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See the Possibility

The Grenfell Tower Inquiry Phase 2 Report

Weightmans LLP's guide to navigating the Phase 2 Report and what comes next on the Building Safety Journey

Introduction

The Grenfell Tower Inquiry (the "**Inquiry**") Phase 2 Report (the "**Report**"), whilst being a significant milestone on the building safety journey, is not the end of the road.

Indeed, as anticipated, whilst the Report provides clarity in some respects, in many ways it asks as many questions as it answers. To us, that is not surprising: the limitations of the Inquiries Act 2005, the further limitations of the terms of reference – and indeed the enormity of the underlying issues the Inquiry uncovered – necessarily meant that the Report would only be able to go so far.

What has also become readily apparent in the immediate fall-out from the Report is that the likelihood of change being driven by government is low, certainly in the short to medium term. Whilst the government has committed to looking at enacting the recommendations in full and said that it will respond within six months, in our view at least, all that confirms is that nothing will change for six months.

If anything, it probably slows matters further, as the likelihood of progress on outstanding secondary legislation needed to fix problems with the Building Safety Act 2022 (the "**BSA 2022**") is now presumably lower. Looking at the wider legislative agenda, and all signals made as to this Autumn's budget, it is also hard to see from where the necessary funds and resource will come to enact the recommendations in any event.

As a result, those operating in the built environment / building safety space – be it designers, manufacturers, suppliers, installers, construction professionals, insurance professionals, legal professionals etc. – will in all likelihood continue to operate in something of a 'limbo state' for some time yet.

In the absence of legislative-driven change, there has been a lot of 'noise' post the Report as to what the industry might or should do to enact change in the interim. How much of that comes to fruition will ultimately depend on the conviction of individuals and organisations. There is certainly an opportunity here and it is our great privilege at Weightmans to work with so many fantastic clients who are looking to pioneer the way forward.

A particular metaphor has remained relevant throughout the life of the Inquiry: *when it is foggy, you can only navigate as far as the fog lights shine.* The Report has shone light into the next part of the journey, foggy as it may be, and we look forward to working with clients, old and new, to navigate the next stage.

At 1,700 pages, the Report is not easy to digest. In this paper, our team of building safety experts – drawing on our professional risk, construction, regulatory, public sector and corporate resilience specialisms – set out what we hope will provide you with a useful reference guide to help think through the implications for you and your business.

The Weightmans Building Safety Team
September 2024

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Abbreviations

ACM	Aluminium Composite material cladding
ADB	Approved Document B
BCO	Building Control Officers
BRE	Building Research Establishment
BSA 2022	Building Safety Act 2022
BSR	Building Safety Regulator
CPS	Crown Prosecution Service
Fire	The devastating fire at Grenfell Tower on 14 June 2017
FRA	Fire Risk Assessment
Grenfell	The Grenfell Tower
Hackitt Report	The Independent Review of Building Regulations and Fire Safety conducted by Dame Judith Hackitt
HRB	Higher-Risk Building
Inquiry	The Grenfell Tower Public Inquiry chaired by Sir Martin Moore-Bick
MPS	Metropolitan Police Service
PEEP	Personal Emergency Evacuation Plans
Report	The Grenfell Tower Inquiry Phase 2 Report
RRO	Regulatory Reform (Fire Safety) Order 2005

Executive Summary

What we cover in this paper

Necessarily, given the size of the Report, this paper is itself long.

In order to make it more manageable it is split into sections, each of which is prefaced with some introductory comments and an overall view. At the start of each article / series of articles, we have then also set out 'key takeaway points' which we hope will assist with navigating the paper.

Finally, to help you navigate to the areas which are of most interest to you, we set out short precises of the various articles below.

Precises

Background

Grenfell did not happen in isolation and the Inquiry has ultimately uncovered wider more systemic issues. Understanding how we ended up at Grenfell is crucial to understanding the context of its conclusions, and also then appreciating why the Report's recommendations will not be quick or easy to implement.

Understanding the Building Regulations / Regulatory Landscape

Whilst there were regulations and regimes in place to govern the construction of buildings and the supply and installation of materials, they were not fit for purpose and afforded opportunities for mis-interpretation and misrepresentation as to how they are met, it at all.

Lessons for Professionals

The Report's findings, conclusions and recommendations will no doubt impact the future regulation and risk profiles of various professions. The findings are not however, necessarily, directly applicable to all scenarios and time (and further guidance) is needed to understand the full impacts.

Architects

The project architect came under significant criticism in the Report. Much of that criticism is specific to the architect in question. Some of it asks questions of the industry more widely. Much of it is not new and should first and foremost stand as a reminder to the profession to remain alive to fundamentals such as contractual scope and competency of staff.

Fire Engineers

The fire engineer came under significant criticism in the Report. In particular, the lack of proactivity identified by the Inquiry – against the level the Inquiry felt should have been engaged – may come as a surprise to some and raises some interesting questions as to scope moving forward. A profession which looks set for much change in the future.

Main Contractor

The Report identifies significant failings on the part of Rydon, and identifies the need for contractors to be much more proactive and take full responsibility for delivering their projects, reinforced by the new regulatory dutyholder regime under the BSA 2022.

Sub-contractors

One of the key takeaways from the Report for subcontractors is to be very clear on – and document – the scope of their roles and responsibilities, and at the same time be aware of and mindful of how this interacts (or, as importantly, does not interact) with the roles and responsibilities of others.

Fire Risk Assessors

Fire risk assessors remain a nascent profession. However, they have very much come more into general consciousness since Grenfell. The Report recognises this in large part. Its recommendation in respect of fire risk assessors are not in large part surprising, but if enacted would bring about substantial change. Again, a 'watch this space' area.

Building Control

The Inquiry's recommendations raise the potential for further significant changes to the building control industry, which will no doubt cause widespread concern within the private building control space in particular.

Opinion Pieces

The Recommendations – what comes next?

The Report makes a significant number of recommendations which government has agreed to look at implementing, but, as of yet, with no commitment. If enacted, they would have wide ranging impacts on a large number of sectors. However, the cost and feasibility of enacting the recommendations is such that change in the short term is unlikely.

Learning from the rest of the world

The issues the Inquiry uncovered are not confined to Britain, nor is the Inquiry the only body to have considered what should be done in response. Other countries have arrived at similar points on many of these issues, often moving more swiftly. This – if nothing else – provides food for thought on the appropriate forum for pushing forward change.

The Future of Inquiries – does Grenfell change anything?

The Inquiry reports at a moment of unprecedented use and scale of public inquiries. There is a need to reflect on their utility and long-term impact. In particular, the recommendation that there be better accountability moving forward for implementing recommendations raises interesting questions for inquiries generally and very much taps into the zeitgeist.

What does the future hold for construction professional indemnity?

Undoubtedly, Grenfell had and continues to have a significant impact on construction professional indemnity. Whilst there was hope in some parts of the market that the Report would mark the start of a new chapter, as the Report raises as many questions as it answers we expect that matters will take some time before there is noticeable change.

Looking ahead to the criminal investigation

Despite calls for 'swift justice' it now looks as though it is unlikely that the CPS will even bring charges before the end of 2026. This will be disappointing to many, however the remaining investigation would appear to be significant.

Background

It is impossible to fully or comprehensively summarise the background to the fire at Grenfell Tower.

Indeed, the closest one can get is to refer to the overview and background chapters of the Report itself. Where able, readers are encouraged to review the Report's overview section in particular.

There are, however, certain important matters which will help you to orientate yourself around the core issues, and we have tried to set these out below to allow you to more easily access the rest of this paper.

Background to Grenfell

On the night of 14 June 2017, a fire broke out at Grenfell Tower, a 24-storey tower block in the Lancaster West Estate in the Royal Borough of Kensington and Chelsea ("**Grenfell**"). The fire exited the window of a flat and traversed at phenomenal speed around the building – the Inquiry has found – due mainly to the presence and use of various façade materials, namely the aluminium composite material cladding ("**ACM**"), the insulation products and window material build-ups which provided access to the cavities ("**Fire**").

The consequences of the Fire were devastating, and at Weightmans we acknowledge that – first and foremost – the Fire at Grenfell was a human tragedy where 72 people lost their lives (and scores more were permanently impacted) in the centre of one of the richest and most developed cities in the world. It is a tragedy which should not have happened and, as the Inquiry concluded, was avoidable.

The subsequent investigation into the Fire, and the circumstances leading up to it, have uncovered huge areas of concern within the construction industry. All of us operating in the built environment space must examine and reflect on the lessons to be learned.

The need to do so is accentuated by the fact that, as is so starkly highlighted in the Report, the Fire does not stand alone as a call to action. Strikingly in the Report, the Inquiry looked back to 1991 where a fire broke out in an 11-storey block of flats in Knowsley Heights, Merseyside. Whilst thankfully no-one was injured in that fire, the tower block was constructed using combustible polymer material and firefighters reported it as being extremely difficult to extinguish. Soberingly, the Inquiry concluded that, had different action been taken at the time, the whole landscape may have been altered and the Fire at Grenfell may not have occurred.

The Inquiry identified various failings by central government (and other responsible bodies in the construction industry) to carefully consider the risks of incorporating combustible materials into the external walls of high-rise residential buildings over some significant time, as well as failing to act on available information, as demonstrated below.

This was not a single moment in time, isolated to the period immediately following Knowsley Heights, however, and the Inquiry concluded that, prior to the Fire, there were many opportunities for government to identify the risks of combustible cladding panels and insulation, especially in relation to high-rise buildings, and to take action. The Inquiry identified what they call the "*seeds of disaster*" and set out a chain of issues in the development of regulations included in the table below.

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The seeds of disaster

Date	Failures relating to development of regulations
1997	The Inquiry consider that after the Building Research Establishment ("**BRE**") was privatised, the scope of advice government sought on fire safety matters was vastly reduced. As a result, the Inquiry consider that they did not have the full benefit of BRE's advice and experience. This then flowed into the development of guidance.
1999	The Inquiry identified a failure to consider the warning by the Environment and Transport Select Committee that action should be taken to minimise the risks of some external cladding systems prior to a serious fire occurring. There was also a failure to apply / review the Committee's recommendation that large-scale tests should be substituted in Approved Document B ("**ADB**") for previous requirements for fire safety of external cladding systems, abandoning Class 0.
2001	The Inquiry identified a failure to deal with the results of a large-scale test involving aluminium composite panels with unmodified polyethylene cores, which were shown to burn fiercely. This was compounded, the Inquiry says, by a failure to identify the extent that such panels were in use or to warn the construction industry of their risks. **Note**: The Inquiry concluded that at various points over the following 15 years, the government were warned that national Class 0 was an inappropriate standard for assessing the suitability of external wall panels. That of course remained in guidance until after the Fire.
2005 - 2006	The Inquiry found that whilst Approved Document B was reviewed, the opportunity was missed to clarify the guidance on compliance with functional requirement B4(1). The Inquiry concluded that, instead, vague and ill-considered wording was added without proper consultation.
2009	After a fire at Lakanal House, a tower block in London, in which six people died, the coroner recommended that Approved Document B needed to be reviewed. This was not treated with any urgency and the Inquiry concluded that the government resisted requests across the fire sector for the regulation of fire risk assessors and for the amendment of the Fire Safety Order to clarify its application.
2012 - 2017	During this period, the government received multiple warnings about the risks of using polymeric insulation and aluminium composite panels with unmodified polyethylene cores, including being notified of major cladding fires abroad.
2013	The Inquiry found that, by this time at the latest (4 years before the Fire), that the government knew that Approved Document B was unclear and not sufficiently understood by a large proportion of the construction industry.
2016	The Inquiry concluded that by February 2016, the government was aware of concerns that combustible insulation and aluminium composite material panels with unmodified polyethylene cores were regularly being used on high-rise buildings. Despite this, no changes or clarifications were made to the guidance on the construction of external walls in Approved Document B.

The Public Inquiry

The Inquiry into the Fire was announced by the then prime minister, Teressa May, on 15 June 2017 and formally set up on 15 August 2017. Former senior judge Sir Martin Moore-Bick was appointed as Chair and remained in post until the Inquiry concluded with the release of the Phase 2 Report on 4 September 2024.

The Inquiry – split into 2 phases – was long and very wide ranging. Again, as a very high-level summary to contextualise mattes, readers are reminded of the following:

- Phase 1 focussed on the factual narrative of events that occurred on 14 June 2017 which were examined in detail to determine what likely occurred from the outbreak of the Fire in the kitchen of flat 16 until the escape of the last survivor. This was done to provide an early opportunity to those directly involved in the Fire, such as the residents and fire fighters, to give their accounts of that night, as well as attempt to explore the reasons for what happened

- in Phase 2, the panel aimed to identify how it was possible for such a building to catch fire in an uncontrollable manner in just a few hours, when it was thought that effective regulations were in place to prevent this scenario

- Phase 2 was divided into separate modules, each reflecting an element of the background to the Fire. The hearings for Phase 2 started on 27 January 2020 and the Inquiry sat through 312 days of evidence and opening and closing statements

- after the hearings began, they were quickly interrupted for a period of about five weeks whilst an undertaking from the Attorney General was obtained to prevent evidence from being used against witnesses in criminal proceedings

- hearings resumed on 2 March 2020 but were suspended on 16 March 2020 due to the restrictions imposed in response to the Covid 19 pandemic. Hearings continued on 6 July 2020 until 9 December 2020. The proceedings were again interrupted between 9 December 2020 and 8 February 2021 due to Covid 19 restrictions. Following this, remote conferencing facilities were used in a way that enabled the hearings to continue whilst the requirements of lockdown were observed. Public access to the hearing room resumed from September 2021 until November 2022

- between June 2023 and April 2024, the Inquiry's solicitors wrote to 247 individuals and organisations notifying them of criticisms being made of them, together with the relevant chapters of the draft Report, and invited final submissions

- the Panel received expert advice and assistance from leading practitioners, in the form of written reports and evidence given at the public hearings; and

- it was identified that racial or social discrimination in the general allocation of social housing fell outside of the panel's investigation, but that any elements which affected the decisions leading to the creation of an unsafe building were within their scope.

Other developments

As set out above, the Inquiry took place over a seven-year period. This, in large part, reflected the scope of matters it had to consider and, as we discuss further in this paper, the end of the Inquiry itself only marks one more step in a wider building safety journey.

That said, however, it became immediately apparent that action would be required before the Inquiry could conclude due to:

- the need to deal with an apparent imminent life safety risk with thousands of people living in high rise blocks clad in similar materials to those used at Grenfell
- the fact that the Inquiry was always going to be limited in scope, notably: (i) by virtue of section 2(1) of the Inquiries Act 2005 preventing the Panel from ruling on the question of civil or criminal liability and (ii) the Inquiry further being bound by its terms of reference; and
- the risk that, un-remediated, guidance / practice would perpetuate the same issues.

There is not space to – or utility in – setting out all changes that have occurred in the last few years. The following key matters are, however, worth remembering, as they both demonstrate the key trends and provide context to understanding the difficulties now faced in implementing the Inquiry's ultimate recommendations (see further page 44 below).

1. **Hackitt Report**
   Shortly after the Fire, Dame Judith Hackitt was asked, and did then produce, various reports known as the *Independent Review of Building Regulations and Fire Safety.* An interim report was published on 18 December 2017 with the final report published on 17 May 2018. Dame Judith was very critical of the existing system and espoused a 'new approach' (the "**Hackitt Report**"). This was done very quickly.

2. **The BSA 2022**
   Introduced to Parliament in July 2021, with the first reading on 5 July 2021, the BSA 2022 sought to enshrine the Hackitt recommendations all before the Inquiry had even concluded its investigations. The BSA 2022 is a long piece of legislation with some areas well developed and others left largely to secondary legislation, (much yet to be passed). In our experience it is not without problems, and notably the new regulator it established – the Building Safety Regulator (the "**BSR**") is struggling.

3. **Other guidance / legislation**
   Various other changes have been made including to ADB (on multiple occasions) and also the Regulatory Reform (Fire Safety) Order 2005 (the "**FSO 2005**"), as well as the new Fire Safety Act 2021 which made various changes.

Navigating the Report

The aim of this paper is to allow readers to quickly get to grips with the conclusions and recommendations arising out of the Report, and also to raise various points for readers to consider in terms of unanswered questions.

There is, however, no substitute for reviewing the Report itself. Whilst few will have the time to review it in full, there are sections which will no doubt be helpful for different readers to review in full.

In order to assist readers with identifying those sections, we have set out some summary points on navigating the Inquiry's reports.

Phase 1 Report

The Phase 1 Report consists of 838 A4 pages. It contains 4 volumes, 6 parts and 34 chapters, as follows:

- **Volume 1 – Part I** – this relates to the background
- **Volume 2** and **Volume 3 – Part 2** – this considers the events that occurred on 14 June 2017 during specific time periods; and
- **Volume 4 – Parts 3 to 6** – this contains the conclusions, remembrance of those who died, the recommendations, and looks ahead to Phase 2.

It contains an executive summary in Chapter 2 and a recommendations section in Chapter 33 which are helpful. A key finding of the report was that the Fire had spread because of the aluminium composite cladding filled with plastic, which had been used on the exterior of the building. The report also made 46 recommendations directed at bodies such as the London Fire Brigade, fire and rescue services and other emergency services.

Phase 2 Report

The Report runs to a substantial 1,474 A4 pages.

There is also an executive summary in Chapter 2 and a recommendations section in Chapter 113. When these are read together they provide a fairly good overview.

The executive summary assists with the navigation of the rest of the Report, which is split into 7 volumes, 14 parts and 113 chapters. The parts often have introductory chapters, and there are various concluding sections throughout. It is therefore recommended to look at these parts if there is a particular interest in one aspect in order to navigate to the key issues.

The volumes and parts have been identified below:

Volume 1

- **Part 1** – this contains the introduction and executive summary
- **Part 2** – this tracks the Inquiry's conclusion that the Fire's roots came from a long history of poor development of legislation/guidance/ regulation and a failure to learn lessons.

Volume 2

- **Part 3** – this tracks in detail the key features, testing and approach to products.

Volume 3

- **Part 4** – this deals with the Tenant Management Organisation
- **Part 5** – this considers the management of fire safety at Grenfell and in particular fire safety features to some extent.

Volume 4

- **Part 6** – this reflects on the refurbishment of Grenfell and the criticisms of key features and actors.

Volume 5

- **Part 7** – this deals with the replacement of the gas riser
- **Part 8** – this concerns the developing criticism of the London Fire Brigade from the Phase 1 Report.

Volume 6

- **Part 9** – this is the section from the coroner and goes through how, when and where people died.

Volume 7

- **Part 10** – this deals with the aspect of the recovery and response
- **Part 11** – this looks at outstanding matters from Phase 1 and largely seems to support conclusions that were reached on the origin and spread of the Fire in Phase 1
- **Part 12** – this considers the fire testing regime
- **Part 13** – this looks at the international response from other countries
- **Part 14** – this contains the recommendations, with many of these causing and requiring the revisiting of BSA 2022.

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Understanding the Building Regulations / Regulatory Landscape

Integral to the design and construction of buildings, including High Risk Buildings, ("**HRBs**"), is a statutory and regulatory framework which:

- sets out clear and well understood standards or functional requirements that need to be achieved
- provides a reliable and robust system of testing materials that are to be used in building works in order to assess their suitability for use when measured against specified functional requirements; and
- a system of ensuring that works undertaken and materials used achieve the relevant functional requirements.

We summarise below, the Report's findings on these important issues.

Opinion

One of the most discussed findings arising from the Inquiry has been the suitability of the materials incorporated on the building, and the way in which these products were tested and marketed to the industry.

Building Regulations and testing requirements have safeguards in place to ensure that specifically HRBs being constructed meet specific thresholds and tolerances to ensure the safety of occupants.

Despite these regulations, the Report concluded that the construction of Grenfell breached the Building Regulations and "*actively promoted, the spread of fire*".

Perhaps the most devastating conclusion was that the original as-built tower, despite being outdated, had a safer external wall system which had withstood previous fires. As a result of refurbishment works in 2016, combustible materials were integrated onto the building.

The findings of the Phase 1 Report have already influenced legislation and the regulation of materials and the Phase 2 Report will also likely do so moving forwards.

The question that remains, however, is whether the amendments to the current system of regulation have – or will – go far enough to deal with the specific criticisms raised within both the Inquiry's reports and also the Hackitt Report. To my mind, at least, that remains very much a live question.

The Building Regulations

Key takeaway points

1) We are still awaiting the full extent of the overhaul of the building regulatory regime, although progress has begun.
2) The Inquiry has called into question much of the existing structure of testing, inspection and compliance in this country and requires further rethinking – even beyond the position articulated by Judith Hackitt. This will be no quick process.
3) The Regulatory Reform (Fire Safety) Order 2005 remains the key legislation for fire safety, but its scope for multi-dwelling buildings was significantly expanded by the Fire Safety Act 2021 to include the building's structure and external walls.

Building Regulations are an integral part of the construction process and set the standards that any development should meet – and will be judged against – to obtain building sign-off.

Building work must generally be carried out in a workmanlike manner using adequate and proper materials which are appropriate for the circumstances in which they are used, are adequately mixed or prepared, and applied, used or fixed so as to adequately perform the functions for which they are designed (Reg. 7, Building Regulations 2010).

The Building Regulations contain a series of broadly defined functional requirements that need to be complied with. By way of example, Regulation B4(1) provides that:

> *The external walls of the building shall adequately resist the spread of fire over the walls and from one building to another, having regard to the height, use and position of the building*.

Section 6 of the Building Act 1984 provides the implementation of a suite of Approved Documents for the purpose of providing practical guidance to meet each specific Building Regulation.

The Building Regulation system was criticised within the Hackitt Report as being confusing and not fit for purpose, and indeed Dame Judith recommended that a new regulatory system be implemented. The Hackitt Report recommended that both the standards to be achieved and the matter of compliance needed to be clear.

Whilst Building Regulations have been amended following this report and the implementation of the BSA 2022, the fundamental overhaul of the Building Regulation system has not yet taken place. As highlighted within the Hackitt report, the Approved Documents are often open to interpretation and can lead to specific trades operating within a silo with no consideration or collaboration across the projects, looking at systems as a whole.

S.7(1) of the Building Act 1984 is another example of this uncertainty, stating that failure to comply with the Approved Documents is not conclusive evidence that there has been any breach of liability. In addition, compliance with the Approved Documents is also not of itself evidence of compliance with Building Regulations. Conversely, whilst the Approved Documents say that following them tends to

demonstrate compliance, that too is not certain. This feature of the Building Regulations was notably met with scepticism by the Inquiry.

The Inquiry's findings have highlighted that the Building Regulations do not prescribe which contractor or trade has the ultimate responsibility for meeting each Regulation and only makes reference to designing and/or building in accordance with the relevant Building Regulations and technical requirements. It is undoubtedly the case that contracts and professional appointments are largely templates and are vague on specific obligations, and the level of co-operation and co-ordination required are all things that need to be considered on a case by case basis.

It follows that if there are a number of consultants who have an obligation to ensure compliance with the Building Regulations – a situation not uncommonly encountered on HRB projects – it will likely be assumed that the designer has the ultimate responsibility for ensuring compliance, but the specialised elements of the project need to work together for all to comply with the Building Regulations; it cannot occur within a vacuum.

In the case of Grenfell, it is clear that the contractors did operate within silos, assuming that the specialty of specific consultants meant that it was not others' responsibility to consider relevant parts of the Building Regulations relating to those specific elements of the building. Ultimately, this lead to the Building Regulations being overlooked and the external wall system was therefore non-compliant.

Façade material and testing regimes

The Report includes scathing criticism of the government as the organisation with primary responsibility for establishing and maintaining a system for the regulation of construction work in the interests of public safety. This includes ensuring that regulations and guidance keep pace with developments in construction materials and techniques. The Report concludes that between 1991 and 2017, the government failed to discharge those responsibilities in a number of ways.

In the aftermath of the Knowsley Heights fire in 1991, the Select Committee made a number of recommendations particularly with regards to the use of aluminium composite panels. The Report concludes that those recommendations were largely ignored by the department responsible for the Building Regulations and statutory guidance.

Although a large-scale system test (which became BS 8414) was subsequently introduced as an alternative way of assessing risk of surface spread of flame – the oft-referred national Class 0 – which was made on small-scale testing, was allowed to remain in the statutory guidance as the primary standard for external wall testing until the Fire. This was despite the clear and well-known limitations of the approach and despite numerous warnings that it was wholly inadequate as a measure of the propensity of composite panels to promote the spread of fire across an external wall.

Despite those warnings, the department missed a further opportunity to clarify the guidance on compliance with functional requirement B4(1) when the ADB was reviewed between 2005 and 2006. The review included changes to para.12.7 of ADB which the Inquiry concluded were introduced without proper consultation, plagued by vague and ill-thought-out drafting, resulting in ongoing confusion and uncertainty over how B4(1) was to be implemented.

Inadequacies in the testing & certification regimes

The BRE

The Inquiry found that the privatisation of the BRE of meant that it was unable to provide robust and independent policy advice to the government and, as a result, lessons that might have improved the robustness and clarity of the regulatory regime were missed.

The Inquiry highlighted that much of the work carried out by the BRE was:

> *marred by unprofessional conduct, inadequate practices, a lack of effective oversight, poor reporting and a lack of scientific rigour*.

In particular, there were weaknesses in the way BRE carried out tests in line with BS 8414:

- it did not identify carefully the materials delivered to the burn hall for individual tests
- it did not ensure that they corresponded to the drawings of the system to be tested
- it did not ensure that the rig as constructed and tested accurately reflected the drawings that had been provided; and
- it did not ensure period checks on systems under construction were clear and it did not provide any clear direction in relation to frequency, timing or purpose.

The Inquiry found that these shortcomings enabled companies such as Celotex to manipulate the testing process by introducing materials other than those described in the test report.

Although BRE recognised from as early as 1991 following the fire at Knowsley Heights that small-scale testing, in particular of the kind that provided the basis for national Class 0, was inadequate to enable a proper assessment to be made of the reaction of external cladding systems to fire, the Inquiry found nothing to indicate that BRE had drawn that to the department's attention, formally or informally.

The British Board of Agrément (BBA)

The Inquiry's investigations into the circumstances surrounding the issue of BBA certificates in respect of Reynobond and Kingspan K15 revealed failings of a kind which undermined their value and rendered them misleading. As such, the BBA failed to:

- ask for any test evidence relating to the product when used in cassette form
- obtain any evidence to support the claim that the version of the product with an unmodified polyethylene core had satisfied the requirements of Class 0
- draw any distinction between the way in which different methods of fixing affected the way in which a particular product reacted to fire.

The root of the problem was considered to be the conflict between the need for the BBA to act as a commercial organisation, and therefore to attract customers in order to generate profits, and the need to maintain a high degree of independence and rigorous investigation in order to satisfy those who might be considering using the products in question that the contents of their certificates could safely be relied on.

Overview of key products (insulation, ACM, cavity barriers)

The introduction of new construction materials, such as polymeric insulation and ACM panels with combustible cores, coupled with the extent to which many in the industry regarded ADB as prescribing the circumstances in which combustible materials could be used in the construction of external walls without regard to the functional requirements, created a dangerous situation.

The Inquiry came to a view that over a period of many years, the department failed to recognise the importance of the Building Regulations and the accompanying statutory guidance as a system of regulation whose purpose was to ensure public safety, including the safety of those who live and work in high-rise buildings. For that reason, it failed to put in place arrangements to ensure that the working of the system was properly monitored and that steps were taken as and when necessary to ensure that it remained capable of achieving its purposes.

Fire Safety Management

Whilst Building Regulations only apply to building works, either at original construction or subsequently, the ongoing management of fire safety within all non-domestic premises is governed by the FSO 2005. Even where the new HRB provisions apply under the BSA 2022, FSO 2005 applies alongside them.

At the heart of FSO 2005 are the duties on the responsible person to undertake a fire safety risk assessment and to take general fire safety precautions to reduce fire safety risks so far as reasonably practicable. FSO 2005 also contains other more specific duties relating to, for example, fire detection, means of escape, training etc. The core of the duties has remained unchanged, although Grenfell has certainly changed the appetite of fire authorities in enforcing them.

However, there were key changes brought in as a result of the early stages of the Inquiry within the Fire Safety Act 2021. Depending upon your interpretation, this either clarified or expanded the meaning of "non-domestic premises" – and the Report does not tackle this issue directly.

The original FSO stated that it did not apply to domestic premises, except to parts of multi-dwelling buildings, (e.g. blocks of flats):

> "*used in common by the occupants of more than one [individual] dwelling*".

As a result of the Fire Safety Act 2021, FSO 2005 now expressly provides that it applies, in relation to such multi-dwelling buildings, to:

> "*the building's structure and external walls [, including windows and cladding,] and any common parts*" and "*all doors between the domestic premises and common parts*".

One ongoing point of contention is regarding duties to conduct Personal Emergency Evacuation Plans – assessments and actions plans, specific to individual residents, regarding their evacuation from premises. PEEPs are not a requirement under FSO 2005, although some guidance recommends their use.

The Phase 1 Report recommended that PEEPs become a legal requirement – the (previous) government decided not the implement this recommendation. The Report reiterated that recommendation, but also, in our analysis, seeks to elevate the existing guidance recommending their use to some form of higher status, and makes criticisms relating to PEEPs as if they were a legal requirement. It remains to be seen whether fire authorities will try to adopt a similar approach.

The Report also sought to lay down some further expectations and best practice in relation to compliance with FSO 2005, which are likely to affect the approach of fire authorities when enforcing the same. Some of these include:

- the use of the PAS-79 risk assessment standard as indicative of best practice
- systems/measures to assess the competence of fire risk assessors used and to provide a measure of quality control of their work
- systems for ensuring that remedial measures identified in fire risk assessments were rectified in good time; and
- the expectation that senior managers of organisations would have effective and rigorous oversight of fire safety, including through specific audits for fire safety performance.

As a result of the focus on Building Regulations in the Phase 1 Report, there has also been an anecdotally increased tendency by fire authorities of seeking to enforce the requirements of newer versions of ADB as if they are: 1) legal requirements of the FSO 2005 and 2) retrospective. We are aware of at least one trade body that has written to the government raising concerns with this approach. It seems likely that the continued focus on Building Regulations arising from the Report will proliferate this approach.

Core take-aways from the Phase 2 Report

The Report shines a light on the widespread misunderstanding of Building Regulations and how buildings should be constructed to prevent external fire spread (Regulation 12.7).

This was in the context of systemic deficiencies in building safety, including the use of poor-quality materials, inadequate fire safety inspections and a lack of proper fire risk assessments. These were further compounded by serious shortcomings in the fire safety management of Grenfell, including the 'stay put' policy, which – certainly sustained as long as it was, in the circumstances – proved fatal during the Fire.

The Report pointed out a fragmented regulatory framework, with unclear responsibilities among different authorities and a lack of stringent enforcement of existing fire safety standards.

Over the years leading up to the Fire there was a trend towards deregulation, with a focus on reducing the perceived burden on the construction industry. This led to relaxed standards and self-regulation which contributed to the use of non-compliant materials. The Inquiry also noted that cost-cutting and the prioritisation of economic factors over safety significantly compromised fire safety standards.

The Report therefore recommended, amongst others things, (see further pg. 44 on Recommendations):

- improving Building Regulations and Guidance: The report called for a comprehensive review and clarification of building regulations, especially regarding fire safety and the use of cladding materials
- enhanced safety inspections: regular, independent inspections of high-rise buildings were recommended to ensure compliance with fire safety standards
- tenant and resident involvement: empowering residents with more information and a stronger voice in safety decisions was emphasized; and
- reforming the "stay put" policy: the Report recommended reconsidering the policy for buildings with similar cladding to Grenfell and ensuring that evacuation procedures are adaptable.

This stricter stance on fire safety compliance is reflected in recent caselaw and enforcement actions, showing a move towards greater accountability in line with the inquiry's findings.

Chris Doran, Partner
Luiza Balan, Principal Associate
James Muller, Principal Associate
Megan Jackson, Associate

Lessons for Professionals

One of the areas where the Inquiry's conclusions were most striking was in relation to its assessment and criticisms of the various construction professionals involved.

Undoubtedly those conclusions will have a major impact for professionals moving forwards – if only in terms of perceived impact – however the extent to which the Inquiry's conclusions are ultimately found to have long-lasting impact very much remains to be seen.

In what is already an uncertain world post-the BSA 2022, those acting in, with and for the construction professions are encouraged to remain vigilant and proactively assess the changing landscape.

Opinion

Everyone can agree – and accept the theory at least – that professionals should do all they can to ensure fire safety. Indeed, in my experience from working with many professionals over the years, for the vast majority this is beyond doubt. As is perennially the case, however, the challenge is when theory meets practice.

There is so much that can be said on this issue, covered below. There are, however, a few summary matters which may assist readers to reflect on before delving into the detail.

1. As covered elsewhere in this paper, we must remember that the Inquiry's frame of reference and scope was limited. Whilst invariably its findings will come to texture much discussion on the scope and responsibilities of various professions, the Report itself carries no precedential weight. It is to a large extent fact-specific – so far as it looks backwards to what was – and a creature of recommendation – to the extent that it looks forward. What government and the courts do with the findings will therefore be crucial before we can say with any certainty whether the Report's findings have wider application.

2. One of the striking conclusions arising from the Report is the identified concerns around the extent of knowledge of professionals' contractual obligations. Again, it must be remembered that the Inquiry's conclusions in the Report are very much fact-specific, and for my part the wider application is still to be known. That professionals should be clear on the extent of their contractual obligations and what is expected of their professional responsibilities (acting as they must with the reasonable skill and care to be expected of their particular profession) is nothing new, and making the point in isolation borders on being trite.

3. What will really be of interest is whether anything in the Report changes our understanding of what was, is or should be required. I put it in that way, as of course the test for professional negligence is what a particular professional acting with reasonable skill and care should have done **contemporaneously** to the actions in question. For my part, the Report does a very skilled job of avoiding being drawn into making these distinctions too definitively – that of course not being the Inquiry's role.

4. If one steps back and tries to assess the Inquiry's comments on professionals generally – tracking that through to the recommendations – a key theme is the need for (and perceived former lack of) cohesion between construction professionals. Many laudable recommendations are put forward to try and rectify this, but none are likely to be immediately actionable or have immediate effect. Again, one queries how the transition from theory to practice is to be achieved. Professions still then need to consider matters in the meantime and remain alive to the changing landscape. It is notable, of course, that so far the drafters of contract suites have also not yet dealt with these issues.

Architects

Key takeaway points

1. The Report stands as a renewed warning for architects to be mindful of their contractual obligations and ensure these match the 'on the ground' understanding of their role.
2. Renewed emphasis will also be placed on ensuring that the project team have suitable expertise and training to for the work involved on any particular project.
3. Finally, architects will no doubt heed the warning of the Report to be mindful of the roles of others involved and ensuring that there is clarity as to delineation of roles and responsibilities.

The Report found that the project architect, Studio E, *"bears a very significant degree of responsibility"* for the Fire.

The findings of the Inquiry are plainly fact-sensitive and are founded in the expert architect advice of Mr Paul Hyett. Claims against architects concerning fire safety issues will be dependent upon the expert input provided by expert architects and the assistance such experts provide to the parties and the court as regards the exercise of reasonable skill and care. Issues of liability or responsibility will therefore be deeply entrenched in the specific facts of each project and the valuable input provided by expert witnesses.

Whilst the Inquiry does not (and cannot) make civil determinations of liability, or create binding judicial precedent, there are points which arise from the Report which can be used by architectural practices to bolster their position and protect their interest moving forward.

Lessons learned:

- carefully consider the appointment documents, collateral warranties and novation documents prepared for each project and assess the obligations and responsibilities recorded in such documents. Ensure that the contents of such agreements reflect the position 'on the ground' and any discussions exchanged between the parties
- ensure that you have an adequately structured team to carry out the works with sufficient expertise and experience of similar projects. Where junior team members are deployed, there must be adequate supervision of those junior team members and sufficient checks and balances in place to ensure that the end work product has been carried out by a team with the experience and expertise required to deal with a project of such size and nature
- when specifying products, ensure that you have satisfied yourself that the products specified comply with statutory requirements and Employer's Requirements. This includes reviewing the technical literature and certification in full to satisfy yourself that the products are compliant with the relevant guidelines and requirements. Consider the BBA certificates, fire tests carried out and ensure that you are satisfied that the products selected meet fire safety requirements

- critically assess the designs of others. Where you assume responsibility to coordinate the designs of others and to lead the overall design, analyse the design proposals to satisfy yourself that the products selected by others comply with the necessary Employer's Requirements and statutory requirements. Adopt a stringent, belt-and-braces approach to satisfy yourself of the design provided as if it were your own design proposal. Only approve designs prepared by others if you are fully satisfied that the products selected and design details are compliant. If you are unsure, raise queries and ask the relevant parties to demonstrate compliance and show their working as specialist subcontractors/subconsultants. Record how and why you have relied upon their specialist input. Record warnings when provided
- carry out regular training for your team members which focusses on regulatory and statutory requirements and technical/advice notes circulated by relevant advisory bodies to remain up-to-date as regards concerns in the sector and materials used on projects
- take notice of the fire strategy. Provide any fire engineer involved in the project with the full range of information required to consider compliance and provide full and proper advice. Carefully read and review the fire strategy and raise queries as appropriate to understand the conclusions reached, correct any areas of deficiency or inaccuracy, and query the conclusions reached
- update design drawings throughout the project as necessary to reflect updated advice, fire strategy documents and 'as-built' design.

Mike Grant – Partner
Sarah Irwin – Principal Associate

Fire engineers

Key takeaway points

1. The Inquiry was particularly critical of what it perceived to be a passive attitude of the fire engineer to its role, and called for a much more proactive role.
2. There was clearly lack of clarity as to the role of the fire strategy / the fire engineer and whilst we sense this has changed already post-Grenfell, we suspect yet further consideration will be given to the matter moving forwards.
3. It seems very likely that there will be a 'step change' in the way that fire engineers are required to be trained and regulated moving forwards, however quite what that looks like remains to be seen: a definite 'watch this space' area.

Fire engineering firm, Exova, was appointed to produce two fire safety strategies for Grenfell: one regarding its existing condition, and a second dealing with its refurbished form.

The Inquiry's criticisms of Exova

The Report raises significant criticisms of Exova, finding that it bears '*considerable responsibility*' for the dangerous condition of Grenfell. It should be noted of course that this criticism is applied equally to various other professions, and the Inquiry – as expected – steers clear of any definitive (or more widely applicable) analysis of attribution of responsibility.

The key criticisms include:

- Exova produced draft versions of its fire strategy reports on both the existing condition and the refurbished, but never completed either; nor did it flag the fact that they were not completed
- Exova made excessive assumptions, taking at face value information provided which it should have verified. It relied on some written information even when it was contradicted elsewhere. It missed important information that was available, or the significance of it
- Exova should not have produced even a draft strategy without obtaining and verifying much more crucial information; it should instead have returned a list of what it needed in order to undertake the exercise
- Exova provided no analysis of the external wall system or its compliance with the relevant Building Regulations
- Exova did not identify the nature of the proposed rainscreen, or therefore the combustible nature of that component
- Nor did Exova identify the unsuitability of the combustible insulation and window infill panels, or the absence of cavity barriers in key locations. It failed to give advice on cavity barriers, even when that was specifically requested

- None of the people who worked on the fire safety strategy visited Grenfell (there was one brief visit, at an early stage, but that employee did not go on to work on the strategy)
- Exova failed in numerous ways to devote the care and attention warranted, including:
  - it did not appreciate that it was a 'designer' for the purposes of CDM Regulations, and that as such, it had duties to avoid foreseeable risks to safety. Failing to ascertain a proper scope for its involvement
  - it used staff who did not have the necessary expertise
  - there was confusion about individuals' respective responsibilities, and no effective internal review process
  - it did not make itself familiar with key guidance material even when aware of its existence, and even though it was aware of inappropriate materials, including cladding, causing fires at other buildings.

Criticisms of other project members regarding Exova's fire safety work

The Report is also critical of others' conduct regarding Exova. The most stark example is that neither Studio E or anyone else ever followed up to demands that Exova produce a completed fire safety strategy. There was no clarity as to whose responsibility that was (or even which party was Exova's client).

None of the parties (including Exova itself) had any proper understanding of the role of the fire engineer, what expertise it needed, what was and was not within its remit to address, or what information and material it would need in order to do so.

Despite this pervasive lack of understanding of who had what responsibilities regarding fire safety, the involvement of Exova as fire engineers appears to have engendered a vague sense that all must be in order or in hand. Where any gaps were noticed, the various parties seemed to assume that these were someone else's responsibility and in hand, or that it would be firmed up in due course. None made any real attempt to check that this was truly the case (tragically, we now know that of course it very much was not).

Recommendations

The report sets out numerous recommendations on various fronts, with key themes including the need for clear and joined-up regulation of fire safety and improving accountability amongst the various parties engaged in construction projects.

Key issues identified regarding fire engineers are in short:

- the term 'fire engineer' has no agreed definition; nor are there any criteria or qualifications needed to practice as one. In short, it is not always clear (in some cases even to fire engineers themselves) what a fire engineer is, or what its role on a project should be
- there is a significant lack of understanding of who bears what responsibilities for fire safety
- the complexity of fire safety is not properly appreciated

- oversight and regulation being patchwork at best.

As such, key recommendations include

- production of an agreed and authoritative definition of the role of 'fire engineer' – to be produced by a working group of practitioners and academic experts, and to definitively set out the knowledge and skills needed
- formal recognition of this important professional role, with the function and title of 'fire engineer' defined and enshrined in law (as with the protected role of e.g. 'architect')
- creation of an independent regulator (along the lines of e.g. the Architects Registration Board), to have overarching responsibility for fire safety in construction
- a fire safety strategy, produced by a fire engineer, to be a mandatory requirement for Building Control applications for the construction of or work on all HRBs – and for this to be updated and reviewed at completion stage (Gateway 3 under the new regime)
- the government (assisted by industry, professional bodies and academia) to urgently take steps to create and increase the availability of suitable education in the subject matter, via high-quality masters-level courses in fire engineering (to be accredited by the new regulator); and
- steps to ensure that other key players – clients, principal contractors, other construction professionals, building control, fire and rescue services, etc- have a working understanding of the principles of fire engineering, and the role of the fire engineer.

Cause for concern, or optimism?

The Report will make for very uncomfortable reading for the various parties involved and may generate some anxiety for the wider industry. However, it should be seized as an opportunity to do all that is possible to avoid a repeat of such tragedy, and there is a lot to work with.

Regarding fire engineers specifically, the recommendations are sound and in principle viable. If carried through, they should see the role of 'fire engineer' better defined, recognised, respected and protected. The proposed regime would give fire engineers a clear mandate to demand all information and material needed to effectively assess and direct fire safety measures. Clients, contractors etc will understand that if the fire engineer is not given what it needs, there will be no fire safety strategy, and therefore no Building Regulations approval – and so no building.

Fire engineers will know that proper time and attention must be devoted to the exercise, and that they will be under regulatory scrutiny. For a diligent and skilled professional, this should be no cause for concern – on the contrary, such a framework reinforces their mandate to gather in all they need, to query and challenge, and to set realistic timescales (and fees), and ultimately to produce a strategy that results in a safe building.

To turn the Reports commendable recommendations into reality will require concerted and co-ordinated 'buy-in' and work from the industry. It will also need the government to provide sustained and concrete support. There will be a cost to implementing the changes. If and when the new regime is bedded in, this cost should become just a relatively minor part of all that is needed in the scheme of taking a project to fruition (and whatever the financial cost, will be dwarfed by the human cost of repeating the errors of the past).

However, it must be recognised that significant investment will be required in the shorter term, to create the new joined-up regime envisaged. The state will have to make significant financial investment in creating a defined and protected role, new guidelines, setting up and staffing the proposed new regulator, the creation of routes to new qualifications, and so on. Just as importantly, it must be clear and consistent in its words and actions regarding this new regime, if the industry is to have confidence that this is the way forward such that it is confident to make its own investments and commitments – being willing to pay for this new gold standard of fire safety strategy, attracting and training staff to enter this essentially new profession, and so on. Similarly, the insurance industry will no doubt move quickly to create suitable insurance products to cater for the sector – again, so long as the role and wider regime are made sufficiently clear. On this insurance front, an argument could certainly be made for compulsory professional indemnity insurance for fire safety engineers, as required for various other professions such as engineers and surveyors, and overseen by their respective professional bodies.

As with any such overhaul, there will be short-term challenges. But, with concerted and sustained commitment from the various stakeholders, the Report's recommendations are the first step towards a much improved fire safety regime, for the ultimate benefit of all.

Alex Marler – Partner
Owen Roberts – Solicitor

Main Contractors

Key Takeaways

1. Contractors cannot merely be 'a management service' but must proactively deliver their projects – they are primarily responsible for delivery of the project.
2. Contractors must ensure their project team is sufficiently experienced for their project, with regular and adequate training and experience to enable them to make informed design decisions, supervise and direct consultants and sub-contractors and inspect works and identify defects .
3. Contractors cannot merely rely on others to 'get it right' but must proactively evaluate and co-ordinate design work and manage and monitor sub-contractors to ensure that the works comply with Building Regulations and their contract.

Rydon Maintenance Limited ("**Rydon**") was appointed by the Kensington and Chelsea Tenant Management Organisation ("**TMO**") as the main design and build contractor and principal contractor (for purpose of the CDM Regulations 2007 and 2015) following an OJEU procurement process.

The Report is critical of the procurement process, which it described as 'manipulated', and particularly the value engineering exercise undertaken to try to reduce cost against the limited budget of TMO. The Report described value engineering as:

> *in practice little more than a euphemism for reducing cost, because substituting a cheaper product for a more expensive one or altering the design or scope of the work in a way that reduces cost almost invariably involves a compromise of some kind, whether in content, performance or appearance…*"

The Inquiry also formed the view that the 'design and build' procurement process, whereby the design team is novated to the main contractor, may result in:

> *a risk that the contractor may wish to adopt lower design solutions than those originally contemplated…*[and that the] *designers, whose client is now the contractor, are not able to advise the employer on matters of that kind…*[and] *there is a risk that a design agreed with the employer…may be watered down as a result of commercial pressures*.

It is important to start with these points as it sets the context in which Rydon was engaged, and the impact (identified by the Inquiry) on their performance and commitment to the project. Indeed, whilst the Report identifies other contributors to the failings in the refurbishment of Grenfell, it is notably critical of Rydon, stating, as it does:

> "[Rydon] *promised the TMO that when completed the refurbishment would comply with the Building Regulations, but it did not. When co-ordinating, supervising and monitoring the work it did not give sufficient importance to the safety of the building's occupants and it displayed*

a casual attitude to fire safety throughout the project. As a result, Rydon bears considerable responsibility for the fire at Grenfell Tower."

Whilst the Report levies numerous criticisms at Rydon, we note in particular the following key issues and learning points:

1. Contractors cannot merely be 'a management service'

The Report states "*Rydon…provided the TMO with nothing more than a management service*" by organising the work through sub-contractors and consultants and acting as a channel of communication, which was inappropriate and unsafe for the Grenfell refurbishment.

Main contractors are primarily responsible for delivering their projects: whilst they generally sub-contract elements of design and work, they remain primarily responsible and must (i) direct the design and work, (ii) make critical design decisions (with input from the consultants and sub-contractors), and (iii) supervise, check and sign-off the design and works.

Merely managing the engagement of sub-contractors and being a communication channel falls significantly below what is required and is an overall philosophy that the Inquiry found led to many of the other failings / learning points below.

2. Contractors must ensure their project team is sufficiently experienced for the project

The Report highlighted that Rydon's team was "*notably inexperienced*" with many "*acting in* [their] *capacities for the first time*." Rydon also failed to "*ensure* [its team] *received sufficient supervision, training and support from others with greater experience*". This resulted in lack of knowledge and understanding of the regulatory regime that applied to the project, statutory and industry guidance, and best practice.

The Report notes that members of Rydon's project team:

- "*never worked with ACM panels*"
- "*never received any training in how to inspect cladding installations or in the requirements of the Building Regulations*"
- "*did not know that there was statutory guidance on the construction of the external walls of buildings over 18 metres in height*"
- "*assumed that all materials installed on the outside of buildings were entirely "fireproof"*"
- "*did not know of the need for cavity barriers to be installed around windows*"
- "*was not aware of the difference between Rockwool (a non-combustible mineral wool insulation product) and Celotex RS5000 (a combustible PIR insulation product)*"

- "*did not understand, even in broad terms, the functional requirements of the Building Regulations*"

Main contractors' project teams must be adequately experienced and qualified to properly undertake their duties to (i) direct the design and work, (ii) make critical design decisions, and (iii) supervise, check and sign-off the design and works, as outlined above.

Even though main contractor teams are not expected to have the same level of knowledge as specialist subcontractors / consultants engaged, without adequate knowledge and experience, Rydon's team could not even ask the right questions or evaluate information relating to the fire safety and cladding.

3. Contractors cannot merely rely on others to 'get it right'

In many instances, Rydon's project team relied upon the design and work of others to 'get it right'. For instance, the Report identified that Rydon relied on:

- the specialist cladding sub-contractor to assess the pre-contract design undertaken by the architect
- the architect to manage the design coordination process and to check design of others. The Report notes that the architect checked the cladding sub-contractor's design for compliance with architectural intent and for any obvious errors but not necessarily fire safety
- the fire engineer to have adequately establish safety of the design and adequately have developed the fire strategy (despite it being described in 'outline' form) before Rydon's involvement; and
- building control to identify design defects.

This is both a primary failure by Rydon to undertake its own obligations to deliver the project in accordance with its contract and (amongst other things) the Buildings Regulations, as well as a secondary failure to check the design and work of its sub-contractors and consultants, which resulted in catastrophic omissions and defects.

4. Contractors must proactively evaluate and co-ordinate design work and manage and monitor sub-contractors

The Report identifies that "*Rydon's internal system for evaluating and co-ordinating the design work was inadequate*" and suggested that it should have used a 'matrix of responsibilities' to "*ensure that everyone involved in a project knows where responsibility lies for each decision*". This resulted in a situation where sub-contractors and consultants struggled to understand their separate responsibilities or that Rydon understood where responsibilities for decisions sat.

Similarly, as noted above, Rydon assumed that the architect was co-ordinating the design work. It failed to play an active role. This meant it was ill-equipped to identify any omissions or defects in design. Rydon also failed to employ a suitable system of recording decision changes.

Moreover, despite the clear reliance on its consultants and sub-contractors to 'get it right', the Report notes that Rydon "*made no serious effort to find out whether* [they] *were competent*." Ultimately, the architect was found not to have previously undertaken a similar project involving over-cladding of high-rise buildings and Rydon made no assessment of the sub-contractor's competence, but merely relied on the fact that it employed them on other projects.

Dan Barchet – Partner

Sub-Contractors

Key takeaway points

1. It is vital that sub-contractors agree a sub-contract which clearly sets out scope, responsibilities, and procedures.
2. Assumption is the mother of all mistakes – it is important to ensuring that as a sub-contractor you have adequate knowledge to ensure compliance – that doesn't mean necessarily have the knowledge of all other sub-contractors and consultants, but enough at least to be asking the right questions.
3. Attention to detail – particularly around products – is vital and this is something to be kept in mind throughout the project (mindful of developments) not just at a single point of time at the early design stage.

Many of the lessons that sub-contractors can take from the Report relate to the performance of Harley Facades who was appointed by Rydon to carry out the design and construction of the over cladding of the building.

The Introduction to Part 6 of the Report confirms "*the decision to use aluminium composite panels with unmodified polyethylene cores in what was known as "cassette" form as the rainscreen … was primarily responsible for the rapid spread of the fire*" with other products contributing, including the insulation boards used (paragraph 4.75).

The key conclusions reached as to Harley's role (in Chapters 50-51, 53, 65 and 67 in particular) are that "*Harley's work was characterised by a failure to take its responsibilities seriously, ignorance, complacency and failure to manage staff and lack of technical competence and failure to improve it.*"

Sub-contractors would be wise to particularly bear in mind the following:

1. Agree a sub-contract which clearly sets out scope, responsibilities, and procedures

Harley had no formal contract in place with Rydon, its contract was comprised of a letter of intent and a number of appendices, which was not replaced by a formal contract as intended. This led to uncertainty as to its obligations. A carefully negotiated, drafted, and executed sub-contract (and appendices) is the cornerstone to risk management for sub-contractors as this should clearly set out the scope of work to be carried out, risk allocation, processes and procedures, and any exclusions of liability.

2. Ensuring adequate knowledge to ensure compliance. Assumption is the mother of all mistakes.

Fundamentally, Harley appeared to not know that, to comply with paragraph 12.7 of ADB, insulation materials used on buildings above 18m in height should be materials of limited combustibility. It also failed to appreciate the difference between a Class 0 rated product and limited combustibility – that the later will also be the first, but the same cannot be said that Class 0 will also be of limited combustibility. It was identified that Harley were referring to out of date specifications.

A number of fundamental, flawed assumptions were made which contributed to the use of combustible materials in the Grenfell refurbishment. Those included assumptions as to the compliance of the cladding and insulation, assumptions as to the meaning of Class 0 rating; the impact on performance of face-fixed vs cassette-fixed rainscreen panels, and assumption as to the knowledge and understanding and responsibilities of others.

It should be noted that at the time these assumptions were complacence and not limited to sub-contractors, however this only compounded the issue with - one view at least (and the one the Inquiry reached) that all involved were relying on someone else to ensure compliance. There was a common theme of reliance on others, taking the word of others, and not undertaking independent investigations or verification.

The Report particularly criticises product manufacturers and acknowledges that Harley received misleading marketing information, which downplayed a warning that the insulation used was suitable for use in buildings over 18 metres only in the system in which it was tested. The Report goes so far as to say that Celotex exploited Harley and was not acting in a way to be expected of an honest and plain-dealing manufacturer. Nevertheless, the Inquiry at least felt this did not excuse the situation, concluding that "*Harley cannot avoid responsibility for its own failures by blaming Celotex for not telling it what it should have known or discovered for itself.*"

This emphasises the importance of all involved to proactively cross-check key design and compliance issues, rather than making assumptions and relying on others. Where appropriate then, sub-contractors should ensure that they suitably qualified and experienced personnel are employed to review and advise on technical issues (as employees or consultants), notwithstanding who else may be engaged on the project.

3. Attention to detail in design, specification and construction

Failure to ensure attention to detail was crucial in a number of respects: the difference between Reynobond PE (polyethylene) and FR (fire resistant) cladding, proper review of BBA certificates which indicated exceptions and limitations of classes awarded, and the Celotex marketing material which gave warnings as to the limitations of RS5000 in the small print.

It is critical to consider what is required for compliance, including: the specific products that might achieve that, verification of compliance of all products individually and as a system, the methodology for construction, in combination with other products being used.

The need for attention to detail stretches across design and construction. It does not matter if the design is fully compliant if construction is not in accordance with the design. The Report criticises the lack of adequate quality management. All key stages of installation need to be inspected - concealment is not an excuse.

4. Change management and clear communication

Lack of proactive monitoring and management of changes was particularly relevant to the selection of the insulation selected. Changes were made from the original NBS specification of Celotex FR5000 (fire resistant) to RS5000 and then to K15 in places due to a lack of availability of RS5000. Many changes were not communicated to the Contractor and other designers, let alone considered and

approved by them. Again, assumptions were made that those products were equivalent, which was incorrect.

The Report criticises a focus on costs and profit and the fact that "*everyone involved concentrated on the appearance of the rainscreen panels to the complete exclusion of their fire performance*" (Paragraph 55.33).

Safety and compliance must be priority number one for all. Contractors cannot avoid blame by engaging specialist sub-contractors – it is responsible for overseeing the work and ensuring compliance. Any warnings or concerns should be taken seriously and considered by all involved and a clear answer found- compulsory risk management meetings might be a potential option in those circumstances. The design and construction process must be lead and monitored proactively by qualified personnel able to identify if something is incorrect or missing.

Products specified and used must be carefully considered and compliance ensured through clear reliable evidence, not simply relying on the word of others, this includes attention to the small print, products cannot be considered in isolation but all aspects of their preparation, incorporation and neighbouring specifications should be considered and for this reason any change requires careful consideration (in its own right and in the context of potential impact on other elements of the design and works). Taking things as read and failing to run own checks will likely be considered failing below the standard of care (subject to precise wording).

The need to work together as a project team has become all the more important to ensure design and building compliance and the success of projects, but taking individual responsibility is an essential element of that.

Sadly, recent developments in contract suites do not seem to have made any significant attempts to provide further provision in this regard – despite the need to 'being on the cards' and certainly foreshadowed by the BSA 2022. Sub-contractors then are advised to seek specific advice on new projects, both in terms of their own appointments, but also in ensuring that those sit well with the wider supply chain.

Natalie Keyes – Legal Director

Fire Risk Assessors

Key takeaways

1. The Inquiry's findings largely reflect industry understanding and contemporaneous guidance which comes as a relief to many.
2. That said, the Inquiry makes recommendations for significant change to the industry which, if implemented, would result in a much a very different looking profession moving forwards.
3. The recommendations are not surprising, but quite how they translate into actual changes is yet to be seen and will necessitate those operating in this industry to keep a careful eye on changes.

To date, fire risk assessors are not in and of themselves a separate defined profession in the way in which, say, architects are. The reason for this is that fire risk assessments ("**FRAs**") – the work product produced by a fire risk assessor – were intended as part of the regulation cutting agenda (i) to be capable of being completed by anyone and (ii) act only as a 'snapshot' in time – i.e. they speak to the state of a building as assessed at a particular moment – there was not necessarily a longer life span beyond that point in time, albeit that FRAs do necessarily in some respects act as to a guide to any remedial work required.

In reality, however, a profession has evolved, certainly around the provision of FRAs for higher risk / more complex buildings, with many former fire service offices becoming fire risk assessors on retirement, since FRAs were formally inaugurated by the RRO. Since then, various working practices, guidance and training has developed (again without legislated need to necessarily adhere), much of which came up for criticism by the Inquiry.

Where then does this leave fire risk assessors?

To answer that question one should begin at the end with the Inquiry's recommendation at paragraph 113.41:

> *'…concern has been expressed for many years about the competence of some of those offering their services as commercial fire risk assessors and the absence of any scheme of regulation to ensure that responsible persons under the Fire Safety Order can have confidence in the skill and experience of those whom they instruct to carry out fire risk assessments on their behalf.* ***We therefore recommend*** *that the government establish a system of* ***mandatory accreditation*** *to certify the competence of fire risk assessors by setting standards for qualification and continuing professional development and such other measures as may be considered necessary or desirable. We think it necessary for an accreditation system to be mandatory in order to ensure the competence of all those who offer their services as fire risk assessors.'*

In this regard, the staunchest criticism in relation to FRAs is perhaps of the government whom the Inquiry concluded:

> *'…determinedly resisted calls from across the fire sector to regulate fire risk assessors and to amend the Fire Safety Order to make it clear that it applied to the exterior walls of buildings containing more than one set of domestic premises.* '

In our view, it was perhaps inevitable that there would be a call for more formal regulation of fire risk assessors, although actually developing and implementing a system of competency criteria will not be easy. For anyone who followed the expert evidence received by this Inquiry:

- on the one hand, Colin Todd – considered to be the leading practitioner, author of the key guidance and thus perhaps best able to speak to 'what was'; and
- on the other hand, Barbara Lane – a staunch critic of the current system and proponent of a much 'higher bar' approach;

it will have been clear that there was a gulf between them. Had Dr Lane's views been taken forward, one would have been left questioning whether there was anyone (let alone a sufficient number of people) suitably qualified to actually carry out the work. In our view, the Inquiry has landed more in line with Colin Todd's evidence and the recommendations seem broadly sensible, and are unsurprising.

That said, the recommendation is itself quite broadly drafted, and much will depend on what the substance of any training / accreditation etc. requires. In that regard, there are various criticisms / conclusions in the Report which those operating in this space would do well to consider and which it will be interesting to see if taken forward beyond the circumstances of Grenfell to inform any future criteria. These include:

- whether adherence with the methodology in PAS 79, the LGA Guide or indeed any new guidance is made mandatory
- whether there will be any differentiation of competence meaning that those who work on higher risk or more complex buildings are required to have additional competency / training / experience (albeit quite how one would get the necessary experience raises in itself some interesting questions)
- what if any requirement there will be to ensure consistency of fire risk assessors / revisiting of former findings / recommendations when assessing a building the next time. The type of approach the Report seems to advocate would – in our view –represent quite a major evolution the fire risk assessor / fire risk assessments
- who and to what extent will people be able to rely on a fire risk assessors moving forwards – will that change / depend on who undertakes it
- will the changes result in positive change, or are they going to simply result in heavily caveated FRAs?

This is an area which is going to be a 'shifting landscape' for some time, and is very much one of the areas where – in our view – as many questions have been posed as answered. Those operating in this space are encouraged to engage with consultations on the future of the profession and seek advice as to how they can exercise best practice in the meantime.

Tom Thurlow – Partner

Building Control – will we come full circle?

Key takeaway points

1. **Independence is key**: those involved in building control should act in the public interest as the custodian and enforcer of the Building Regulations, rather than as a source of advice for the project team. Similarly, the project team should not regard building control as a "safety net". Reviews of appointment documents and commercial terms of business should be considered to reflect this.
2. Key steps to good risk management include: **training**, to ensure adequate industry knowledge and the ability to interpret technical documentation; **processes** to ensure that missing information is followed up and findings are recorded, and adequate **supervision** to ensure capacity constraints and delays are quickly identified and rectified.
3. The recommended **consultation** as to whether the building control function should be operated by a national authority, rather than private Registered Building Control Approvers, could mean that we come full circle to the building control regime that existed prior to the Building Act 1984. Seeking advice at this early stage could assist with **strategic thinking** for businesses who could be affected.

The Inquiry's comments on the involvement of RBKC's Building Control department in the refurbishment of Grenfell will have provided a sobering read for RBKC, to say the least.

From a wider perspective, the Inquiry's recommendations raise the potential for further significant changes to the building control industry (to be considered by an independent panel).

This will no doubt cause widespread concern in the private building control (formerly Approved Inspectors, now Registered Building Control Approvers since the BSA 2022) space if that panel concludes that all Building Control functions should be carried out by a national authority. In those circumstances, there are huge practical and commercial considerations for those who currently operate in the industry.

The Role of RKBC's Building Control department and officers

The Inquiry has concluded that Building Control must bear considerable responsibility for the dangerous condition of Grenfell immediately after the renovation works.

RBKC have since admitted that the work of its Building Control officers (**"BCOs"**) fell below the standard that should have reasonably been expected of them. However, the Inquiry felt that this admission did not go far enough finding that Building Control ought to have been the last line of defence and had:

- a statutory obligation to check for compliance with the Building Regulations; and
- a responsibility to protect the public.

The Report concludes that RBC Building Control failed to perform that function. This – it seems to us – is borne out of a fundamental misunderstanding between the core participants' contemporaneous understanding of the role of Building Control, and the actual statutory role which the Inquiry says ought to have been carried out.

The Building Control body for the Grenfell refurbishment was RBKC's Building Control department. The Inquiry is very critical of the department's flaws, as well as those of the individual BCO. At plan stage, the BCO appears to have made no real effort to obtain missing information and, notwithstanding that, felt able to approve the full plans application in circumstances where we now know that it ought to have been rejected altogether. Thereafter, the BCO was unaware of the advice in ADB and felt unqualified and unable to interpret test certificates for the materials used. He therefore did not satisfy himself that the materials used were of limited combustibility, or that appropriate cavity barriers were in place.

But that is not to say that the BCO alone was responsible for Building Control's failures. The Inquiry consider that RBKC did not provide the BCO with enough relevant training such that, during his involvement with the renovation, he did not have sufficient knowledge of industry guidance and the technical documents to adequately perform his role.

The BCO was overworked, and the quality of his work suffered as a result. RBKC knew about this, as well as the fact that he was behind on attending site visits and recording his findings and did nothing to prevent this.

However, and perhaps more fundamentally, the parties involved with the renovation regarded Building Control as an extension, and sometimes part, of the project team. As a result, various Core Participants deemed Building Control to be a source of advice and turned to the BCO for assistance. Similarly, the BCO appears to have considered that he ought to "work with" the parties to enable them to complete the work, rather than to act as the custodian and enforcer of the Building Regulations, in the public interest.

The Inquiry have made it clear that this misunderstanding is not acceptable. Building Control Bodies must properly understand their function, which is to police and enforce the regulatory regime. They ought not to be advising others as to how compliance might be achieved, and those parties should not regard them as a "safety net".

Recommendations for the future and the associated implications for the industry

The Inquiry is of the view that changes are required in relation to the way in which Building Control Bodies: (a) understand their function; and (b) carry this out. Of course, the government has already taken steps to implement means of regulating the standards of building control professionals and increase accountability across the sector: indeed the changes in this area are one of the most developed arising out of the BSA 2022.

The Inquiry has further recommended that the government appoint an independent panel to consider whether: (a) it is in the public interest for Building Control functions to be carried out by those who may have a commercial interest in the process; and (b) all Building Control functions should be carried out by a national authority. This is interesting as, of course, the Building Control function throughout the Grenfell refurbishment was carried out by the Local Authority Building Control, and not a private Building Control Body.

If this recommendation were to be adopted, then there would be huge ramifications for the industry. The latest report from the Health and Safety Executive, at the end of July 2024, detailed that just over 4,000 building professionals have registered as Building Inspectors with the new Building Safety Regulator. Anecdotally, from our extensive experience of working with private building control bodies, we also know that many local authority Building Control departments have few, if any, staff qualified to

deal with HRBs. This then is very much an area where it is hard to see how theory would translate into practical reality.

Quite what the Inquiry's recommendations mean for the future of private Registered Building Control Approvers remains to be seen. Should it be determined that Building Control functions ought to be carried out by a national authority then one can assume that the situation would revert back to how things were prior to 1984, and the introduction of private Building Control Bodies.

This would see an entire sector of the construction industry wiped out overnight and would put unprecedented demand on any such national authority: a demand which it seems impossible would be met. It would also make something of a mockery of the BSA 2022. It is unclear whether such demand would actually result in improved processes and safer construction.

There is also a question as to what would happen to any potential future claims. It is generally accepted that there can be no claim in contract against a Local Authority Building Inspector, since no contract is usually entered into. Furthermore, *Murphy v Brentwood* held that there could also be no claim in negligence. It is yet to be decided by the courts as to whether the position is different for private Building Control Bodies but, what seems clear, is that if the "national authority" envisaged by the Inquiry is given the status akin to a Local Authority Building Control Body, claimants are likely to find themselves back in the same position legally, as was decided by *Murphy,* when looking at potential recovery targets.

There is still a great deal yet to be decided in the world of building control but the direction of travel is becoming clearer. A close eye will need to be kept on the evolving situation given the potentially significant changes to the industry and those who work within it.

Richard Palmer – Partner
Katy Ames – Principal Associate

The Recommendations – what comes next?

Key takeaways

1. The recommendations are wide-ranging and if implemented would represent a significant shift in the regulation of building safety issues.
2. If implemented the recommendations would involve significant reconsideration of existing legislation, guidance and regulation, including the changes brought in post Grenfell via the BSA 2022.
3. The cost and consequences of implementing the recommendations would however be significant, and it is hard to see in the current climate where the necessary funds and resources would come from.

Having concluded that the system of regulating the construction and refurbishment of high rise residential buildings at the time of the Fire was seriously defective in a number of respects, the Inquiry has made various recommendations which it considers would rectify these shortcomings.

The recommendations are wide-ranging and include better regulation and training of various construction professionals, the urgent review of Approved Document B and statutory guidance generally, reviewing the approved inspector role in building control approval and establishing an independent regulator in whom all aspects of building safety will be drawn together as a single point of responsibility.

Readers are referred to Chapter 113 of the Report for the full recommendations. We set out the main recommendations below.

Regulatory arrangements

Perhaps the most eye-catching recommendation is that of the appointment of a "Construction Regulator".

The Inquiry concluded that, over time, the arrangements for regulating the construction industry have become too complex and fragmented, with various government departments and entities being responsible for different elements of fire safety. The Report recommends that all construction functions referred to in the Report should be exercised by a single independent body (headed by a person provisionally called the "**Construction Regulator**") reporting to a single Secretary of State, rather than to multiple government departments.

This would provide a focal point to drive the change in culture needed and would enable information to be better shared between those responsible for different aspects in the industry. The Construction Regulator's functions would be comprehensive and include product regulation, the development of methods for fire testing materials, the certification of products, regulation and oversight of building control, licencing contractors for work on higher risk buildings, monitoring Building Regulations, fire safety research, accrediting fire risk assessors, collecting information on matters affecting fire safety and maintaining a publicly available library of test data and publications.

While the BSA 2022 regulated work on "higher risk" buildings and established a "Building Safety Regulator" responsible for building control and overseeing standards of competence, responsibility for the various functions remained dispersed and should be drawn together under a single regulator. In this regard, it is arbitrary to define a building as "higher risk" (as it does in the BSA 2022) by reference to its height and so the definition in the BSA 2022 should be reviewed by reference to a building's use and the likely presence of vulnerable people.

Government

The Inquiry recommends that all functions relating to fire safety in buildings should be brought into one department (rather than the MHCLG, the Home Office and the Department for Business and Trade sharing functions as at present) and there should be a Chief Construction Adviser to assist the minister with a sufficient budget and staff that can advise on all aspects of the construction industry.

Legislation & guidance

The Inquiry found that, whilst expressing the legal requirements of the Building Regulations in terms of functional requirements is not unsatisfactory, as currently drafted, Approved Document B does not provide the information needed to design buildings that are fire safe. Accordingly, the Report recommends that the statutory guidance generally, and Approved Document B in particular, should be reviewed and revised urgently. A revised version of the guidance should contain a clear warning in each section that the legal requirements are contained in the Building Regulations and that compliance with the guidance does not necessarily mean the Building Regulations have been complied with.

Fire safety strategy

The Inquiry found that those involved in the design and execution of the Grenfell refurbishment failed to properly understand the need for a fire strategy. It further considered that Grenfell was in a dangerous condition on completion, as the final version of the fire safety strategy was not completed. To avoid a repeat of this error, the Report recommends that it should be made a statutory requirement that a fire safety strategy be produced by a registered fire engineer and submitted with building control applications for any higher-risk building and that this be reviewed and re-submitted at completion. This strategy needs to take into account vulnerable people and the additional time it may take for evacuation/to reach a place of safety.

Fire performance tests / certification of products and publication of test data

The Report recommends that steps should be taken, in conjunction with the professional and academic community, to develop new test methods to provide information needed for fire performance assessments to be carried out reliably on the basis that those designing buildings must have access to reliable information about materials and products. The Inquiry also found that some of the manufacturers of products used on Grenfell used misleading marketing material and made claims calculated to give the impression products had been tested as suitable for a particular use. The Inquiry further concluded that certification bodies failed to ensure that statements in certificates were accurate and based on relevant testing.

Accordingly, the Report recommends that the Construction Regulator should be responsible for assessing the conformity of products with the requirements of legislation and statutory guidance and issue certificates which should become pre-eminent in the market.

Fire engineers

The term "fire engineer" does not at present denote any formal qualification. Given the importance of ensuring fire safety, the Report recommends that the profession of fire engineer should be recognised and protected by law. It also recommends that an independent body should be established to regulate the profession, define standards for membership, maintain register of members and regulate their conduct. Pending that, the Report recommends that a group of practitioners and academic fire engineers should produce a statement of the knowledge and skills required of a competent fire engineer.

Architects

The Inquiry recommends that the Architects Registration Board and RIBA should review the changes already made since the Fire to improve the training of architects. This is in view of the suggestion that there may be a widespread failure among the profession to investigate properly or understand the nature of building materials, such as insulation and rainscreen panels. The Report also suggests that it should be a statutory requirement that an application for building control approval for a higher risk building should be supported by a statement from a senior manager of the principal designer, that all reasonable steps have been taken to ensure that on completion, the building will be as safe as is required by the Building Regulations.

Contractors

The Report advocates a licensing scheme to be operated by the Construction Regulator for Principal Contractors for higher-risk buildings. It further recommends that it should be a legal requirement that a building control application for a higher-risk building is supported by a personal undertaking from a director/senior manager of the principal contractor under the BSA 2022 that all reasonable care has been taken to ensure that, on completion, the building is as safe as required by the Building Regulations.

Building Control

The BSA 2022 has already taken steps to improve the regulation of building control and to introduce a new climate in which both applicants for approval and building control officers understand that the function of building control is regulatory, rather than a source of advice and assistance. The Inquiry recommends, nonetheless, that there should be an independent panel to consider whether it is in the public interest for building control functions to be performed by those with a commercial interest in the process, i.e. approved inspectors who compete for work with other approved inspectors and with local authority building control departments. The Inquiry suggests that the panel should also consider whether all building control functions should be performed by a national authority, in the interests of professionalism and consistency. This, if adopted, would have very wide ranging implications indeed.

A construction library and response to recommendations

The Inquiry proposes that the Construction Regulator should sponsor the development of a construction library for building designers, to give them access to test data on products, reports on fires and academic papers. They also suggest there should be a legal requirement for government to maintain a publicly accessible record of recommendations from select committees, coroners and inquiries, along with an implementation record.

Fire risk assessors

The government should establish a system of mandatory accreditation to certify the competence of fire risk assessors by setting standards for qualification and continuing professional development. This will ensure that those who offer fire risk assessor services are competent. At present there is no such scheme of regulation.

Vulnerable people

Finally, the Report recommends that further consideration be given to the recommendations in the Phase 1 Report as to the owners and managers of every high rise residential building to be required by law to prepare a personal emergency evacuation plan for all residents whose ability to evacuate the building without assistance may be compromised and to include such information in a premises information box.

Comment

The Panel does not set out likely timescales regarding implementation for each of its recommendations, although the review of statutory guidance and of Approved Document B is unsurprisingly said to be urgent. Whilst in theory one would expect the government to consider this a priority focus, implementing the recommendations will be no simple task.

Indeed, some of the recommendations represent significant shifts in the way that fire safety of high rise buildings has been handled to date, such as the reconsideration of the role of the private sector in building control approval and the consideration of whether to move building control function to a national, rather than regional, level. Many of the recommendations flow from the implementation of the Construction Regulator and it is hard to see how there will be resource (and importantly funds) to implement this any time soon, if indeed it is practicable at all. There will also likely be significant opposition to these from some quarters, perhaps along with the requirement for personal statements from senior office holders of leading designers and Principal Contractors.

We are still then very much 'watching this space' and whilst we will be keeping an eye on any incidental announcements in the autumn budget, we suspect it will not be until we get the government's response in six months that there is any clarity (if indeed it is then forthcoming).

Anne-Marie Knight – Partner
Autumn Lish – Solicitor

Learning from the rest of the world

Key takeaway points

1. The issues the Inquiry identified with cladding / façade materials exist worldwide.
2. Much of the response of other countries has been similar in terms of end result, however the means for asserting control has differed.
3. Some other countries, notably Australia, have moved much more quickly and this must raise questions over whether change should be driven by the Inquiry process.

Combustible cladding: the global response

We consider some of the different international responses to the use of combustible cladding in the construction industry which are discussed in chapter 112 of the Report.

UAE response

The United Arab Emirates has a large number of high-rise buildings and has encountered a high number of cladding-related fires, including a serious fire in a 336 metre high building in Dubai in 2012. Following this, the UAE amended its legislation to provide minimum requirements for cladding systems and fire stopping, leading to the introduction of the UAE Fire and Life Safety Code ("FLSC") 2018. FLSC 2018 prohibits cladding assemblies for mid and high-rise buildings that are not fire-rated, and requires buildings over 15 metres in height to incorporate a fire-resistant spandrel panel. Cladding materials must also be tested with prescribed tests similar to those used in the UK, and cladding systems must be tested using a similar method to BS 8414.

The UAE also now utilises a "House of Expertise" made up of consultants who are experts in designing external walls and supervising façade contractors who review proposals for construction of new buildings. Further, FLSC 2018 demonstrates a change in approach to fire safety in acknowledging that "stay put" strategies require careful consideration, accepting that partial evacuation may be acceptable in high-rise buildings. This is a similar position to that in the UK's National Fire Chiefs Council "Stay Put" Position Statement; whilst the Statement advises that tenants of flats in high-rise buildings should remain in their flats if there is a fire in another part of the building, it acknowledges that the advice is dependent on the circumstances.

Australia response

Whilst the Commonwealth of Australia is made up of states, the National Construction Code, ("**NCC**"), which sets the standards to be met by new buildings, is applied to the entire country.

Following a serious fire at the Lacrosse building in Melbourne, a number of reports were produced which investigated construction practices in Australia. One report by the Warren Centre highlighted that only two Australian state governments, Queensland and Tasmania, operated licensing schemes for fire engineers. Another, (report 5), recognised the skills that fire engineers are required to have and established the need to raise standards for those seeking to qualify as fire engineers. Engineers Australia (Australia's national body for engineering), now bases its assessment for applicants for membership of the profession on the findings of report 5. Australia also introduced a new testing

system to complement its existing materials combustibility test, AS 5113, which is almost identical to BS 8414.
Australia's state of Victoria goes further to deter construction professionals from using sub-standard cladding materials on new buildings: Victoria's Building Act makes it an indictable offence to knowingly carry out building work that is not compliant with the Act or its regulations. The offence carries a penalty of a maximum five-year prison sentence. Additionally, Victoria's regulation of construction professionals allows the state to take disciplinary action against construction professionals where appropriate, and by September 2020 had done so in the case of 11 practitioners who had been involved in the installation of defective cladding. Conversely, the UK's BSA 2022 provides that offenders may be prosecuted and imprisoned for up to two years.

The state of New South Wales has similarly introduced legislation to improve the safety of building materials: the Building Products (Safety) Act 2017 gives the Commissioner of Fair Trading powers to prohibit products which can reasonably be regarded as unsafe. In 2018, the Commissioner prohibited the use of ACM panels, (the same panels used on Grenfell Tower), with cores of more than 30% polyethylene on certain buildings. The UK has undertaken similar measures in preventing the use of combustible materials, (such as ACM panels), on buildings which exceed 18 metres in height.

Comment

There is some crossover between the measures that have been carried out by the jurisdictions mentioned in this article: they all now prescribe testing systems similar to BS 8414 and regulate the use of combustible materials on high-rise buildings. It is clear that, whilst the UK has made significant progress in making the construction industry safer by bringing in a number of new measures, it could still go further to deter construction professionals from making the same mistakes.

Whilst it is perhaps something for greater reflection in due course, readers might find it striking that both Dubai and Australia have grasped the need for change far more quickly than the UK. Both jurisdictions have made changes with far less delay, given that the UK has required a seven-year long inquiry into the fire at Grenfell to be carried out in order to acknowledge the need for change. Further, Australia's jurisdiction is comparable – and indeed derivative – of the UK's. This indicates that the UK's priorities may be elsewhere, and that it will likely need to go further to prevent combustible cladding from causing a similar tragedy again.

Storm Evans – Solicitor
Craig Blakemore – Consultant

The future of inquiries – does Grenfell change anything?

Key takeaway points

1. The Report notably includes recommendation 113.40 which suggests that a formal system be put in place to monitor whether and/or how Inquiry recommendations are implemented.
2. This ties into calls from other public inquiries and would represent a significant de facto change in the effective power Inquiries have when making recommendations.
3. There is growing support for this change and would make an evolution of public inquiries – we will be watching with interest whether this recommendation is implemented.

Contained within the Report were a number of recommendations intended to realise positive change for the future.

One such recommendation, whilst framed within the findings of the Inquiry specifically, struck a chord with an ongoing wider discussion about how inquiries provoke meaningful change and is of particular significance to inquiry lawyers and public bodies alike. Recommendation 113.40 states:

> "*We recommend that it be made a legal requirement for the government to maintain a publicly accessible record of recommendations made by select committees, coroners and public inquiries together with a description of the steps taken in response. If the government decides not to accept a recommendation, it should record its reasons for doing so. Scrutiny of its actions should be a matter for Parliament, to which it should be required to report annually".*

This connects to a recurring theme of concerns raised by inquiry chairs around the need to implement change from inquiries.

Change from inquiries – the mixed picture of success

In recent years, the recommendations established by many public inquiries and large scale inquests have seen positive change to the society within which we live. Inquiries such as Leveson, Francis and the inquests into the 7/7 bombings all resulted in recommendations that led to substantial change that has positively impacted society. The positive impact of inquiries to effect change is proven by key changes such as the implementation of safe staffing levels for nursing, the introduction of a statutory Duty of Candour in the healthcare sector and the development of specialist emergency service teams work under joint operating principles.

Despite some previous success, however, public inquiries often face significant hurdles in ensuring their recommendations are accepted and changes thereafter implemented. A challenge that is made somewhat more difficult in the absence of any legal power on the part of the inquiry to insist that organisations, be that locally, regionally or nationally, make any attempt to take action in response to their recommendations. Furthermore, some chairs of public inquiries have taken to monitoring recommendations from previous reports whilst the inquiry remains ongoing. The chair can exert pressure on those who can make change by requesting evidence and call a responsible person to give evidence to account for actions taken. However, such a strategy is time-limited by the duration of the inquiry itself, with the power to monitor the recommendations extinguishing when the inquiry's terms of reference have been met and the chair's report placed before parliament.

Recommendation 113.40 – the recurring theme of inaction on change

In the context of the Inquiry, the specific concern on which this recommendation was prefaced, was that the Inquiry had identified that some important recommendations affecting fire safety were ignored by the government in the years leading up to the Fire. Notably, recommendations made by the Select Committee in 1999 were not implemented and the response to the recommendations made by the *Lakanal House* coroner were inadequate. There was no system for recording recommendations made by public bodies or keeping track of the response to them. The Inquiry confirmed that to their mind this was "*obviously unsatisfactory*".

It is noticeable that this recommendation appears in the Report at the end of the Inquiry marking the end of the chair's remit. Whilst a public inquiry is ongoing, the momentum of those proceedings, as well as the public scrutiny very often played out within the media, assists with ensuring change takes effect as the inquiry and wider public would anticipate. One good example of this is the Protect Duty, known as Martyn's Law. Named after one of the 22 victims of the Manchester Arena attack, Martyn Hett, the recommendation to introduce a compulsory duty on businesses to take measures to improve public safety was born out of the recommendations of the Manchester Arena Volume One Report. However, the momentum behind the change was and continues to be driven largely by the tireless campaigning of Martyn's mother, Figen Murray, who was instrumental in ensuring the government recognised the important changes needed in this area.

The Inquiry recommendation also marks the third inquiry in quick succession to touch upon the need to ensure recommendations from inquiries are actioned. In the summer of 2023, when concluding the Manchester Arena Inquiry, the chair – Sir John Saunders – made the following comments and published his comments on the inquiry website as his final act:

> *I am particularly concerned to ensure, now the Inquiry has come to an end, the continuation of the monitoring of the recommendations I made. There have been reports of occasions when an inquiry has made detailed findings and recommendations only for that work to be side-lined and the important learning from that inquiry lost, until another disaster or tragedy leading to another inquiry causes the same issues to be examined again. I had direct experience of this problem myself, in that failings identified in the 7/7 Prevention of Future Deaths Report had not been adequately addressed and reoccurred on 22 May 2017. I have been determined that does not happen here. It was an important reason for monitoring recommendations during the course of this Inquiry and doing so publicly*.

Sir John Saunders' comments serve to demonstrate that the limitation of the process that the inquiry has no legal power to mandate that where learning and recommendations are yet to be fully implemented, that that work continues and is completed as hoped. The inquiry itself had no power to direct the government, or any other organisation, to make the necessary changes. There is no defined route or mechanism for the overview or monitoring of inquiry recommendations once the inquiry's functions are defunct.

The chair of the Infected Blood Inquiry, Sir Brian Langstaff, adopted a different approach to trying to secure a legacy of change from inquiry recommendations. On 20 May 2024, the Infected Blood Inquiry published its final report. Despite the inquiry lasting six years, covering a period of many decades and producing a report running into 2,700 pages, the chair made only 12 recommendations. His rationale was simple and logical:

> *There is a danger in Inquiries making too many recommendations; it becomes difficult to see whether action is truly being taken to avoid the errors of the past being repeated.*

If there is no oversight or ongoing monitoring of recommendations, this represents one possible strategy to overcome the challenge is to distil the key learning into a limited number of laser-focused recommendations. However, such an approach of limiting recommendations to increase their likely effectiveness is the exception to the general trend of recent inquiry reports. It is a strategy to try and work around the problem of a lack of monitoring rather than address the problem itself.

The campaign for improving effectiveness

Recommendation 113.40 from the Inquiry seems to have landed at a poignant moment, one that has seen a national garnering of support for the introduction of a system that would monitor the response to recommendations made at inquiries and inquests.

Charity organisation INQUEST, have been campaigning for some time for a 'National Oversight Mechanism' consisting of a new independent public body who would be responsible for collating, analysing and following-up on recommendations arising from inquests, inquiries, official reviews and investigations into state-related deaths. It mirrors neatly the type of monitoring recommended by Sir Martin Moore-Bick. INQUEST maintains that such change is required as hundreds of vital recommendations are made following inquests and inquiries, yet there is no system in place to oversee them or ensure changes are made. INQUEST believe that potentially life-saving recommendations are too often forgotten, dismissed or simply not implemented, which leads to yet more preventable deaths and harms. Sir Brian Langstaff's rationale around the recommendations for the Infected Blood Inquiry would seem to support INQUEST's own rationale.

INQUEST's campaign has now gathered traction and a group of more than 40 organisations, including Criminal Justice Alliance, Liberty and Grenfell United have rallied in offering their support to the suggestion of a national oversight mechanism. Additionally, the House of Lords' Statutory Inquiries Committee was set up this year to consider whether the Inquiries Act 2005 provides an effective framework for public inquiries. With some 18 inquiries taking place this year alone, a report published by the committee in September this year said:

> *Too often, inquiries are failing to meet their aims because inquiry recommendations are not subsequently implemented, despite being accepted by the government. This is inexcusable, as it risks the recurrence of a disaster and undermines the whole purpose of holding an inquiry in the first place*.

This report calls for a new joint parliamentary public inquiries committee that would publish inquiry reports and government responses in one place, monitor implementation of accepted inquiry and inquest recommendations and scrutinise the government's response. This is exactly what Recommendation 113.40 of the Inquiry also suggests should happen. It is in many ways an irony that the Inquiry have issued a recommendation that governments should monitor the completion of recommendations on the basis that recommendations have not been adequately completed historically.

Conclusion – what does the government do

If the government acknowledge what appears to be an increasing mountain of support for the proposition outlined by this recommendation, it might well see the introduction of additional powers

to those judges who preside over inquiries and inquests, which would allow recommendations to be monitored, with the potential for sanctions to be imposed for those who fail to comply.

Whilst however the exact mechanism with respect to enacting Recommendation 113.40 or indeed whether it will be enacted at all remains to be seen, what is clear is that the Inquiry is amongst a growing number of concerned individuals and organisations who have identified the need for greater oversight when it comes to learning lessons.

The significance of this recommendation was aptly summarised by House of Lords Statutory Inquiries Committee Chair Lord Norton of Louth when he said:

> *'Lessons learned' is an entirely vacuous phrase if lessons aren't being learned because inquiry recommendations are ignored or delayed. Furthermore, it is insulting and upsetting for victims, survivors and their families who frequently hope that, from their unimaginable grief, something positive might prevail."*

Whilst the new government's legislative agenda does include important changes around new duties of candour and public funding for certain inquests and inquiries, the issue of monitoring recommendations and learning is not (yet at least) covered.

The ongoing question will be whether the raft of recent reports together with the ongoing campaigning provide sufficient momentum to garner the political will to introduce a monitoring process. This, we will be monitoring with interest.

Martin English – Partner
Jessica Swift – Principal Associate

What does the future hold for construction professional indemnity?

Key takeaway points

1. There is no doubt that Grenfell has had a noticeable impact of the availability and cost of construction professional indemnity cover, which has in tern impacted the viability of various businesses.
2. There had been a hope that the Report would provide vital clarification allowing the start of the opening up of this area. Unfortunately, however, we think it unlikely that this will come to pass.
3. Much is still to be known / worked through on the back of the Report and Insurers are urged to remain cautious for the time being.

The Grenfell tragedy itself had a very significant effect on the professional indemnity insurance market, particularly in terms of the withdrawal of capacity, higher premiums, wide exclusions of liability and reductions in indemnity limits for construction professionals such as designers, design & build contractors and specialist subcontractors.

The difficulty of obtaining suitable cover at an economic cost has undoubtedly caused many of those affected to withdraw from the market altogether or to take on work with inadequate professional indemnity insurance in place. A position which can never be recommended and carried incredible risk, not just for the under-covered individual, but also the industry more generally.

Alongside this, and no doubt in part due to this, the costs of construction have risen generally, which perhaps ironically only increases some of the – potentially concerning – market forces (e.g. drive for value engineering) of which the Inquiry was particularly critical.

The introduction of the BSA 2022 has compounded the problem yet further, as it introduced new responsibilities, increased the limitation period for bringing claims to 30 years retrospectively and up to 15 years going forwards and has turned the once almost largely dormant Defective Premises Act 1972 into a potential 'pandora's box'.

Many had hoped that the Report would have provided clarity, perhaps contextualising the BSA 2022 changes which in turn may have at least shed some 'light at the end of the tunnel' for construction professional indemnity. Indeed, in the last year or so we have started to see some softening e.g. of exclusion provisions in policies which seems to be indicating this expectation.

It is our view that the Inquiry's conclusions may have a positive effect on the professional indemnity insurance market, as the implementation of the lessons learned ought significantly to reduce the future risk of claims arising from poor design and specification practices. That however is not going to be a short-term consequence for reasons rehearsed elsewhere in this report.

It is largely reliant too on government's swift adoption of the Inquiry's recommendations, which we think is unlikely.

We would therefore expect (and indeed encourage) professional indemnity insurers to remain cautious for the time being, with a relaxation of policy restrictions happening only slowly if and when positive effects of the changes become apparent.

Underwriters would also be wise to keep a careful eye on how various industries adapt to matters in the meantime, as indeed the evolving jurisprudential picture from the courts which may yet prove to be the more decisive branch in this area.

Quentin Fox – Partner

Looking ahead to the criminal investigation

Key takeaway points

1. The Report does **not** provide a 'short-cut' to criminal proceedings – indeed the CPS is unlikely to even charge before the end of 2026.
2. The fact that the Inquiry was so comprehensive, combined with the Attorney General's undertaking, means that in effect the Metropolitan Police Service ("**MPS")** have to go over a lot of the same ground.
3. Nonetheless, the political pressure for prosecution is substantial and we expect many – any serious – prosecutions to take place in due course.

Former residents, and families of those who lost their lives, at Grenfell have been vocal in their criticisms of the time that the criminal investigation, conducted by the MPS into the tragedy, has taken so far.

Now that the Report has been published, where does this leave that criminal investigation, and how long will it take before any criminal prosecutions are brought?

What does the Report mean for the criminal investigation, and who will be criminally charged or convicted?

It is important to understand that the Inquiry and any criminal proceedings are entirely separate. They have different purposes, use different rules of evidence and apply different legal tests. A public inquiry makes findings based on a different standard of proof ("on the balance of probabilities" rather than "beyond reasonable doubt") and does not provide participants with the same procedural safeguards afforded to criminal defendants. Additionally, and importantly, the findings of the Inquiry are not admissible as evidence in criminal proceedings. This means that anything established at the Inquiry would effectively have to be proven again at any criminal trial.

To add further complication, many of the individuals who gave oral witness evidence at the Inquiry did so only after receiving a legal undertaking from the Attorney General that none of that oral witness evidence could be used against them in any subsequent prosecution, or in deciding whether criminal proceedings should even be commenced. This means that investigators/prosecutors will need to re-establish via other (admissible) means any important evidence or admissions given in such evidence. Whilst they may well do so, it takes more time

From the perspective of those investigating the criminal offences and those making decisions on what criminal charges should be brought, this means that, although the Inquiry and Report will be useful in having identified, explored and challenged some of the evidence, it does not provide a short-cut in terms of the criminal investigation or criminal proceedings.

Once all of the evidence is gathered by the MPS and submitted to the Crown Prosecution service ("**CPS**"), the CPS will need to determine who to charge with what offences. In doing so, they will need to apply the "Full Code Test" in the Code for Crown Prosecutors. This is a two-stage test assessing a) whether a conviction is more likely than not on the evidence gathered so far (the "evidential test") and b) whether a criminal prosecution is in the public interest (the "public interest test")

It does not follow that those criticised in the Report, even where those criticisms effectively amount to finding of potentially criminal breaches of the law, will be prosecuted. Just last month the High Court confirmed in another case that the CPS was perfectly entitled to not instigate criminal proceedings where a jury in a coroner's inquest had made a finding of unlawful killing.

Similarly, because of the differences between the Inquiry and criminal processes, evidence, tests and standards of proof, it does not follow that those so criticised in the Report will be convicted of any criminal offences. By way of illustration, David Duckenfield was acquitted of manslaughter at a criminal trial despite having been found to have unlawfully killed the Hillsborough victims by the inquest jury.

How long are any criminal proceedings likely to take?

Now seven years since the Grenfell disaster, and the MPS has already indicated that it will likely take a further 12 to 18 months to examine the Report "*line by line*" before files are submitted to the CPS for a charging decision. It may of course take even longer.

In our experience, once the CPS have the files it could take some considerable time for charging decisions to be reached and for the evidence to be organised into a form which is suitable for use in criminal proceedings. In corporate manslaughter cases – a charge many urge be explored against some involved in Grenfell – this usually takes upwards of two years, although here one would assume the matter would receive a higher priority within the CPS given its high profile.

Once charges are brought, there would likely be a number of hearings in the Magistrates' Court and then the Crown Court long before any criminal trial takes place. It is not uncommon for more than 18 months to pass between charges being brought and the date of any trial in the Crown Court. The scale and complexity of any proceedings here, and the court time and resources required, are also likely to necessitate an even longer timetable for trial.

What are the potential outcomes of criminal prosecution, and will anybody go to prison?

There are two types of "persons" who could be charged with criminal offences – corporate bodies/companies and individuals. For obvious reasons, corporate bodies/companies themselves cannot be sent to prison, nor does the conviction of a company in itself mean that any individual director or board member could go to prison – for that to happen, that individual director or board member would have to be individually charged themselves.

Corporate bodies can be fined any amount the court judges appropriate. It is open to the court to fine a company an amount that would immediately render the company insolvent (although it would be highly unusual). Foreign companies can be fined just like UK-based companies, with fines recoverable against any UK-based assets.

For any individual convicted, the potential for prison and the length of any custodial sentence would depend on the specific offences concerned. Gross negligence manslaughter can carry anything up to life imprisonment. Many regulatory offences, including those involving directors or board members who consent, connive or neglect in the failings of their corporate bodies/companies, carry the potential for up to two years' imprisonment.

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See the Possibility