONESS disaster, the
11 Metropolitan Police were the only functioning Police
12 Service that provided a regular patrolling presence on the
13 River Thames 24 hours a day. Police Officers will always
14 endeavour to save life and protect property, though their
15 main function is to preserve law and order, arrest law
16 breakers and bring them before the courts. The
17 Metropolitan Police are not responsible for major rescues
18 of large numbers of people on water. They have neither
19 the training nor the equipment to perform such a task.
20 On 20th August 1989 they were discharging their
21 duty and providing the usual policing functions, but by
22 virtue of their presence nearby on the river they were
23 fortuitously able to offer timely assistance in the
24 research and rescue operation.
25 Of the other agencies, the London ambulance
26 service had no waterborne vessels and, therefore, no
27 independent capacity to provide paramedic services on the
28 river. The London Fire Brigade had a fire boat at
29 Lambeth, but it was not deployed straightaway.
30 The Port of London Authority had their boats

1 that were manned between the hours of and 7.00 a.m. and
2 10.00 p.m. each day, but they were moored nine miles to
3 the east of London Bridge. The local authorities, whose
4 areas abutted the river, provided neither a maritime
5 presence nor any assistance.
6 As is known, at about 1.20 a.m. the MARCHIONESS
7 had set off from Charing Cross pier with 127 passengers,
8 two crew and two bar persons on board for a party that was
9 to go on until 6.00 a.m.. At 1.46 a.m., a little less
10 than half an hour later, it was involved in a collision
11 with the BOWBELLE and sank within a minute, giving little
12 time for most of those on board to realize what was
13 happening and no opportunity for many of them to take any
14 action to save their lives.
15 Officers of the Metropolitan Police did not
16 witness the incident which led to the casualty and, of
17 course, were not able to prevent it from occurring.
18 The speed with which the MARCHIONESS sank,
19 together with the lack of any warning, militated against a
20 favourable outcome for many of those on board. No one but
21 the survivors can imagine the horror of the boat suddenly
22 tipping over and being immersed in water which, although
23 not cold, probably felt cold to those shocked to
24 experience river water flooding over them. They were
25 plunged into darkness and the water of the Thames was the
26 colour of brown Windsor soup with underwater visibility so
27 limited that a person could only see his hand if it was
28 immediately in front of his face.
29 As those who went under the water lost their
30 footings and their balance as the boat turned over and

1 other people and objects fell on to them into the
2 darkness, overwhelming fear and panic must have gripped
3 them all. A few of the passengers dived in. Others
4 jumped. Many were tipped into the water, while some
5 fought their way out of the boat and others were probably
6 swept out as the boat sank. It is known that at least 24
7 people were trapped inside the boat and had no prospect of
8 being saved.
9 The passengers who were on the foredeck had the
10 best chance of successful escape, and three-quarters of
11 them survived. The passengers who were within the bar had
12 a similar chance of survival because the roof of the bar
13 collapsed, and provided them with means of escape and the
14 debris gave them buoyancy assistance until they were
15 rescued.
16 Of those passengers who were elsewhere lower
17 down on the boat, only a third or less survived.
18 Prolonged immersion in water, the difficulty people
19 experience in holding their breath for more than a short
20 time when they were hyperventilating and the effect that
21 struggling to get out of the boat had on them
22 significantly prejudiced their chances of survival.
23 It is also common for people to become quickly
24 disorientated and some of them may have swam or moved into
25 the wreck instead of getting clear of it. The people who
26 got clear of the boat did not all surface together and
27 some may not have surfaced at all. Others may have
28 surfaced momentarily before drowning and others may have
29 been dragged under water by the ferocious tide and
30 currents and swept away out of sight of there would-be

1 rescuers. Five persons whose bodies were later recovered
2 were positively identified as being alive on the surface
3 of the water at a time after the MARCHIONESS went down.
4 The tidal section of the River Thames is not a
5 suitable or hospitable place for recreational swimming at
6 any time. The strength of the tide would have made it
7 impossible for a strong swimmer to swim against it and a
8 non-swimmer or an exhausted person who gave up swimming
9 would quickly drown.
10 Tall and fit young men who were thin or muscular
11 and long limbed would have had greater negative buoyancy
12 than women or those of heavier build and would, therefore,
13 have had to swim harder and continuously or been supported
14 by buoyant material to avoid drowning.
15 The bodies of 18 men and nine women were
16 eventually recovered from the river, but it is possible
17 some of them drowned on the wreck and their bodies were
18 dislodged during the salvage operations.
19 By the time of the disaster, Officers of the
20 Thames Division had completed what was usually for them
21 the busiest part of their Saturday night tour of duty.
22 Some late parties were still going on, but most of the
23 pleasure boats had landed their passengers and the
24 majority of people had gone home for the night.
25 On that night, a constable from Thames 3 had
26 arrested a man for a serious assault of causing grievous
27 bodily harm on a party pleasure boat and taken him to
28 Bow Street Police Station. The remaining crew Thames 3
29 had returned to Wapping where one of the Officers was
30 taking his scheduled meal break.

1 The Officers on Thames 4 had been on their
2 routine patrol which took them between Blackfriars bridge
3 and Dartford. They had returned to Wapping for a comfort
4 break and were ready to resume their patrol. The Officers
5 on Thames 6 from Waterloo were at their pier completing an
6 incident report. The Officers of Thames 7 were patrolling
7 at Barnes but were too far away to be of immediate help.
8 Therefore, at 1.46 a.m. of the original shift of
9 the 14 Officers, two were at Barnes, one was at
10 Bow Street, one was on the road. There were eight Thames
11 Divisional Officers to respond to the emergency with two
12 Officers remaining at Wapping to deal with the
13 communications. Those eight acted on their own initiative
14 and provided the crucial first wave response to the
15 victims.
16 All prepared plans and experienced based on
17 previously rehearsed simulated exercises provided limited
18 practical assistance to those who were required to react
19 instinctively to real life emergency situations.
20 An incorrect radio message of a location of the
21 disaster was given and repeated over a period of two and a
22 half minutes, but that did not affect the Officers of
23 Thames Division. No time was lost by them. The eight
24 Officers disregarded their own safety instructions which
25 required three men to crew a boat and quickly mobilized
26 four Police launches, each with a crew of two, and
27 immediately took off in the right direction.
28 As the crisis deepened, the dangers of
29 under-manning the boats became apparent. Their efforts
30 could not have been more effective if coordinated, for

1 they understood the single task on which they needed to
2 concentrate was to locate and remove to safety all persons
3 they found in the water. The first Police boat reached
4 the survivors in the water within six minutes, two more
5 were there within 10 minutes and a fourth within 15
6 minutes of the casualty.
7 The problems of search and rescue were
8 compounded by the fact that there was no physical wreck to
9 see, no crash scene to inspect and when persons and debris
10 rose to the surface, they did not remain static, but were
11 swept away by the tide, leaving no clues as to their
12 starting point.
13 The first boat that came from Wapping Thames 3
14 was crewed by Police Constables Wilson and Melville, and
15 initially carried out a difficult and precarious rescue of
16 two women under Blackfriars Bridge which was a hazardous
17 operation which could have sunk the boat. They switched
18 off the engine, drifted on to one of the bridge buttresses
19 sideways on in order secure their position while they
20 pulled the women aboard.
21 It takes two strong men kneeling in a boat to
22 pull a person from the river because, although the free
23 boards, that is the sides of the boat, were relatively low
24 on the Police launches, a person in the water cannot reach
25 the top and, even if they could, would be physically
26 unable to pull themselves aboard. They also saved a third
27 woman and continued to search for others before taking the
28 three to Waterloo pier. They then immediately continued
29 the search for survivors until 10 o'clock that day but
30 without further success.

1 During the rescue operation they did not put the
2 anchor down because that would have wasted time and
3 pulling it up would have taken several more minutes.
4 Thames 4 also came from Wapping and was crewed
5 by Police Sergeant Wenham and Police Constable Mills.
6 They rescued about 20 people in all, including Andrew
7 McGowan, the mate of the MARCHIONESS between Southwark and
8 Blackfriars Bridge. To facilitate the rescue, the
9 Officers lowered car tyres on ropes so that some of the
10 stronger survivors could attempt to hurl themselves up
11 into the boat.
12 Many of the victims were too weak to help
13 themselves and the crew had to physically lift them into
14 the boat. Their boat was several times in danger of
15 capsizing or careering into one of the bridges or being
16 swept by the current under the stern of HMS President.
17 In order to correct the heading of the boat and
18 avert a further disaster, Police Constable Mills had to
19 enter and leave the cabin through the window because
20 access to the doorway was blocked by those they had
21 already rescued. They managed to deliver all their
22 survivors to safety at Waterloo pier and one Officer,
23 together with Andrew McGowan, who was the last person to
24 come aboard, continued to search for other survivors until
25 3.45, but without further success.
26 Thames 6, which came from Waterloo, was crewed
27 by Police Sergeant Whitehead and Police Constable Gibson.
28 Police constable Whitehead was writing up a report book
29 when he heard a vessel passing on the water blowing its
30 horn and, together with Police Constable Gibson,

1 immediately got into his boat and asked Woolwich radio for
2 details.
3 They travelled east towards Blackfriars Bridge
4 where they found a large group of survivors in the water.
5 The turbulence of the water close to the brick piers added
6 to their difficulties in keeping the boat safe and in a
7 fixed position. They dragged and lifted another 20 or
8 more people out of the water, putting their boat and
9 themselves in peril, but safely landed them all at
10 Waterloo pier.
11 Thames 106 also came from Waterloo pier and was
12 a stand-by boat kept at Waterloo pier for emergencies.
13 This was crewed by Police Constables Brown and Mckenzie,
14 who also acted in response to blasts on a horn from
15 another boat and followed Thames 6.
16 Thames 106 rescued four people from the river,
17 and looked for more before delivering them to Waterloo
18 pier. The Officers then split up so they could each take
19 out another boat, both of which continued to search for
20 survivors until 5.30 and 6.30, respectively, but without
21 further success.
22 There was spare and probably sufficient capacity
23 in two out of the four Police boats to accommodate any
24 additional survivors if they had been found before they
25 reached Waterloo Bridge. Two of the four boats were
26 overloaded, and two of the boats contained only a handful
27 of survivors. If there had been more survivors in the
28 water at or around the vicinity of Blackfriars Bridge
29 where the majority were rescued, the Police could have
30 saved them. It is likely that the efforts involved and

1 trauma experienced by the passengers on the MARCHIONESS
2 who were not on the foredeck or in the bow caused them to
3 be so exhausted as to be incapable of surviving at all or
4 for more than a very short time in the river that night.
5 If there had been any more boats at the scene
6 they may have got in each other's way. If rigid
7 inflatable boats had been used which require a crew of
8 two, they could only have taken a maximum of six people
9 each at a time out of the water. The four Police launches
10 could have taken a maximum of 80 people, 20 per boat, if
11 that many people had survived and were there and then
12 visible in the water in the moving rescue zone between
13 Waterloo Bridge and Southwark Bridge. The single engine
14 boats from Waterloo had less distance to cover against the
15 tide, but the boats from Wapping were faster as they were
16 twin engine.
17 Thames Division Officers without hesitation put
18 their own lives at risk in order to rescue everyone from
19 the water who was seen or called out or was pointed out to
20 them. The Police did not knowingly leave anyone behind in
21 the water and the survivors who had been rescued were also
22 looking out for any other people. Two of the Thames
23 Division boats became dangerously overloaded, but the
24 Officers ignored the risks and pulled everyone they saw
25 aboard.
26 None of the survivors was lost because they
27 could not be rescued into a Police boat and no one who was
28 pulled aboard a boat subsequently perished. The rescue
29 effort was timely and effective.
30 The Thames Division Officers had used all their

1 skill, courage and strength to save lives and, while a
2 precise figure cannot be given, it is estimated that
3 Police boats picked up between 39 and 47 survivors in the
4 crucial first few minutes after the casualty occurred
5 which, as I have previously said, amounted to half or more
6 of all the survivors.
7 At 1.49 a.m. while the duty officer, Inspector
8 Howard Neil, was driving towards Bow Street Police Station
9 to collect the constable who had finished dealing with his
10 prisoner and needed a lift back to Wapping, he received a
11 message from Thames 4 that a pleasure boat had sunk in the
12 vicinity of Southwark Bridge.
13 Inspector Neil diverted and immediately made his
14 way to the scene where he took command. At 2.00 a.m. the
15 established emergency procedures were triggered by
16 Inspector Howard Neil and the emergency services plan was
17 put into action.
18 At 2.38 a.m. Commander Tony Speed gave his first
19 instructions and by approximately 3.40 a.m. he had assumed
20 overall control of the scene. Unfortunately, although the
21 seconds phase of the rescue was put into operation, no
22 further survivors were found. The search was not
23 abandoned for many hours in the forlorn hope that someone
24 else might miraculously have survived. The Police and the
25 other emergency services continued the search to recover
26 the bodies of the victims and assisted in maintaining
27 order and facilitating the salvage of operation.
28 It must have seemed like an eternity for those
29 survivors in the water who were waiting to be rescued. It
30 is known that people in distress, in panic for their

1 lives, and anxious about the fate of others they were
2 with, can be unreliable in their estimates of time. They
3 were all shocked and confused, and many of them may have
4 become disorientated.
5 However, there is strong evidence to suggest
6 that none of the survivors could have been in the water
7 for very long. All those rescued by Police boats were
8 taken to Waterloo Pier, and the times when they were
9 placed in ambulances after receiving treatment were
10 recorded. They show that the majority of those rescued
11 were deposited at Waterloo Pier before 2.15 a.m. and taken
12 by ambulance to hospital by about 2.29.
13 The majority were picked up before they had
14 passed Blackfriars Bridge. We know that within about 10
15 minutes of being free in the water they would have been
16 carried further than that by the tide. It is estimated
17 that people from the MARCHIONESS with a tide of only 2.5
18 knots would have travelled to Southwark Bridge in one and
19 a half minutes, would have reached Blackfriars Bridge in a
20 further eight and a half minutes, and in a further 10
21 minutes would have cleared Waterloo Bridge.
22 Therefore, if anyone had been in the water for
23 even as long as 20 minutes, then, unless they were
24 strongly anchored to a fixed point, they would have passed
25 Waterloo Bridge which is a mile from where the MARCHIONESS
26 sank. No one was rescued alive that far away from the
27 wreck.
28 It is significant that none of the survivors
29 required treatment for near drowning, and most of them
30 were fit to go home and many were able to assist in the

1 rescue of others once they had been pulled into the
2 boats. Generally, the longer people are in the water the
3 greater the risk that they will come close to drowning.
4 It is a surprising feature of those who were rescued that
5 they were not in a worse condition from the effects of
6 being in a rough, fast river where waves and turbulence
7 would cause even good swimmers to inhale significant
8 amounts of water into their airways and produce symptoms
9 of near drowning which require hospitalisation and for
10 which the prognosis is often poor.
11 The most likely explanation for the good
12 condition of the survivors is that they were rescued
13 quickly. These factors point to the likelihood that those
14 who were saved were saved quickly, and many of those who
15 died drowned in the first five minutes of immersion and
16 prior to 1.55 a.m. The distance between Cannon Street
17 rail bridge and Waterloo Bridge is just over one mile, 1.1
18 mile.
19 The difficulties involved in rescuing even one
20 person from the tidal Thames on a flooding spring tide
21 cannot be exaggerated. People in the water were in
22 constant danger of being dragged upwards by small
23 whirlpools or being propelled along the river at a rate of
24 5 feet per second away from and out of sight of their
25 rescuers. If they were pulled away from the main tidal
26 stream to the sides of the river they might not be seen
27 and may have lacked the strength to call out or wave
28 before they drowned. Anyone who tried to remove part of
29 their clothing whilst in the water could easily drown in
30 the process. The parts around the buttresses of the

1 bridges provided further hazards as the water speeded up
2 in those areas and the effects were unpredictable.
3 Of the victims that were drowned and were found
4 outside the boat, one was recovered on 20th August, eleven
5 on 22nd, fourteen on 23rd and one on 1st September, making
6 a total of twenty-seven. Most of the survivors were
7 delivered on to dry land between 2.00 a.m. and 2.30 a.m.
8 Of the 69 survivors who were transported by ambulance, all
9 but six had left the scene for hospital by 2.29 a.m.
10 Thereafter the river was continuously patrolled
11 by Police vessels, singularly and in lines, conducting
12 sweeps as the search for survivors and victims went on.
13 The stretch of the river between Hammersmith and Greenwich
14 was searched by Police boats for survivors and victims and
15 foreshore and sweep searches were also made each day at
16 low tide of the section between Wapping and Vauxhall. A
17 casualty bureau was opened and operational at New Scotland
18 Yard by 3.20 a.m.
19 If there was in the battle against the river
20 some initial confusion and the appearance of chaos as
21 desperate people bobbing in the water in strong currents
22 cried out to be saved before they were carried out of
23 reach of their would-be rescuers and rescue people were
24 traumatized and became hysterical, no one should be
25 surprised, for how could it be otherwise?
26 There is in the context of multi-agency
27 co-operation between the emergency services, the PLA,
28 local authorities and others, sound reasons why the Police
29 should take control of disaster management after it has
30 occurred, for the command structure superimposed on the

1 Police Force provides an army-like discipline where
2 Officers are trained and accustomed to responding
3 immediately and without question to orders from the
4 designated command Officers, which is vital in emergency
5 situations. In addition, the Police have traditionally
6 been the lead emergency service and have developed
7 considerable expertise in managing such operations. But
8 as of today, the question of who should be responsible for
9 the provision of a dedicated search and rescue facility
10 for the River Thames remains unresolved.
11 The Police have regular first-hand experience of
12 human tragedy, including those concerning loss of life.
13 They are called upon to deal with it as part of their
14 varied daily diet, but they do not become used to it or
15 find it acceptable, and what is often not appreciated is
16 that Police Officers, men and women, also grieve with and
17 for the victims. When they are present or called out,
18 whether on or off duty, for a Police Officer is never off
19 duty when there is a crisis of any description that
20 requires their assistance, they do not look the other way,
21 walk on or ignore a ringing telephone. The loan Police
22 Officer often finds him or herself an active participant
23 in unfolding events which they cannot prevent or control.
24 It is the nature of the job that requires Police Officers
25 to react to events and do what they can in the
26 circumstances.
27 It is impossible not to feel deeply for those
28 families who lost sons and daughters, relatives and
29 friends in the MARCHIONESS disaster. It is hard to come
30 to terms with bereavement, particularly involving the

1 young, some of whom had already made their mark in
2 business, the professions and the arts, while others
3 looked to beyond the brink of glittering careers as their
4 previous accomplishments suggested. The acute sense of
5 loss suffered by bereaved families may diminish over time,
6 but it is acknowledged that those who have lost their
7 loved ones in such tragic circumstances never completely
8 recover from it.
9 May I finally on behalf of the Commissioner of
10 the Metropolitan Police express sympathy and regret to all
11 the families of the victims of this tragedy on the their
12 grievous loss, and also pay tribute to their determination
13 for over a decade to obtain this Inquiry which everyone
14 hopes will enable them to find the answers they have been
15 seeking.
16 LORD JUSTICE CLARKE: Thank you very much. Mr Seligman.
17 MR SELIGMAN: I represent Debra Faldo and Andrew McGowan,
18 effectively the crew of the MARCHIONESS, Stephen Faldo was
19 the skipper of the MARCHIONESS through his widow.
20 LORD JUSTICE CLARKE: Could you either speak up little or
21 possibly sit down, because the microphone is not as
22 elongated as it would be for people standing up.
23 MR SELIGMAN: Is that any better?
24 LORD JUSTICE CLARKE: Yes. Thank you very much.
25 MR SELIGMAN: To repeat then, I represent effectively the crew
26 of the MARCHIONESS, Stephen Faldo through his widow Debra,
27 and Andrew McGowan. Stephen, as has already been said,
28 died in the accident. Andrew survived and will be here
29 next week to give evidence. I adopt my learned friend
30 Miss Cameron simple analogy of a highway accident, because

1 it illuminates the terrible simplicity of this accident,
2 an accident that was described in a radio transmission
3 from the BOWBELLE at the time timed at 1.48.02 like this:
4 "It is a pleasure boat that we didn't see, sir, a simple
5 running down accident".
6 I would make three points at this stage. First,
7 as on land, an overtaking vessel in no circumstances is
8 absolved of its duty to keep clear of the vessel being
9 overtaken. In my submission, the various rules of the
10 road or collision rules at sea will make that clear when
11 we go to them. That is what overtaking is, moving or
12 staying out of the way of the vessel or vehicle in front
13 in order to pass it. That is what the international
14 collision rule 13 says. Although the Port of London
15 Authority do have a By-law No. 19 that gives a right of
16 way to larger vessels, that does not make it a clear way
17 which, in my submission, is how the BOWBELLE might have
18 been treating it.
19 Point No. 2, and again this reiterates a point
20 already made, those at the bridge of the BOWBELLE did not
21 see and were not told of the presence of the MARCHIONESS
22 at any time before the collision. Effectively, this huge
23 85-yard long vessel at night, effectively blind, relied on
24 lookouts that do not on this occasion appear to have
25 looked out. The MARCHIONESS must have been straight ahead
26 of the BOWBELLE as the vessels made their away along
27 King's Reach on the river, and actually slowly overtook
28 the HURLINGHAM. That may have been a period of up to 10
29 minutes, and it is almost inexplicable that nothing was
30 said.

1 Point 3, the running down from behind, it is
2 suggested in some of the literature that the MARCHIONESS
3 was not run down from behind at all, but turned
4 dramatically to port shortly prior to the collision. That
5 is inconceivable, in my submission. The MARCHIONESS was
6 on her way to the Thames barrier, had no reason to make a
7 turn at that point. These were two of the most closely
8 positioned bridges on the river. The river bank is
9 narrow, the tide begins to race even more, and there was
10 simply no reason to make a motiveless turn to port without
11 looking and into the path of the BOWBELLE. It is not what
12 happened. It is not what the people outside on the deck
13 of the MARCHIONESS remember. If anything, the evidence is
14 to the contrary and is of a turn to starboard by the
15 BOWBELLE.
16 If that, Sir, is the accident, fingers of blame
17 are pointed at both crews. The crew that I represent of
18 the MARCHIONESS was a young crew, Stephen Faldo was 29 at
19 the time and Andrew McGowan was 21. Both obviously are
20 criticised to varying degrees, but can I just say at the
21 outset that, in my submission, Andrew McGowan is wrongly
22 criticised at all at the outset. As I said, a young man,
23 an apprentice waterman. He had been given no specific
24 lookout duties. He had spent his time during the 25 short
25 minutes of the voyage that elapsed busy with the boat and
26 the passengers, helping the bar staff, sorting out the
27 problem with the electrical supply for the DJ, as he was
28 asked to do, getting everyone settled down and the party
29 on the way. He finished those duties shortly before the
30 accident.

1 There was no failure of lookout and there was no
2 requirement on Andrew McGowan to lookout. He should be
3 exonerated totally. I do in passing point to the way he
4 returned to the sinking boat after the accident to help
5 people in the water. That is not the action of a man that
6 neglects his duty.
7 Stephen Faldo and his responsibilities will have
8 to be considered. As to lookout, we do know from his
9 actions that he did not see the BOWBELLE, but we do not
10 know whether or not he looked. I would say in that
11 context that the problems with the visibility of this dark
12 hulk on the river at night should not be glossed over and
13 the two navigation lights that there should have been on
14 that vessel reduced to one because the forward mast was
15 down for the vessel to pass through the bridges.
16 There may be a criticism of Stephen Faldo for
17 not hearing announcements on the VHF radio that the
18 vessel, the BOWBELLE, was on the way. Again here the
19 difficulty is that Stephen Faldo is not here to assist
20 us. We do not know if it is inattention, momentarily
21 inaudibility. I accept that will have to be gone into.
22 In the generous concessions some of those who have spoken
23 before me of accepting fault, I feel a little bit
24 disadvantaged because all that I have heard of the man
25 that I represent that was the Skipper of the MARCHIONESS
26 is that if he had been at fault he would also be here
27 conceding it, but unfortunately I cannot do that on his
28 behalf. What we do know is that he was busy at the
29 wheel. No one says anything else, and whatever those
30 faults he would always have expected and been entitled to

1 expect an audible warning from the BOWBELLE of her
2 approach behind.
3 Turning then to the BOWBELLE, her failure as a
4 ship was a failure to do a much more obvious thing than
5 look or be aware of what was behind it, and that is to
6 look where you are going. Whatever questions there are as
7 to the MARCHIONESS and whether she was where she ought to
8 have been or not, she was certainly there to be seen and
9 was not seen. She was entitled, in effect, to the
10 protection of the Collision Rules in that situation and to
11 be alerted of the presence of the BOWBELLE behind her.
12 Sir, at this stage that is all I want to say on
13 what, effectively, concerns what has been described as the
14 human element of this problem. In closing we do also make
15 some criticisms of the regulatory background. As the
16 other occupant of the MARCHIONESS I share the complaints
17 that certainly all was not done to protect the safety of
18 those on the river by the regulatory authorities. Much of
19 the evidence that will be called is witness evidence, much
20 is expert evidence, but I would urge you, Sir, not to be
21 blinded by science. This accident is as simple as it was
22 described on the radio at the time.
23 LORD JUSTICE CLARKE: Thank you very much. Mr Russell-Flint.
24 MR RUSSELL-FLINT: Yes. May it please you, Sir. May I begin
25 what I promise will be a short address by mentioning
26 something easily overlooked, and that is this. A few days
27 before the terrible tragic accident which has touched the
28 lives of so many people and which is the subject matter of
29 this formal investigation, there was another accident, an
30 accident which, understandably, has received no publicity,

1 has received no press comment and which by itself is
2 distinctly trivial and unimportant. I think it was a
3 broken toe. But the consequences of that accident have
4 now been visited upon Terrence Blayney for these past
5 eleven years and will stay with him for the remainder of
6 his life, because that accident meant that the recipient
7 of the broken toe, Mr George Page, could not continue his
8 tour of duty as able-seaman on the BOWBELLE, and instead,
9 as Mr Pages' replacement, the owners and operators of the
10 BOWBELLE drafted in Able-seaman Blayney who should, if his
11 normal shift pattern had been followed on the night of the
12 19th and 20th August 1989, have been enjoying his last few
13 days of shore leave.
14 So by a quirk of fate that brought about that
15 other accident, Mr Blayney started off as Mr Pages'
16 replacement on Wednesday, 16th August, a week earlier than
17 he should have done. As is revealed from the documents,
18 he then went with the BOWBELLE to the dredging grounds off
19 the North Sea and returned to Nine Elms at round about
20 half past 1 in the afternoon of Saturday, 19th August.
21 What Mr Blayney did and recalls having done
22 thereafter has been well documented. There are and have
23 been from him in number more statements, more
24 declarations, transcripts of evidence and other documents
25 than any other witness to this tragedy. He has, as is
26 well known, been called to give evidence as a witness of
27 truth for the Prosecution on four separate occasions,
28 three times for the Crown in proceedings taken against
29 Captain Henderson and once by my learned friend
30 Mr Mansfield in the private proceedings brought against

1 South Coast Shipping and some of its directors. In
2 addition, he has given evidence on oath at the resumed
3 inquest.
4 In all of his statements, from the first date of
5 20th August 1989 given by him to the Police to the last
6 prepared for the purposes of this investigation and dated
7 September of this year, Mr Blayney has been consistent in
8 his recollection of what occurred in those moments
9 immediately preceding the collision between the BOWBELLE
10 and the MARCHIONESS. He cannot change those memories. He
11 cannot now tailor his account so as to try to conform with
12 hypotheses or theories advanced by persons who were not
13 present, but who purport to tell him what did or what must
14 have occurred. All that Mr Blayney can do, as he proposes
15 to do, is to give his account to this investigation, give
16 his account as he has done on oath in courts of law on
17 five previous occasions.
18 He has been criticised by some in the
19 documentation already submitted to this investigation for
20 having failed to keep a proper lookout. As I expect that
21 we shall hear from former Master, mates and able-seaman
22 who served on board the Bow boats, it seems that there was
23 never a requirement imposed upon those at the forecastle
24 head to report every single vessel observed in this part
25 of the Thames, only those which could be considered to be
26 a cause for concern. In the event, before the collision
27 on the morning of 20th August he, Mr Blayney, had seen and
28 had observed the MARCHIONESS, and so too had the other
29 gentlemen up on the forecastle with him, Mr Quantrill.
30 Neither man, neither Mr Blayney nor Mr Quantrill both

1 experienced long-serving able-seaman, considered that the
2 MARCHIONESS posed any cause of concern at that time. She
3 was ahead to the starboard of the BOWBELLE on a parallel
4 course and there was no change of collision.
5 May I address one of the criticisms which has
6 been made of Mr Blayney? Even if Mr Blayney had seen and
7 taken notice of the MARCHIONESS before Southwark Bridge,
8 had seen her and taken notice of her at sometime after
9 Waterloo Bridge, some 10 minutes or so before the
10 collision, he would have concluded that she posed no cause
11 for concern, that she was not a danger to the BOWBELLE,
12 nor in any danger from the BOWBELLE. So he would not have
13 reported her presence to the Master upon the bridge of the
14 BOWBELLE, because when he and Mr Quantrill did see the
15 MARCHIONESS she was not on a course which was of any cause
16 of concern. The collision, we contend, occurred because
17 of, and only because of, an alteration to the course of
18 the MARCHIONESS so as to place the MARCHIONESS into the
19 path of the oncoming BOWBELLE. We do not contend that
20 lightly. We do not say that in an attempt to shift blame
21 or to avoid responsibility or in any way to darken the
22 name of Stephen Faldo who cannot, regrettably, answer for
23 himself. It is something, however, which Mr Blayney
24 contends is a fact, a fact which has been stated by him
25 from the very beginning. The fact of the alteration to
26 the course was seen by him. It was a fact told
27 immediately by him to the Master, and it was a fact passed
28 on almost immediately thereafter by the Master over the
29 radio to the representative of South Coast Shipping. It
30 is a fact which Mr Blayney has repeated ever since, that

1 without that alteration to port by the MARCHIONESS there
2 would not have been the tragedy.
3 Sir, as you know, Mr Blayney is further
4 criticised by some for "having consumed excessive
5 quantities of alcohol so as adversely to affect his
6 ability to perform his duties". There is, in our
7 submission, no evidence to support that assertion. If
8 Mr Blayney had not been honest and truthful and candid
9 when he spoke to the Police on 20th August 1989 as to what
10 he had drunk the previous day, no one could even begin to
11 criticise him upon that ground. His blood alcohol reading
12 from the sample that he provided to the Police surgeon
13 when he was asked to do so at I think 4.25 in the
14 afternoon of 20th August was 0. It was negative. As has
15 been outlined by the Attorney-General this morning,
16 experts instructed by a number of the parties have got
17 together for the purposes of assisting this investigation
18 and, as you know, they have calculated based upon various
19 assumptions the blood alcohol concentration of Mr Blayney,
20 allowing for an average rate of elimination of alcohol
21 from his body. That agreed calculation shows, we say,
22 that contrary to what is now asserted by some of the
23 parties in their criticisms at the time of the collision
24 he, Mr Blayney, would not have had a blood alcohol
25 concentration so high as adversely to affect his ability
26 to perform his duties, but would have had one which was
27 the equivalent of less than half of the legal limit for
28 driving a motor vehicle. I stress that, less than half.
29 He was well able to do his job. He was not drunk and the
30 collision did not occur because of the consumption of

1 alcohol on the part of Mr Blayney.
2 What we say gives the lie to the criticisms of
3 him which are made, other than of course hose calculations
4 by the experts, is that on that forecastle of the BOWBELLE
5 with Mr Blayney from at least Blackfriars Bridge was
6 Mr Quantrill, not on duty, but there to do a job
7 immediately at the time the ship passed through
8 Tower Bridge and an able-seaman of even more years
9 experienced than Mr Blayney. Mr Quantrill, who first saw
10 the MARCHIONESS it seems at exactly the same time as
11 Mr Blayney did as the bow of the BOWBELLE emerged from
12 Southwark Bridge, and yet Mr Quantrill is a man who does
13 not drink, it seems, save for the odd pint of beer at
14 Christmas time, a man who had drunk no alcohol on 19th or
15 20th August 1989. As I say, his sighting of the
16 MARCHIONESS was at the same time as Mr Blayney, and his
17 observations of the MARCHIONESS show that he too did not
18 regard the MARCHIONESS as being a cause for concern until
19 she altered course to port and into the path of the
20 BOWBELLE.
21 Sir, nobody who encountered Mr Blayney that
22 night at any time has considered that he gave any
23 impression of being drunk or in any way unfit to perform
24 his duties, not the Master of the BOWBELLE, not the mates,
25 not any other member of the crew, nor the representative
26 of the company who came on board to the BOWBELLE when she
27 moored. Neither too did the Police when they saw him when
28 they had boarded the vessel in order to investigate the
29 cause or causes of the collision, which even at that stage
30 the Police knew had led to such terrible loss of life.

1 The Police did not gain any impression of drunkenness or
2 unfitness on the part of Mr Blayney when one would
3 legitimately have expected them to have done so if that
4 was indeed the case. So we, on his behalf, say that this
5 is not a proper criticism of him. It is a criticism made
6 without foundation and not supported by evidence.
7 Sir, that is all I propose to say at this
8 stage. May we say that we hope that the answers to the
9 many questions asked by this formal investigation can be
10 properly answered, and may we indicate that we, on behalf
11 of Mr Blayney and Mr Blayney too, will seek to assist the
12 investigation so far as we are able to do so.
13 LORD JUSTICE CLARKE: Thank you very much. Mr Caplan.
14 MR CAPLAN: I think, Sir, I speak last and I do so of course on
15 behalf of Captain Douglas Henderson, the Master of the
16 BOWBELLE on 20th August. I appear here today on his
17 behalf together with my partner Mr John Harding. Can I
18 firstly recall as I do speak last, I am sure on behalf of
19 all those who have preceded me, our grateful thanks for
20 the assistance and co-operation to date by the whole
21 Inquiry team and by those appearing on behalf of the
22 Attorney-General.
23 It is the end of a long and very emotional day
24 for very many people who have been touched by this
25 terrible tragedy. Therefore, I will keep my comments
26 brief and of course will not go through all the very many
27 points which have been made and touch upon Captain
28 Henderson himself. We would respectfully ask you, Sir, to
29 appreciate that Captain Henderson himself has suffered
30 through this terrible tragedy. He has not made public

1 statements or given media interviews, despite in fact
2 repeated requests and often the press and the media have
3 hounded him at his home. He has not complained about the
4 stress or strain on him and his family, but you will know,
5 Sir, the strain he has been under from the recently
6 disclosed documents by the company who employed him at the
7 time.
8 As I said, this is not the place for us at this
9 stage to seek to analyse or indeed anticipate the evidence
10 you are going to hear in the coming weeks, some of which,
11 we are bound to observe, we have not seen before, and some
12 of which we are bound to say would have substantially
13 assisted Captain Henderson at his two trials had they been
14 available to us at the time. I mentioned his trials
15 where, in fact, throughout all the many words that have
16 been said today both by the Attorney-General and by the
17 parties, his trials have only been mentioned for one
18 fleeting moment by those appearing on behalf of
19 Mr Blayney. We hope, Sir, and indeed are confident that
20 you and your learned Assessors will not allow this formal
21 investigation to turn into a third trial of Captain
22 Douglas Henderson.
23 I said I did not go through, and I will not do
24 so, all the matters which touch upon Captain Henderson on
25 which he will give assistance to this Inquiry, but there
26 are, Sir, a couple of matters I am bound to mention.
27 Alcohol: For some years Captain Henderson has
28 been vilified about the consumption of alcohol before
29 boarding BOWBELLE on 19th August 1989. In that context it
30 should not be forgotten by this formal investigation that,

1 firstly, he informed Detective Constable Bottomley on that
2 officer boarding the BOWBELLE shortly after this terrible
3 tragedy that he, Captain Henderson, had been drinking.
4 Secondly, that he, Captain Henderson, agreed to a blood
5 sample being taken from him at the request of the Police
6 immediately following the tragedy. It was a voluntary
7 request and he could of course have refused to do so. If
8 there was any delay in that sample being taken, then that
9 certainly was not the fault of Captain Henderson.
10 Thirdly, he informed the Police at the
11 commencement of his Police interview on that day of
12 precisely where he had been and the amounts he had
13 consumed. He could have refused to answer these questions
14 without any adverse criticism being drawn at his trial.
15 We all know that a blood sample taken at the time in 1989
16 when tested showed no traces of alcohol in his blood.
17 That, perhaps understandably because of the circumstances,
18 did not satisfy everyone. Now for the first time a decade
19 afterwards we have at least two new pieces of evidence to
20 assist this formal investigation. The first of those is
21 that at least three toxicology experts agree that, subject
22 to certain assumptions, at the time of the tragedy the
23 alcohol rate of elimination for a normal person, Captain
24 Henderson's blood alcohol concentration was nil. That of
25 course will be tested and discussed at some length before
26 the Inquiry.
27 Therefore, perhaps more importantly, Sir, is the
28 evidence that for the first time we hear that the first
29 two Police Officers to board the BOWBELLE in the early
30 hours of 20th August, Police Sergeant Gospage and Police

1 Constable Sara, looked particularly, as indeed sensible
2 and experienced Officers after a collision or accident
3 would do, for evidence that those involved had been under
4 the influence of drink, and they have concluded expressly
5 that there was no such evidence. That in fact, Sir, was
6 not evidence available to us at any stage prior to them
7 recently giving a statement to that affect.
8 Therefore, it amounts to this as far as alcohol
9 is concerned, that all the evidence available at this
10 stage is all one way. It is evidence as it stands at the
11 moment, as described by the Attorney-General in his
12 opening, that with an average rate of elimination of
13 alcohol Captain Henderson's blood alcohol concentration at
14 the time of the collision in the early hours of the
15 morning of 20th August was nil.
16 Criticism seems to have gathered momentum about
17 Captain Henderson's medical notes, and if necessary and in
18 dowse course we will seek to deal with those matters.
19 Captain Henderson, Sir, was trying to do his work as
20 Skipper or Master of the BOWBELLE conscientiously to the
21 best of his ability. He was following the practice and
22 custom as he genuinely and honestly believed it to be. If
23 there is criticism of the system, that criticism should be
24 directed against those who allowed it to continue on the
25 River Thames.
26 Immediately after the collision took place he
27 assisted those with the task of investigating this
28 terrible tragedy. On the day he was arrested he was
29 interviewed at length by the Police. It must not be
30 forgotten that he was detained in custody. We do not

1 company of that, but it must not be forgotten that he
2 could have exercised his right of silence, and at the
3 subsequent trial no adverse influence, as the law stood at
4 that time, could have been drawn from that refusal to
5 answer any questions.
6 The next day he assisted South Coast Shipping in
7 a lengthy interview. The day following that he attended
8 at the offices of the Marine Accident Investigation Branch
9 and fully co-operated with them with their investigation.
10 We, of course, know that after a full and thorough
11 investigation the Director of Public Prosecutions brought
12 a criminal charge against him under the Merchant Shipping
13 Act. On being charged he told the MAIB that he had no
14 objection to their report being published in advance of
15 his trial. He had nothing to hide and hopes that may
16 assist anyone wishing to learn anything about this tragedy
17 to be able to do so.
18 Sir, we of course know that the DPP was unable
19 to satisfy two juries that Captain Henderson was guilty of
20 any criminal offence, and a finding of not guilty was
21 entered by the High Court Judge.
22 The matter does not end there. One of the
23 particulars placed before the jury by the DPP was that no
24 proper instructions were given to Mr Blayney, the forward
25 lookout. At both trials the judge separately decided that
26 Captain Henderson had no case to answer on this allegation
27 and separately and quite independently withdrew that
28 particular from the jury.
29 20th August 1989: Captain Henderson will be
30 attending this formal investigation now that an undertaken

1 has been given by the Attorney and will give every
2 assistance that he can, Sir. He was, as I think you may
3 know, due to give evidence at the very end of this Inquiry
4 and had made arrangements with his employers to do so. It
5 was then suggested that it would be more convenient and of
6 greater assistance if he did in fact give evidence at the
7 commencement. At the request of the Inquiry, and indeed
8 some of the parties I believe, he has made arrangements to
9 be able to attend here. In fact I believe he is flying in
10 from aboard and I hope shortly to be able to confirm that
11 he will be in London available to give evidence first
12 thing tomorrow morning.
13 Everything he did or did not do as he undertook
14 that voyage has and will be scrutinised, of course with
15 the benefit of hindsight. We have seen endless charts,
16 diagrams, reports and visualizations. It is interesting
17 that a comparison has been drawn between this tragedy and
18 the collision in June 1983 between the BOWBELLE and the
19 PRIDE OF GREENWICH. I think it was referred to by one
20 learned counsel as a mirror image of this tragedy, and
21 reference was made to a minute from the Department from
22 Mr McGroul, I think at page 869. You do not need to turn
23 it up, Sir. It is quite interesting that that minute,
24 I think dated 16th June 1983, refers to the difficulty on
25 the BOWBELLE and also says that it would be difficult to
26 criticise the Master of the BOWBELLE, I think it was
27 Captain Coull, and I think in due course he will be called
28 by the Attorney-General to give evidence before you.
29 It cannot be doubted, Sir, that Captain
30 Henderson on 29th August informed on his radio that he was

1 leaving Nine Elms. Then, as you know, he did only report
2 when he arrived at Tower Bridge. As a mark, we would say,
3 of good seamanship he reported in voluntarily both when he
4 reached Vauxhall Bridge and then Waterloo Bridge. The
5 judge at the Central Criminal Court told the jury at the
6 first of the two trials that this was not the act of a
7 complacent Master. He was, as you know, taking centre
8 arches down the Thames. He was in the only position he
9 could be, known or should have been known to all those who
10 use the River Thames and his presence was well broadcasted
11 by Woolwich and voluntarily himself.
12 Importantly perhaps, although it has derived
13 some criticism in the overall context of this case, his
14 presence on the river was also broadcast as he was about
15 to enter Southwark Bridge. In those last 45 minutes
16 before this terrible tragedy and the collision I think
17 will you find, Sir, that the BOWBELLE was mentioned on
18 Woolwich Radio probably as many as ten times. Again, of
19 course with the benefit of hindsight, it can always be
20 said that he, Captain Henderson, like anyone else in
21 charge of be it a motor vehicle, a boat, should have
22 reacted or done something differently. What we do know is
23 that he was in the wheelhouse throughout observing him,
24 standing behind him, was Mr James the engineer, the one
25 independent witness who observed Captain Henderson from
26 Waterloo Bridge over those last important ten minutes
27 before this terrible collision. I say again we can all
28 say of course with the benefit of hindsight that Captain
29 Henderson should have been doing other things, should have
30 looked this way or that, but Mr James there watching him,

1 behind him and watching his every move, concluded, and
2 these are the words of Mr James, that Captain Henderson
3 was "concentrating, moving from side to side looking and
4 trying to do his job."
5 Of course, Sir, what Captain Henderson did and
6 not do will be considered carefully. There will be many
7 who will suggest, indeed they may be appropriately right
8 on many occasions, he should have done this or not done
9 something else. However, hindsight is a wonderful thing
10 and we ask this Tribunal to bear in mind that it is very
11 easy to look with hindsight. We ask this Tribunal to
12 consider that what Captain Henderson he was doing to the
13 best of his ability, he may be criticised, but he was
14 there in the wheelhouse concentrating, trying, in the
15 words of Mr James, to do his job.
16 You, Sir, and others at the conclusion of this
17 formal investigation may feel that this is the case not so
18 much about the role of Captain Henderson on 20th August
19 1989, but of far more other reaching and deep rooted
20 concerns on the river for which others bear considerable
21 responsibility as well as him on that voyage at that time.
22 In conclusion, Sir, we are conscious on behalf
23 of Captain Henderson of your disciplinary powers in this
24 formal investigation. If you require at the end of this
25 Inquiry us to address you, then of course we willingly do
26 so. We are confident and we hope, Sir, that you will
27 approach those disciplinary powers with regard, if need
28 be, to all the circumstances of this case, including all
29 that Captain Henderson has been through in the past eleven
30 years, and of course the passage of time since the

1 terrible tragedy.
2 Unless I can assist you further, Sir.
3 LORD JUSTICE CLARKE: Thank you very much. I would just like
4 to make one or two observations of my own.
5 MR DOYLE: Sir, before you make those observations, may I be
6 forgiven for raising one important matter on behalf of
7 Mr Quantrill whom I represent?
8 LORD JUSTICE CLARKE: Yes, I am sorry.
9 MR DOYLE: Not at all, Sir, because Mr Caplan can be forgiven
10 for assuming that he was to speak last, not least because
11 we do not feature on the batting list, which came as no
12 surprise to us because to date we have received no formal
13 notice of substantial criticism in relation to
14 Mr Quantrill from any party ----
15 LORD JUSTICE CLARKE: Are you?
16 MR DOYLE: Mr Doyle -- including those representing the
17 MARCHIONESS Contact Group. We were, therefore surprised,
18 if I may be permit that understatement, that Mr Quantrill
19 should first hear of their substantial criticisms of him
20 at the same time as the media. Mr Mansfield alleges that
21 Mr Quantrill displayed a complete disregard for the safety
22 of other vessels, motivated by his own appreciation that
23 when the BOWBELLE was on the river the safety of other
24 vessels was an irrelevance. He further alleges that
25 Mr Quantrill's failure to see the MARCHIONESS before he
26 did, can only be explained by a combination of that
27 complete disregard and incompetence. There appears to be
28 a further criticism of him, namely an allegation that he
29 failed properly or at all to assist in the deployment of
30 any life-saving equipment.

1 We currently cannot identify any plausible
2 explanation for this failure to follow your clear
3 directions as to the service of proper notice. We,
4 therefore, invite Mr Mansfield before we leave the
5 building this evening to provide us with a proper notice
6 in writing of criticisms of Mr Quantrill if they are to be
7 pursued. If not, no doubt they can be publicly withdrawn
8 before the adjournment.
9 I do not require the document to be in typed
10 form; manuscript will do. We are concerned with substance
11 and not form. Thank you, Sir.
12 LORD JUSTICE CLARKE: Thank you very much. Just on that point,
13 Mr Mansfield, the way in which the Inquiry has proceeded
14 to date is that it was for each party who wished to make
15 substantial criticisms of any other to do so in writing in
16 accordance with the directions we gave earlier. It
17 appears to me that there is a good deal of force in what
18 Mr Doyle says. So, are you in a position to provide him
19 with a short statement of your written case?
20 MR MANSFIELD: Sir, we are.
21 LORD JUSTICE CLARKE: That is if you wish to proceed with it.
22 MR MANSFIELD: Yes. It is done in a context, namely of course
23 the responsibility, I hope I made clear, resides on the
24 vessel itself, Captain Henderson, which is part of five
25 people who failed to spot, that is how it is put. I am
26 perfectly prepared to put it in writing."
27 LORD JUSTICE CLARKE: Very well. I will simply direct that the
28 MCT should put its case in writing, if it has one, against
29 Mr Quantrill personally this evening or to abandon it.
30 I would just like, however, to make one or two

1 points before we adjourn this afternoon. The first is to
2 say this, that I process in general to sit from 1030 till
3 1300 and from 1400 to 1630 each day in order to hear oral
4 evidence. I am not proposing to have a break in either
5 session, except for some good reason as, for example, the
6 interests of a particular witness. I hope and trust that
7 there will be so much co-operation between the parties
8 that no one will wish to make an interlocutory application
9 of any kind, but if such an application should be made I
10 will hear it at 1630 or possibly at 10 o'clock, that is
11 after the evidence has finished for the day or before it
12 starts. In this way it should be possible to avoid
13 interrupting the evidence.
14 This morning I stressed the importance of
15 co-operation between the parties, and I would like to say
16 just a brief further word about it now. I am sure that
17 everyone appreciates its importance if the Inquiry is to
18 run smoothly. It does seem to me to be of great
19 importance that the witness timetable should be adhered to
20 if at all possible. I quite understand that events may
21 occur during the course of the investigation which may
22 alter the position. For that reason I attach particular
23 importance to counsel estimating how long he or she wishes
24 to examine each witness orally. I am sure everyone will
25 appreciate that the Secretariat has gone to considerable
26 lengths to locate witnesses and to arrange for them to
27 attend on particular days. Re arrangement will be very
28 difficult. So if there is anyone who has not completed
29 the witness schedule giving an estimate of the likely
30 length of his or her cross-examination, please would they

1 do it straightaway. I appreciate that this is not always
2 terribly easy, but I would ask everybody to do their
3 utmost to complete the schedule so that everybody will
4 know the position. The final schedule with everybody's
5 estimates in it will then be included in the core bundle
6 so everybody knows the position.
7 Next, and this is a point which has been made by
8 a number of people already today, some of the witnesses
9 will undoubtedly have been through a most traumatic time
10 and may find giving evidence very distressing, and that
11 I think includes all the survivors, including indeed all
12 those on the MARCHIONESS. It is also I think likely to be
13 stressful for witnesses from the BOWBELLE, including
14 Captain Henderson. Other witnesses are now elderly. All
15 are being asked to recollect events which occurred many
16 years ago. Some witnesses may not now be in good health.
17 Although some witnesses have been more reluctant to attend
18 than others, all those who attend will have voluntarily
19 agreed to give evidence to assist at the Inquiry in this
20 tragic case.
21 I am sure that I can rely on all counsel to
22 treat all witnesses both sensitively and fairly, and that
23 includes all those who are subject to criticism. Just a
24 small point in this regard. I would ask anyone who is
25 calling a witness, or indeed anyone who is examining a
26 witness, not to ask that witness for their address. We
27 are proposing to put the evidence on the website, and it
28 would therefore be appropriate that that should be
29 excluded. It does not seem to me to be a relevant factor
30 in any event for the Inquiry to know.

1 I recognize, as has been indicated today, that
2 criticisms have been made of particular individuals, each
3 of whom must of course have an opportunity to meet them.
4 There is naturally a good deal of overlap between the
5 criticisms made by different parties. This will no doubt
6 necessitate some cross-examination, but I hope that I can
7 rely on counsel not to ask questions that have already
8 been asked by other counsel. I also hope that counsel
9 will bear in mind that the purpose of cross-examination is
10 to elucidate the facts and not to develop argument or to
11 make a speech. All parties will have a full opportunity
12 to make detailed submissions at the end of the evidence.
13 The timetable has been drawn up in order to give
14 time for the preparation of submissions. It will thus be
15 possible for the submissions to be substantially written,
16 which will be of particular assistance to me and my
17 Assessors when the report comes to be written, but there
18 will be an opportunity for oral submissions to be made at
19 the conclusion of the Inquiry.
20 So far as individuals are concerned, I should
21 I think add this, and this is the point or part of the
22 point being addressed by Mr MacDonald a little earlier.
23 It also underlines the point made on behalf of
24 Mr Quantrill a minute ago. Direction No. 29 provided that
25 any party who intended to make a substantial criticism of
26 any person or body should do so before 18th August.
27 I understand that in some cases that period was extended
28 to some extent. I observe that the individuals criticised
29 were two of those on board the BOWBELLE and two of those
30 who were on board the MARCHIONESS, and perhaps now it

1 seems Mr Quantrill.
2 I am sure that careful consideration was given
3 on behalf of each of the parties as to whether any other
4 individual should be criticised, and that it was decided
5 that the public interest did not warrant criticism of
6 others, whether employed by the owners or managers of
7 either vessel or by the DETR or the PLA. It was no doubt
8 decided in each case that the public interest was
9 sufficiently served by making criticisms of the systems in
10 operation, and thus by making allegations against the
11 corporate bodies concerned.
12 I only mention this point now because it must be
13 recognized that it follows from that decision or those
14 decisions that it will not be open to any party to make
15 personal criticisms of any witness in the course of
16 cross-examination. The reason is self-evident, namely
17 that it would not be fair to any witness to make a
18 substantial personal criticism of him unless he had been
19 given, he or she had been given, sufficient advance notice
20 of it such that he could consider it carefully in advance,
21 and in the words of Rule 9, have an opportunity of making
22 his defence. As I see it, this position might change only
23 if significant new material came to light.
24 I have not, of course, yet considered the
25 evidence, but in the light of the written submissions that
26 I have seen and the opening statements that have been made
27 most helpfully today, while some facts may be in dispute,
28 it seems to me that the vast majority of the primary facts
29 will not be in dispute. It was for that reason that
30 Directions 24 and 25 were given. The Attorney-General

1 served a detailed chronology in accordance with Direction
2 24 and, so far as I am aware, no party has indicated any
3 disagreement with it or any part of it as required by
4 Direction 25. In those circumstances, it is likely that I
5 shall treat those facts as correct and append the
6 chronology as part of my report. The same is true of the
7 SAR chronology which is the subject of Directions 26 and
8 27. If any party wishes to propose any amendments to
9 either chronology, it should do so in the near future.
10 I recognize, of course, that there will be
11 documents upon which one party or another may wish to rely
12 which are not in the chronology, and indeed some of them
13 have been referred today. I think Mr Haddon-Cave referred
14 to a number of documents which are not referred to in the
15 chronology. One example is DP_02048. It would be of
16 great assistance to me, and I think possibly also those
17 representing the Attorney-General, if anyone who does
18 refer to a document could refer to it not only in the
19 original numbering system, but also in the numbering
20 system which has been developed for the Inquiry itself,
21 namely, for example, WIT_00296 or CRA_00497 or as the case
22 might be. I would also hope to be able to add to the
23 chronology as time goes on any relevant materials such as
24 those referred to during the course of submissions today.
25 I very much appreciate the assistance of counsel in that
26 regard as we go along in order to keep the thing in some
27 sort of control, otherwise I will be in a hopeless muddle
28 at the end of the day which is something I am trying to
29 avoid.
30 I will also perhaps ask each counsel if they

1 could carefully check the transcript at the end of today
2 just to ensure that it does correctly refer to any
3 documents or any vessel names to which they have referred.
4 I would like to say now a word about expert
5 evidence. One of the features of the case in respect of
6 which there has almost without exception been commendable
7 co-operation between the parties is expert evidence.
8 There obviously have been a number of experts in a number
9 of different disciplines who have considered a number of
10 different parts of the case. So far as I have been able
11 to understand the position, there appears to be agreement,
12 or near agreement, on a very large number of matters.
13 I hope that it will be possible for the experts in each
14 area to reach agreement so far as possible on where they
15 have done so to reduce that agreement into some document,
16 and to identify what, if any, issues there remain between
17 them and then to reduce those issues to a document so that
18 the expert evidence or such expert evidence as is
19 necessary, can focus on those matters which really are in
20 issue as opposed to matters which are really not in
21 dispute or not really capable of being in dispute at all.
22 If necessary, I could give some further
23 directions in relation it that, but I feel sure that I can
24 rely upon the good sense of the parties in that regard as
25 in many others.
26 A word about the website. I understand that the
27 parties and the majority, if not all, of the witnesses who
28 are coming to give evidence have been informed of the
29 proposal to disclose statements and documents which will
30 be tendered in evidence by putting them on the website,

1 and in a document library at Central Hall.
2 While it has not been possible to obtain
3 everyone's formal consent to this disclosure, as
4 I understand it, no objection is now taken to it by any of
5 those who have responded. In all the circumstances, it
6 seems to me that disclosure via the website and the
7 document library is appropriate and, indeed, necessary in
8 the public interest if the formal investigation is to
9 be open and fair to all.
10 It follows that, subject to any submissions
11 which anyone present may wish to make, both the documents
12 and statements put in evidence will be available on the
13 website and in the library together with the transcripts
14 of the evidence given each day. I am hoping so long as
15 nobody asks an inappropriate question, it will not be
16 necessary to redact any of the material before it is put
17 on the website.
18 A point on the criticisms: I understand that
19 some of the parties wish to amend their provisional
20 answers and notices of substantial criticism. I think
21 I am right in saying that those, subject perhaps to the
22 Quantrill point, have now been distributed. Unless
23 anybody objects to any of the particular amendments,
24 I propose that they all be made and included in the core
25 bundle.
26 Then just a point about the documents: I too
27 would like to pay particular tribute to Mr Sandal and his
28 team for the present state of the documentation, both
29 paper and paperless, if you have can have paperless
30 documentation. There seems to be quite a lot of paper for

1 a paperless Inquiry, but still.
2 It is obviously of the utmost importance, again
3 if the Inquiry is to run smoothly, that all parties should
4 keep their documentation up-to-date, so that when a
5 document is referred to everybody has the same number for
6 it, and so on. To that end, I understand from Mr Sandal
7 that a pigeon hole will be allocated to each party where
8 new material will be placed as it arrives. Please could
9 I, therefore, ask each party to check their pigeon hole
10 perhaps three times a day, in the morning, at lunch time
11 and in the afternoon, in order to ensure that additions
12 are made to the bundles promptly? So it will be the
13 responsibility of each party to keep its own documentation
14 up-to-date in this way.
15 Two other points perhaps arising out of today:
16 Miss Cameron referred to the position of the London Fire
17 Brigade. The position, if I have understood this
18 correctly, appears to be that in the course of his opening
19 the Attorney-General indicated that there was a delay in
20 one of their vessels proceeding to the casualty, and
21 suggested that one of the questions for the Inquiry to
22 consider was why that had happened.
23 As I read the opening, the suggestion appeared
24 to be that the problem might be in the giving of the
25 information. It may be, on the other hand, that it is
26 suggested, as appears to me to have been suggested by
27 Miss Cameron, that the problem was not in the giving of
28 the instruction, but in the acting upon it, in which case
29 it may be that that is something about which the London
30 Fire Brigade should be notified. I invite Mr Tier --

1 I think Mr Haddon-Cave also made a submission in relation
2 to the vessel, is it the LONDON PHEONIX? I am not sure if
3 I have the name of the vessel right. Perhaps I could ask
4 Mr Tier just to give some consideration to that between
5 now and tomorrow because, while I do not think on the
6 information at present that it would be appropriate or
7 necessary to make the Fire Brigade a party, it may be
8 necessary for some notice to be given to them so that they
9 can focus on this particular point if they wish, perhaps a
10 notice under the Rule to which I referred earlier.
11 Finally, the only remaining point upon which, so
12 far as I am aware, there is an outstanding issue, or
13 potential issue, does relate to the medical condition of
14 Captain Henderson and Mr Blayney. I do not invite
15 argument about this at the moment. I would just like to
16 say this. One of the questions identified by the
17 Attorney-General in his opening was were any of the
18 crewmen on duty that night affected by alcohol? Several
19 counsel in the course of their addresses have referred to
20 this problem.
21 In order for the Inquiry to focus upon this
22 problem, it will be necessary, as far as I can understand
23 it, to answer these two questions: (1) how much did each
24 such person, in fact, drink, and (2) what, if any, effect
25 would the amount he drank have had on his ability to carry
26 out his duty? As has been pointed out by several people,
27 these are matters which have been considered by
28 toxicologists instructed on behalf of one or more of those
29 interested.
30 As I understand it, in order for a toxicologist

1 to arrive at a satisfactory conclusion, he or she needs
2 information about the individual concerned and that
3 information includes height, weight and physical
4 condition. It does appear to me that, in the interests of
5 an entirely open Inquiry, it would be desirable, if there
6 were made available to the relevant toxicologists in the
7 first instance information about the physical condition of
8 Mr Blayney and Captain Henderson at the time. That is, of
9 course, before 1989, not obviously now.
10 I recognize that questions of this kind are of
11 an entirely confidential nature, but I wonder whether,
12 specially in the light of the fact that I understand that
13 one of the toxicologists has had the information and,
14 indeed, has expressed an opinion on the topic, Captain
15 Henderson and Mr Blayney might not think it would be
16 appropriate perhaps just to make that information
17 available to the toxicologists, as it were, on the other
18 side, so that nothing is being, as it were, swept under
19 the carpet. I am not suggesting that it is, but that the
20 matter will be entirely open.
21 I do not think it will be appropriate or
22 sensible to have any further discussion about that at the
23 moment. I just suggest that both those two gentlemen
24 might just consider that. They might think that that was
25 the most sensible way forward. I quite understand.
26 I have read some of the correspondence and I quite
27 understand the way it has arisen to date, but I just
28 wonder whether that is not the most sensible way forward.
29 But unless anybody wants to say anything about
30 that at the moment, I think it would be better to leave it

1 there.
2 Does anybody wish to say anything about anything
3 at the moment? Good. Then we will begin tomorrow morning
4 at, I think, half past 10. We hope it will be possible to
5 start with the evidence of Captain Henderson. Mr Caplan,
6 you are reasonably confident that that will be possible?
7 MR CAPLAN: Sir, I may have spoken last, but, clearly, my party
8 is going to bat first tomorrow morning. I am hoping, I am
9 very confident, because, of course, Mr Harding and myself
10 have been here during the whole of the day, we are hoping
11 there is a message, as it were, on some technology
12 upstairs to confirm that position.
13 What I will undertake, sir, if that is not the
14 position, I will inform Mr Sand before I leave the
15 building, but I am confident.
16 LORD JUSTICE CLARKE: If you could because, obviously, you will
17 appreciate it would rather affect tomorrow's business if
18 he could no come.
19 MR CAPLAN: That is why, sir, and it is a dangerous thing for
20 any advocate to say, I am pretty confident we will be in
21 business tomorrow.
22 LORD JUSTICE CLARKE: In that case, I would like to thank
23 everybody for their assistance today. I will adjourn now
24 until 10.30 tomorrow morning.
25 (The hearing adjourned until the following day)
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