

CITY OF
WOLVERHAMPTON
COUNCIL

Scrutiny Review Group - Fire Safety

29 January 2020

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny
Venue Committee Room 3 - 3rd Floor - Civic Centre

Membership

Chair Cllr Greg Brackenridge (Lab)

Cllr Philip Bateman MBE
Cllr Alan Butt
Cllr Susan Roberts MBE
Cllr Jacqueline Sweetman
Cllr Simon Bennett
Cllr Paul Singh
Karen Ryder (One Voice)
Bob Deacon (Wolverhampton Tenant's Association)
Barry Appleby (Representative of DAGLA)
Angela Davies (Chair of Wolverhampton Homes Board)

Quorum for this meeting is four Councillors.

Information for the Public

If you have any queries about this meeting, please contact the Democratic Services team:

Contact Martin Stevens
Tel/Email 01902 550947 / martin.stevens@wolverhampton.gov.uk
Address Democratic Services, Civic Centre, 1st floor, St Peter's Square,
Wolverhampton WV1 1RL

Copies of other agendas and reports are available from:

Website <http://wolverhampton.moderngov.co.uk/>
Email democratic.services@wolverhampton.gov.uk
Tel 01902 555046

Some items are discussed in private because of their confidential or commercial nature. These reports are not available to the public.

If you are reading these papers on an electronic device you have saved the Council £11.33 and helped reduce the Council's carbon footprint.

Agenda

Part 1 – items open to the press and public

- | <i>Item No.</i> | <i>Title</i> |
|-----------------|--|
| 1 | Apologies for Absence
[To receive any apologies for absence]. |
| 2 | Declarations of Interest
[To receive any declarations of interest]. |
| 3 | Minutes (Pages 1 - 12)
[To approve the minutes of the Fire Safety Scrutiny Group meeting held on 17 July 2019]. |
| 4 | Update from the Chair
[The Chair to give a verbal update on fire safety matters relating to Wolverhampton and the West Midlands Region]. |
| 5 | Grenfell Tower Inquiry - Phase 1 Report (Pages 13 - 44)
[To consider the Executive Summary of the Grenfell Tower Inquiry – Phase 1 Report]. |
| 6 | Full List of Phase 2 Grenfell Tower Inquiry Issues (Pages 45 - 54)
[Attached is a full list of Phase 2 Grenfell Tower Inquiry Issues for the Panel's consideration]. |
| 7 | Private Tower Blocks in Wolverhampton (Pages 55 - 58)
[To receive a briefing note on fire safety matters relating to the privately owned tower blocks in Wolverhampton]. |
| 8 | Wolverhampton Homes / WV Living Update on Projects
[To receive a presentation on Wolverhampton Homes / WV Living projects relating to fire safety]. |
| 9 | Fire Safety at Schools
[To receive a verbal update on the initiatives to improve Fire Safety at Schools]. |
| 10 | Exclusion of the Press and Public
[To pass the following resolution: |

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following items of business as they involve the likely disclosure of exempt information on the grounds shown below]

[By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information) under Schedule 12A of the Local Government Act 1972 as amended].

- 11 **i10 Update**
[To receive a verbal update on the remedial work to the Council owned i10 building].

This page is intentionally left blank



Scrutiny Review Group - Fire Safety

Minutes - 17 July 2019

Attendance

Members of the Scrutiny Review Group - Fire Safety

Cllr Philip Bateman MBE
Cllr Greg Brackenridge (Chair)
Cllr Alan Butt
Bob Deacon
Cllr Susan Roberts MBE
Cllr Jacqueline Sweetman

Employees

Martin Stevens (Scrutiny Officer) (Minutes)
Richard Lawrence (Director of Regeneration)
Kate Martin (Director for Assets and City Housing & Vice Chair WV Living Company Board)
Martyn Sargeant (Head of Governance)
Peter Taylor (Head of City Development)
Julia Nock (Head of Assets)
John Scott-Lee (WV Living Chief Operating Officer)
Jagtar Singh (Project Manager)
Neal Shore (Interim Compliance Officer)

Witnesses

Kevin Manning (Assistant Director Property Services – Wolverhampton Homes)
Simon Bamfield (Head of Commercial Services and Stock Investment – Wolverhampton Homes)

Part 1 – items open to the press and public

Item No. *Title*

- 1 **Apologies for Absence**
Apologies for absence were received from Cllr Simon Bennett and Karen Ryder (One Voice).

The Chief Executive of Wolverhampton Homes (Shaun Aldis) had also sent his apologies as an invited person to the meeting.

2 **Declarations of Interest**

Cllr Phil Bateman declared a non-pecuniary interest on the item, "Fire Safety at Schools Update" as Chair of Governors at Ashmore Park Nursery School.

3 **Minutes**

The minutes of the meeting held on 6 February 2019 were approved as a correct record.

As a matter arising the Chair stated that he had continued to give presentations on the work of the Fire Safety Scrutiny Group including to the Tenant Management Organisations. He was pleased to report that local fire stations had been reporting a large uptake in safe and well visit referrals from the organisations.

The Chair of the Group reported that he was now the Chair of the West Midlands Fire Authority which had given him better access on a national level. He had attended a recent Building Safer Futures Conference where a representative from the MHCLG (Ministry of Housing, Communities and Local Government) had spoken about the Government introducing new legislation on composite materials and toxicity. During the conference they had received a presentation from a University Professor who was a leading national authority on the level of toxicity various products gave off. It was clear deaths in fire were hugely increased where there were products giving off hydrogen cyanide during the fire. 80% of people who died in a fire did so from breathing in toxic fumes rather than from the flames of the fire.

4 **Civic Halls - Fire Safety Strategy**

The Director for Regeneration referred Members of the Group to the current Civic Halls Fire Strategy document produced by Tenos which had been circulated with the agenda for the meeting. He stated that there was a robust fire strategy in place as part of the overall scheme which exceeded current regulations based on the present designs. The strategy did not include the provision of sprinklers. It was deemed that these were not required. If there was a need to look at sprinklers, they had advised the team they could be included, but there would be a programme delay and cost increase.

The Head of Project and Works stated that the Tenos report was the most current they had; it was however based on the initial design scheme, which had evolved over the last few months. They had worked with the independent Fire Safety Consultants and a new updated report would be available in the next few weeks.

The Chair referred Members of the Group and the Director of Regeneration to Paragraph 7.24 on the Tenos report. The paragraph stated, "We have been instructed by our client (Space and Place Architects) to design the fire strategy on the basis that sprinklers will not be provided as this is an aspiration of their client." The Chair expressed his utmost concern about this paragraph. The Fire Safety Scrutiny Group had, in March 2018, made a number of recommendations to the Council's Cabinet. One of those recommendations was that sprinklers should be fitted in all major Council refurbishment projects, unless a report was brought specifically explaining the reasons why not. He therefore found paragraph 7.24 of the report very strange, as it completely contradicted the recommendation from the Fire Safety Scrutiny Group. He asked for a full explanation on paragraph 7.24 of the Tenos Report and wanted to know which person from the Council had given the instruction.

The Chair referred Members of the Group to pg. 16 of the Fire Safety Strategy (pg. 34 of the agenda pack) where under the heading internal fire spread linings, there was a table (Table 6.1) under paragraph 6.3. One of the recommendations from the Fire Safety Scrutiny Group to the Council's Cabinet in March 2018 had been that only zero rated fire retardant materials would be used in refurbishment projects, the table however referred to materials that were not zero-rated. He asked if his understanding was correct, that some of the materials that would be used in the Civic Halls refurbishment were not zero rated and some were actually class 3. If this was the case, it would mean that a recommendation of the Fire Safety Scrutiny Group to the Council's Cabinet had been disregarded.

The Chair stated that the whole process of the Civic Halls had not been one which had stood the Council in good stead. There had been a substantial increase in the budget from what had been originally set a few years ago, there had also been significant delays and it seemed clear that fire safety had not been at the heart of the refurbishment plans. He was shocked that the Regeneration Department of the Council had commissioned a report by Tenos which effectively in paragraph 7.24 of the report had said that the Council had told fire safety experts not to consider sprinklers. He thought this question should have been left for the fire safety experts to determine. The Chair had recently attended a meeting with the Regeneration Department and the fire safety consultants from Tenos. He commented that he had told the consultants from Tenos that he did not point any blame at them because they were using existing legislation in the compilation of the report. He and Members of the Group had repeatedly stated that the current legislation was not fit for purpose, as the Hackitt Inquiry had concluded. The Fire Safety Scrutiny Group wanted the Council to set its own fire safety standards in all areas of the work they undertook. He was extremely disappointed that the Regeneration Department had not taken on the points the Fire Safety Scrutiny Group had consistently made and had been relayed to them on a number of different occasions.

The Head of Project and Works responded that the Tenos Fire Strategy report had been written in March 2019 and Officers in collaboration with Tenos were now reviewing some of the materials in the design. With reference to the meeting with the fire consultants prior to the Civic Halls Board meeting, she could confirm all of the Chair's comments had been taken on board. On the matter of sprinklers, if they were to be included in the design they would require approval for the funds. They were trying to establish where paragraph 7.24 of the report had originated because she was not aware of a formal instruction given to put sprinklers in or out of the Civic Halls. There was a natural break in the refurbishment project at the moment because the contractor had gone bankrupt. In this natural break, they had time to re-evaluate the project, take on board the comments of the Group and go through the complete design. The most important aspect was to take on the learnings from the last few months and move forward with the project.

A Member of the Group complimented the Chair of the Group stating that he had done a remarkable job as Chair, which he thought was partly due to his extraordinary knowledge on fire safety matters. He was glad that he had uncovered the anomalies in the Tenos Fire Safety Strategy document relating to sprinklers and fire retardant materials. The Local Authority needed to take into account the views of the Fire Safety Scrutiny Group. It was critical that the refurbishment of an iconic building and others across the city were dealt with appropriately in relation to Fire Safety. There

was now an ideal opportunity to improve fire safety at the Civic Halls and given the national inquiries following the Grenfell tragedy and all the previous work of the Fire Safety Group, it would be unwise not to press the case that sprinklers should be installed. He was aware of the budget pressures, but he felt they should not take precedent over matters of public safety. He believed that the project should not move forward without the approval for sprinklers. The building needed to be as safe as it could be and sprinklers were a fundamental part of ensuring the highest standards of fire safety.

Members expressed their frustration that the spirit of the recommendations from the group were not being adhered to. The Grenfell tragedy was a wake-up call but it appeared in the instance of the Civic Halls it was not having an effect on the decisions regarding sprinklers and using zero rated fire retardant materials.

The Chair of the Group expressed disappointment with the former Interim Director of Place who had left the Council in March 2019. This was because he had articulated to the Group at the last meeting that he had commissioned an independent report into whether sprinklers should be installed at the Civic Halls, but no report on this subject matter had materialised. There was clearly a systematic block somewhere in the Council on sprinklers. He wanted lessons to be learnt and for all future development and major refurbishment to include sprinklers, hard wired fire alarms and for zero fire rated retardant materials to be used. If they were not going to be used, he wanted there to be a report explaining the reasons why not. Dame Hackitt as part of her inquiry had noted that safety had been put aside in developments. Attitudes to fire safety needed to change, she had declared the current regulations as not fit for purpose. The Council needed to lead the way on fire safety and to not put costs before safety. It was important that projects such as the i9 and the West Side Development were built to high fire safety standards, abiding by the existing not fit for purpose legislation was not good enough, as it had already been declared broken by Dame Hackitt.

The Director of Regeneration said that to reassure the Group, the Fire Safety Strategy report for the Civic Halls was due to be updated and would certainly address the issues raised in paragraph 6.3 and 7.24. A change to installing sprinklers could be accommodated, there would need to be a discussion, but it would have an effect on the programme timing and costs and mitigation would be required. The Chair had met with Tenos to raise his concerns and they were updating the strategy. The West Side project was in the early stages of design and so there was a lot more autonomy to put in the right future proofing levels for fire safety. The i9 scheme was already developed, contractors appointed and planning secure. It was being delivered externally, if the project design was to be revisited, there was a risk that the project would not go ahead. Accordingly, they would have to look at other measures such as retro fit and redesign as i9 had been designed to meet current legislation.

A Member of the Group commented that as a new contractor needed to be appointed for the Civic Halls it was a perfect time to ensure that the Civic Halls refurbishment design included sprinklers and zero-rated fire-retardant materials. There needed to be urgent talks to ensure the design ensured the highest standards of fire safety. It was a waste of the group's time if they were going to be continually ignored. Members of the Group agreed with the comment.

The Chair expressed disappointment that he had not been invited to meetings of the Cabinet, in his capacity as the Lead Member for the Fire Authority, when an issue concerning fire safety had arisen, this was in violation of the recommendation that had been made and had been accepted by the Council's Cabinet in March 2018. On a positive note the Chair remarked that the Council was leading the way nationally on fire safety in a number of areas, such as the work being done by WV Living and Wolverhampton Homes. It was the Regeneration Department which was not understanding the significance of the Grenfell Tragedy, the not fit for purpose current legislation and the work of the Fire Safety Scrutiny Group.

Resolved: That the Chair of the Council's Fire Safety Scrutiny Group on behalf of the Group arrange a meeting with himself, the Managing Director of the Council, the Director of Regeneration and the Leader of the Council to raise the importance of having sprinklers installed at the Civic Halls and using zero rated fire retardant materials during the refurbishment.

5 **West Side Regeneration Plans - Fire Safety**

The Director for Regeneration stated that the West Side scheme was progressing based on the outline consent received in the previous year. Detailed work was ongoing with the developer to conclude the legal agreements further to Cabinet's approval of the scheme in February 2019. They were hoping that the legal process to allow the scheme to go forward for planning and subsequent construction would take place in the Autumn. As part of this process there had been conversations about the design and the requirements of future proofing the design for future regulations. His colleague, the Head of City Development had been leading on the scheme in collaboration with developers Urban & Civic.

The Head of City Development remarked that there was a particular focus that egress from the building was carefully designed and planned. The West Side scheme was at a good point in the design for the Fire Safety Scrutiny Group to have an impact. The developers had made a commitment to engage with the Fire Safety Scrutiny group and they would attend with the architects and necessary specialists to have detailed discussions about the design. They were however driving a high standard in terms of fire safety regardless.

The Chair asked when the West Side scheme developers would be available to attend a meeting of the Fire Safety Scrutiny Group, there was a meeting planned for when the Phase 1 Report of the Moore-Bick Inquiry was published, which was currently scheduled for release in October 2019. The Head of City Development suspected this would be too early to look at the detailed designs. The Chair suggested February/March 2020, he was however keen to talk to them early before detailed designs had been finalised. The Head of City Development stated that he could invite them to the planned October session for an initial discussion in addition to looking at the detailed designs the following year. There was also a planned meeting with the Chief Executive of the Developers and the Leader and Managing Director in the near future, so he could relay some of the points raised by the Group. The Chair asked that the Head of City Development to relay all the relevant points the Group had raised during the previous item to the Chief Executive of the Developers.

6 **i9 Update on Project**

The Director for Regeneration remarked that the i9 project was in its final stages of pre-development. If sprinklers were to be installed they would have to be retro fitted. There had been discussions in June 2018 at City Centre Portfolio Board, where it had been resolved that the building would progress without the inclusion of sprinklers. His concern was that if it was to be reviewed there would be a detrimental effect to the project. The Head of City Development commented that a decision to install sprinklers at this stage would require a complete redesign of the basement floors, which would have a serious knock-on effect for the delivery timetable of the scheme. The i9 scheme was at a critical juncture, it was reliant on LEP funding, the spending window for which was becoming increasingly tight. The contractor had been on board for over six months and they were trying to get the scheme on site as soon as possible. A fundamental re-design of the building could effectively prevent the project from going ahead.

The Chair asked if zero rated fire retardant materials would be used in the building both internally and externally. The Head of City Development responded that there had been ongoing discussions through various design meetings throughout the process on the specification and in particular on the cladding material. There had been some up lifts to the specification of the materials used as from what had been compliant with the current building regulations model. Some of the insulation materials did not carry the highest fire rating in parts of the building. At the current point in time he was not sure of the implications of substituting the materials for improved performance. They were still in dialogue with the architect and developer on this matter.

A Member of the Group commented that on major building projects there should be a section in reports which specifically addressed the matter of fire safety. The Chair commented that this had been recommended in March 2018 to Cabinet and he would raise the matter with the Leader and Managing Director. The i9 Building was another example of the Fire Safety Scrutiny Group's recommendations being ignored. He would raise serious concerns with the Leader if flammable materials were going to be used on the outside of the building. The location of the building was at a strategic transportation point in the City and a fire would cause significant community and economic disruption.

7 i10 Update on Remedial Work

The Director for Assets and City Housing informed the Group that from last month she had taken over responsibility for City Assets as part of her role, this included what was commonly known as Corporate Landlord. The i10 building was one area which they were reviewing.

The Head of Assets commented that the final report from consultants Aecom had been received on the i10 building. The Council needed to make a decision on the action to be taken with reference to the external cladding on the i10 building. They were also having discussions with the contractor Balfour Beatty, to find the evidence on what they installed in terms of fire stopping and installation on the i10. This had been challenging and they were still awaiting the information. They had promised to provide the information they had been asking for over the next two weeks. Legal advice was also being sought. A specification had been put together and they were working with the consultancy company, Arcadis, who were compiling a number of options and costs on matters such as removing and replacing the cladding and

looking at the associated implications for firestopping and insulation. The report was due to be completed by 2 September 2019.

The interim compliance Officer described in detail the issues regarding the i10. Aecom had stated that they would not recommend flammable materials being incorporated on any building. Balfour Beatty had been asked to provide information on what basis the original cladding specification had changed to what was on the building, some questions regarding the thickness of the insulation and some questions on the curtain walling and a service shaft. In addition, on the main escape corridor there were some defects, for which the Council had already obtained rectification costings should Balfour Beatty not agree to carry out the works. A legal opinion had been sought, which could be relayed confidentially in the future.

The Chair commented that the Consultant's report had vindicated the concerns the Group had expressed about the i10. He praised the Aecom report that had also picked up on the fact that the fire alarm could not be heard in all parts of the i10 building. He hoped lessons could be learnt from the i10 building for all projects in the future. Overall, he was pleased that progress was being made on rectifying the problems with the i10 building.

8 **Fire Safety at Schools Update**

The Interim Compliance Officer stated the fire risk assessments for the 46 community schools had been completed with the exception of one new school which would be done before they started operating. They had been requesting that community schools provide an update on the actions identified in the fire risk assessments. They were also asking schools to return a form, twice a term, confirming that regular fire checks were being undertaken such as extinguishers, evacuation drills, emergency arrangements and provision of Fire Marshals. At the previous meeting he had reported that 40-45% of schools were returning the forms on a regular basis. Subsequently, the Head of School Organisation had written to all schools who were not returning the forms. They were now up to 85% compliance. The process would be relaunched at the beginning of the next school year, reaffirming what was required in addition to a "How to Guide."

The Interim Compliance Officer remarked that they had offered to roll out the training to schools which had been given to the site responsible persons looking after corporate and community buildings.

The Chair complimented Officers on the substantial improvement in schools responding to the fire safety returns. It was in the interests of schools to carry out the checks, the Fire Service would be more than happy to assist schools with their fire safety checks. Fire prevention work was critical to the safety of children.

The Interim Compliance Officer confirmed that the Director of Education would continue to write to academy schools on a periodic basis reminding them of their legal obligations with reference to Fire Safety.

9 **WV Living & Wolverhampton Homes - Update on Projects**

The WV Living - Vice-Chair of the Company Board stated that at the previous meeting of the Fire Safety Scrutiny Group they had challenged them on their new

build programme. She was now pleased to outline in a letter to the Chair of the Fire Safety Scrutiny Group, included with the agenda pack, that sprinklers would be fitted in all new build homes for rent and sale at the building development at the Marches at Lakefield Road in Wednesfield. This was the largest WV Living building development scheme to date in the City. The second part of the letter was regarding a stronger approach to fire safety in all their new build homes. As of June 2019, WV Living would be fitting integrated sprinkler systems in all of their future new build homes across the City. They had an ambitious programme for house building across the City. They already had 1000 homes in the pipeline and their first scheme had sold. They were working with the WV Chief Operating Officer to plan their next commercial plan until 2026. As part of the plan fire safety would be integral and integrated sprinkler systems would form a central part of their fire safety strategy.

Members of the Group applauded and thanked the WV Living Company Board for their stronger approach to fire safety and especially the news about sprinklers being included in all their new builds in the future. This excellent news was most welcome, and Members of the Group completely endorsed the new approach. Fire safety was of paramount importance, making any extra cost for sprinklers completely justified. A fire could have a devastating impact and therefore any system which would help mitigate a fire was the correct approach. They completely supported the contents of the letter to the Chair of the Fire Safety Scrutiny Group.

A Member of the Group commented that the installation of sprinklers in new build WV Living properties was a huge positive step forward and would make all the difference for tenants. She thanked the WV Living Team and the Chair of the Fire Safety Scrutiny Group who had recently given a presentation to the WV Living Company Board on fire safety.

The Chair stated he would be presenting on fire safety at a regional level and was actually giving a presentation on the forthcoming Saturday. In his role as Chair of the Fire Authority he hoped to influence the West Midlands Combined Authority (WMCA) on fire safety matters and therefore hoped other local authorities would follow WV Living's lead. He believed other regions could be influenced by the work being carried out in the West Midlands. He believed England should have the same standards of fire safety as Wales and Scotland for new build dwellings. The new approach by WV Living he saw as a first step in a very long campaign moving forward. He was extremely pleased with WV Living's stronger approach to fire safety and thanked them for their collaborative approach with the Fire Safety Scrutiny Group. Sprinklers would only add approximately 0.5-1% cost in new builds, which was about the cost of new carpets. Insurance premiums would also be reduced but most importantly it would save lives.

The WV Chief Operating Officer gave a short presentation on technical points regarding the fire safety strategy of WV Living. The presentation slides are attached to the signed minutes. He particularly highlighted that there was no incoming gas supply to any of the new build properties with all heating and cooking appliances being electric. Management of the blocks including the maintenance of the communal areas would be provided by Wolverhampton Homes. The WV Living Board would be reviewing the potential to use zero fire rated materials where possible. All WV Living Board papers relating to property development proposals would in future include a reference to fire safety as a key consideration to be given in the design and costing of each scheme at the first stage.

The Assistant Director Property Services – Wolverhampton Homes stated that he was pleased to confirm that all new build schemes for Wolverhampton Homes from the date of the WV Living letter to the Chair of the Fire Safety Scrutiny Group, included in the agenda pack, would also be fitted with sprinklers. This would ensure consistency across the City and they would be working with City of Wolverhampton Council to ensure the scope and specification were identical. Wolverhampton Homes did build on a number of infill sites across the City.

The Chair of the Group praised Wolverhampton Homes for the decision that had been made on including sprinklers in new build schemes. He was very proud of the exemplary attitude Wolverhampton Homes had shown over the last two years on matters of fire safety. Wolverhampton Homes nationally had an outstanding name. He asked the Assistant Director of Property Services for Wolverhampton Homes to pass on his and the Fire Safety Scrutiny Group's appreciation of the action they had taken. Members of the Group fully endorsed the Chair's comment.

The Head of Commercial Services and Stock Investment – Wolverhampton Homes stated that Wolverhampton Homes managed 36 tower blocks across the City. There was also one Council owned block which was leased to Sanctuary Housing (Hampton View in Heath Town). 6 High rise blocks were privately managed.

The Head of Commercial Services and Stock Investment – Wolverhampton Homes gave an update on the infrastructure work being undertaken in the tower blocks managed by Wolverhampton Homes. A copy of the presentation slides are attached to the signed minutes. The consultation with residents had already started on the first phase. Open evenings about three months from delivery were normally held for residents explaining how they would be impacted by the work and the benefits. They also met with lease holders.

The Head of Commercial Services and Stock Investment – Wolverhampton Homes remarked that retro fitting of sprinklers would start in the Autumn. Kitchens, bedrooms, living rooms and bathrooms would have sprinklers installed in the apartments in the tower blocks. All communal areas would also have sprinklers installed. The Fire Rescue Service would be notified automatically if the sprinklers were activated and a secondary signal would be sent to the Concierge Management Centre. The current programme budget for the tower block improvements was approximately £29 million plus the costs of the sprinkler's installation of a further £19.2 million. It was anticipated that the budget would need to increase as they were finding further problems as they carried out works, which was to be expected given the age and condition of the buildings.

A Member of the Group congratulated Wolverhampton Homes on their work undertaken to date in Chetton Green Tower Block.

The Chair stated that he was grateful for the update from Wolverhampton Homes and he welcomed all the work they had completed and the work they had outlined would be undertaken in the future.

10 **Private Housing Services Update**

The Director for Assets and City Housing introduced the item on private housing. From May 2018 the Council had received guidance from the MHCLG (Ministry for Housing, Communities and Local Government) on how they should approach inspections in private blocks under the Housing Act arrangements. They had been working closely with partners and consultants to review privately owned high rise blocks in the City.

The Project Manager stated that to date they had completed fire safety inspections at St Cecilia's in Wednesfield and The Studios, located just outside the City Centre. They were in dialogue with the property managing agents to develop some action plans to remedy the various issues that had been discovered. With reference to the three Liberty Height blocks, which were student accommodation blocks, located just off the Wednesfield Road, he was in the process of organising inspections to take place during the Summer when the students were on vacation. They were watching with interest what enforcement action other local authorities were taking in regard to privately owned residential tower blocks.

The Director for Assets and City Housing confirmed that the blocks they were investigating did not have ACM cladding on them. The three Liberty Height blocks did originally have the ACM cladding but that was removed. The inspection during the Summer of the Liberty Height Tower blocks was part of a proactive approach to ensure they were being well managed.

The Chair complimented Officers on the work being undertaken with reference to privately owned tower blocks. Ensuring they were well managed was an integral part of fire safety.

The Chair stated that he was arranging for a press release to be published highlighting some of the excellent work that had taken place over the last two years. A photograph of the group would also be taken at the end of the meeting. He thanked the Fire Safety Scrutiny Group Members and supporting Officers for their efforts since the inception of the Group.

The Chair stated that he hoped a site visit in the future would be facilitated by Wolverhampton Homes to see sprinklers being installed at some of the Council owned residential tower blocks. The site visit could also incorporate a visit to look at some access issues at one of the Council owned estates in Hallett's drive and a couple of other locations. He hoped the visit would take place early next year.

The Assistant Director Property Services – Wolverhampton Homes responded that he would welcome a site visit from the Group. They would be in touch with the Scrutiny Officer to ensure the timing was appropriate to observe the installation of sprinklers and other maintenance work. He suggested about three hours for the visit.

11 **National Updates**

The Chair stated he had attended the Fire Safety Conference at the West Midlands Fire Service the previous day. He expected new legislation within months. He had welcomed people to the Conference and had informed them of some of the excellent work being undertaken in Wolverhampton. Representatives from around the region and further afield were impressed with the work he had described from WV Living, Wolverhampton Homes and the Council.

The Chair referred to the national consultation documents which had been circulated with the agenda. He was aware that the Director for Assets and Housing would be giving a response on behalf of the Council and he suspected Wolverhampton Homes would also give a response. The West Midlands Fire Service would be submitting a response as would the National Fire Chiefs Council.

Resolved:

- A) That the Fire Safety Scrutiny Group delegate authority to the Chairman of the Group to officially respond on behalf of the group to the Building a Safer Future – Proposals for reform of the Building Regulatory System Consultation.
- B) That the Fire Safety Group delegate authority to the Chairman of the Group to officially respond on behalf of the group to the Regulatory Reform (Fire Safety) Order 2005 – Call for Evidence.

12

Next Meeting

The Chair reported that he intended to call a meeting of the Fire Safety Scrutiny Group after the publication of the Phase 1 Report from the Moore-Bick Inquiry, which was scheduled to be released in October 2019.

This page is intentionally left blank

Grenfell Tower Inquiry

GRENFELL TOWER INQUIRY: PHASE 1 REPORT OVERVIEW

REPORT of the PUBLIC INQUIRY into the
FIRE at GRENFELL TOWER
on 14 JUNE 2017

Chairman: The Rt Hon Sir Martin Moore-Bick
October 2019

Grenfell Tower Inquiry

GRENFELL TOWER INQUIRY: PHASE 1 REPORT OVERVIEW

REPORT of the PUBLIC INQUIRY into the
FIRE at GRENFELL TOWER
on 14 JUNE 2017

Chairman: The Rt Hon Sir Martin Moore-Bick
October 2019

This report contains images and content which some may find distressing.



© Crown copyright 2019

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to us at contact@grenfelltowerinquiry.org.uk

ISBN 978-1-5286-1620-1

CCS0719597372 10/19

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office

Contents

This Phase 1 Report Overview contains the following chapters from the full Phase 1 report:

Chapter 2: Executive Summary.....	1
Chapter 33: Recommendations	11
Chapter 34: Looking Ahead to Phase 2.....	21

Chapter 2

Executive Summary

Overview

- 2.1 This first report of the Grenfell Tower Inquiry is divided into six parts. **Part I** contains a broad introduction to the events that took place during the early hours of 14 June 2017. It contains a description of Grenfell Tower itself and of the organisation of the London Fire Brigade (LFB) and sets the scene for **Part II**, which contains a detailed narrative account of the fire and the steps taken in response to it. **Part III** contains my conclusions about the origin and development of the fire and my analysis of the response of the LFB and the other emergency services which attended the incident. The hearings commemorating those who died constituted an important part of the Inquiry's proceedings. A summary of the tributes paid to their loved ones by their families and friends is contained in **Part IV**. **Part V** contains recommendations arising out of the findings made earlier in the report and **Part VI** looks ahead to identify some matters of particular importance on which the Inquiry will concentrate its attention in Phase 2.
- 2.2 I am grateful to all those who gave evidence, both those called to give evidence in person and those who provided written statements but were not called. I am very conscious that many of those who gave evidence found it a challenging and emotional experience.

Part I: Background matters

- 2.3 **Chapter 1** of the report contains a general introduction to the Inquiry. In it I explain why I decided to conduct the Inquiry in two phases and how the Phase 1 hearings were organised, beginning with commemorations of those who lost their lives in the disaster. I draw attention to the fact that the Inquiry is being conducted in parallel to investigations being carried out by the Metropolitan Police Service (MPS) and Her Majesty's Coroner for Inner London (West), Professor Fiona Wilcox.
- 2.4 **Chapter 3** describes Grenfell Tower itself, completed in 1974, and the changes that were subsequently made to the building and its immediate surroundings, culminating in the tower's most recent refurbishment, which was completed in 2016. It explains the mix of rental and leasehold properties in the tower, the community which lived there, and the different functions of the Royal Borough of Kensington and Chelsea (RBKC) as owner of the building and the RBKC Tenant Management Organisation (TMO) as its manager.
- 2.5 In **Chapter 4** there is an explanation of the principles underpinning fire safety in high-rise residential buildings, such as Grenfell Tower, which have led to the adoption of the "stay put" strategy in response to fires occurring within individual flats.
- 2.6 A summary of the primary and secondary legislation relevant to the original construction and the later refurbishment of Grenfell Tower is to be found in **Chapter 5**, together with a reference to certain aspects of the relevant guidance on methods of complying with the legislative requirements.

- 2.7 **Chapter 6** provides an overview of the refurbishment. It contains a description of the new cladding system, associated changes to the windows and their surrounds, and the addition of an architectural crown, as well as other features of the building that were intended to promote safety in the event of a fire.
- 2.8 The structure and organisation of the LFB, including its statutory responsibilities, the principles which govern its operations (particularly in relation to fighting fires in high-rise buildings) and the equipment at its disposal, are described in **Chapter 7**. That chapter also contains a description of the control room and its method of working. The chapter concludes with a description of some of the equipment used by the LFB to which reference is made in subsequent chapters.
- 2.9 **Chapter 8** refers to the Lakanal House fire, which represents an important aspect of the background to the Grenfell Tower fire. On 3 July 2009 a fire broke out on floor 9 of Lakanal House, a 14-floor building in Southwark. The fire spread rapidly to other floors and smoke affected large parts of the building. Six people died. The coroner made a number of recommendations for change following the fire, some of which were directed at the LFB. The LFB undertook a detailed internal review of its practices and policies relating to 999 call-handling in general and to those calls requiring potentially life-saving fire survival guidance (FSG calls) in particular. The review questioned whether the control room should assume that fire crews would reach FSG callers quickly and whether in general it correctly balanced the risk of staying put against the risk of attempting to escape. Despite changes in policy, similar shortcomings were displayed by the control room when responding to callers from Grenfell Tower.

Part II: The events of 14 June 2017

- 2.10 **Chapters 9 – 20**, which make up **Part II** of the report, contain a detailed narrative of the events organised into 11 separate periods between 00.54, shortly before the control room received the first call concerning a fire at Grenfell Tower, and 08.10, when the last survivor left the tower. The account relies on the evidence of survivors and firefighters, source material such as records of 999 calls, and the evidence of expert witnesses called to assist the Inquiry. Each period covers the behaviour of the fire, the events at the incident ground and in the control room, the conditions in the tower itself, the movement of the occupants, and the actions of the MPS, the London Ambulance Service (LAS), RBKC and the TMO. Annex A to Part II contains a list of those who were present in the tower as at 00.54 and the times at which they left the building.
- 2.11 The following key events form the backbone of the Narrative:
- 00.54** Behailu Kebede calls 999 to report a fire in Flat 16, floor 4 Grenfell Tower.
 - 00.59** First firefighters reach the tower.
 - 01.09** Fire breaks out of Flat 16 into exterior cladding and starts to climb the east facade rapidly.
 - 01.14** Firefighters enter the kitchen of Flat 16 for the first time.
 - 01.21** First 999 call to the control room from an occupant in the tower (Naomi Li, Flat 195, floor 22).
 - 01.25** First 999 call to report smoke coming into flat from lobby (Denis Murphy, Flat 111, floor 14).

- 01.26** MPS declares a Major Incident.
- 01.27** Fire reaches the roof and starts to spread horizontally.
- 01.29** WM Michael Dowden, the LFB incident commander, makes pumps 20 (having made up from 4 to 6, to 8, to 10 and to 15 between 01.13 and 01.28).
- 01.30** First 999 call reporting fire penetrating a flat (Mariem Elgwahry, Flat 196, floor 22).
- 01.31** WM Dowden makes pumps 25. By this time 110 out of 297 occupants have escaped; the fire starts to spread to the north elevation of the tower.
- 01.42** The LAS declares a Significant Incident.
- 01.45** First NPAS (police) helicopter arrives at the scene.
- 01.50** WM Dowden hands over incident command to SM Andrew Walton. By this time 168 of 297 occupants had escaped.
- 01.58** SM Walton hands over incident command to DAC Andrew O’Loughlin.
- 02.00** Flames travel across the north and east elevations of the tower, and start to spread around the crown and diagonally across the face of the building, affecting flats in the south-east and north-west corners.
- 02.04** GM Richard Welch declares himself incident commander, not knowing that DAC O’Loughlin has already assumed command.
GM Welch makes pumps 40.
- 02.06** GM Welch declares a Major Incident.
- 02.11** DAC O’Loughlin takes handover from GM Welch.
- 02.15** SOM Joanne Smith arrives at the control room.
- 02.17** Bridgehead moves from floor 2 up to floor 3.
- 02.20** Flames start to spread to south elevation.
- 02.26** The LAS declares a Major Incident
- 02.35** Control room decides to revoke the “stay put” advice and tell all occupants calling 999 to leave the tower.
- 02.44** AC Andrew Roe takes over incident command from DAC O’Loughlin.
- 02.47** AC Roe revokes the “stay put” advice.
- 02.50** Fire spreads horizontally across the south elevation at the crown.
Commissioner Dany Cotton arrives at Grenfell Tower.
- 03.00** Fire starts to spread across the west elevation of tower, from north to south.
- 03.08** Bridgehead relocates to ground floor lobby.
- 03.20** First Tactical Co-ordination Group (TCG) meeting.
- 03.30** Flames continue to spread across the south and west elevations of the tower.

- 04.02** Fires on the south and west elevations start to converge at the top of the southern corner of the west face.
- 08.07** Elpidio Bonifacio, the last survivor to leave the tower, is evacuated.

Part III: Conclusions

The cause and origin of the fire and its escape from Flat 16

- 2.12 In **Chapter 21** I consider the cause and origin of the fire and find that it was started by an electrical fault in a large fridge-freezer in the kitchen of Flat 16, for which Behailu Kebede bears no blame. I have not been able to establish the precise nature of the fault in the fridge-freezer, but consider that to be of less importance than establishing how the failure of a common domestic appliance could have had such disastrous consequences. That question is pursued in **Chapter 22**, in which I find that:
- a. The fire is most likely to have entered the cladding as a result of hot smoke impinging on the uPVC window jamb, causing it to deform and collapse and thereby provide an opening into the cavity between the insulation and the ACM cladding panels through which flames and hot gases could pass. It is, however, possible (but less likely) that flames from the fire in the fridge-freezer passed through the open kitchen window and impinged on the ACM cladding panels above.
 - b. The fire had entered the cladding before firefighters opened the kitchen door in Flat 16 for the first time at 01.14.
 - c. A kitchen fire of that relatively modest size was perfectly foreseeable.

The subsequent development of the fire

- 2.13 The progress of the fire after it had entered the cladding is considered in **Chapter 23**. Once the fire had escaped from Flat 16, it spread rapidly up the east face of the tower. It then spread around the top of the building in both directions and down the sides until the advancing flame fronts converged on the west face near the south-west corner, enveloping the entire building in under three hours. I find that:
- a. The principal reason why the flames spread so rapidly up, down and around the building was the presence of the aluminium composite material (ACM) rainscreen panels with polyethylene cores, which acted as a source of fuel. The principal mechanism for the spread of the fire horizontally and downwards was the melting and dripping of burning polyethylene from the crown and from the spandrel and column panels, which ignited fires lower down the building. Those fires then travelled back up the building, thereby allowing the flame front to progress diagonally across each face of the tower.
 - b. The presence of polyisocyanurate (PIR) and phenolic foam insulation boards behind the ACM panels, and perhaps components of the window surrounds, contributed to the rate and extent of vertical flame spread.
 - c. The crown was primarily responsible for the spread of the fire horizontally, and the columns were a principal route of downwards fire spread.

The loss of compartmentation and the spread of fire through the tower

- 2.14 In **Chapter 24** I consider the evidence relating to the penetration of the building by fire and smoke and the rapid loss of compartmentation. The fire on the outside of the building quickly entered many flats and smoke spread rapidly through the interior of the building. As a result, effective compartmentation was lost at an early stage. Compartmentation failed because:
- a. The intensity of the heat was such that the glass in the windows inevitably failed, allowing the fire to penetrate flats.
 - b. Extractor fan units in the kitchens had a propensity to deform and become dislodged, providing a point of entry.
 - c. A number of key fire protection measures inside the tower failed. Although some fire doors held back the smoke, others did not. Some were left open and failed to close because they lacked effective self-closing devices; others were broken down by firefighters or wedged open with firefighting equipment.
- 2.15 The spread of fire and smoke within the tower is described in **Chapter 25**. Many lobbies had started to fill with smoke by around 01.20 and some were significantly smoke-logged by 01.40. By 02.00 a significant number were heavily smoke-logged. Until around 01.50 there was less smoke in the stairs; by then 168 people had been able to escape. After that time the stairs started to fill with smoke, particularly at lower levels. At some levels the smoke was thick and the heat considerable. By 02.20 the smoke in the stairs did pose a risk to life, but the stairs were not absolutely impassable to all even after that time.

Compliance with the Building Regulations

- 2.16 It was not my original intention to include in Phase 1 of the Inquiry an investigation into the extent to which the building complied with the requirements of the Building Regulations. However, as I have explained in **Chapter 26**, there was compelling evidence that the external walls of the building failed to comply with Requirement B4(1) of Schedule 1 to the Building Regulations 2010, in that they did not adequately resist the spread of fire having regard to the height, use and position of the building. On the contrary, they actively promoted it. It will be necessary in Phase 2 to examine why those who were responsible for the design of the refurbishment considered that the tower would meet that essential requirement.

The LFB: planning and preparation

- 2.17 Planning and preparation by the LFB for fires in high-rise buildings is examined in **Chapter 27**. National guidance requires fire and rescue services to draw up contingency evacuation plans for dealing with fires in high-rise buildings that spread beyond the compartment of origin causing a “stay put” strategy to become untenable. They should understand, for any given high-rise building in their area, when a partial or full evacuation might become necessary and provide appropriate training to incident commanders.
- 2.18 The LFB’s policy for fighting fires in high-rise buildings, PN633, envisages that evacuation of a high-rise residential building may be necessary and suggests that during familiarisation visits officers consider evacuation arrangements. However, the LFB’s preparation and planning for a fire such as that at Grenfell Tower was gravely inadequate. In particular:
- a. The otherwise experienced incident commanders and senior officers attending the fire had received no training in the particular dangers associated with combustible cladding, even though some senior officers were aware of similar fires that had occurred in other

- countries, and of the fact that construction materials and methods of construction were being used in high-rise building facades with a limited understanding of their behaviour and performance in a fire.
- b. LFB incident commanders had received no training in how to recognise the need for an evacuation or how to organise one.
 - c. There was no contingency plan for the evacuation of Grenfell Tower.
 - d. Although the LFB purports to maintain an operational risk database (ORD) for buildings in London and has a risk assessment policy (PN800) accessible by all operational firefighters at an incident, the entry on the ORD for Grenfell Tower contained almost no information of any use to an incident commander called to a fire. Such information as was contained in the ORD was many years out of date and did not reflect the changes made by the refurbishment.
 - e. In some cases, basic information relating to the tower held by the LFB was wrong and in others it was missing altogether.

The LFB: at the incident ground

- 2.19 My findings about operations on the incident ground are to be found in **Chapter 28**. The firefighters who attended the tower displayed extraordinary courage and selfless devotion to duty, but the first incident commanders, although experienced, were of relatively junior rank. They were faced with a situation for which they had not been properly prepared. In particular:
- a. None of them seem to have been able to conceive of the possibility of a general failure of compartmentation or of a need for mass evacuation; they neither truly seized control of the situation nor were able to change strategy.
 - b. Once it was clear that the fire was out of control and that compartmentation had failed, a decision should have been taken to organise the evacuation of the tower while that remained possible. That decision could and should have been made between 01.30 and 01.50 and would be likely to have resulted in fewer fatalities. The best part of an hour was lost before AC Roe revoked the “stay put” advice.
 - c. The LFB continued to rely on the “stay put” strategy in place for Grenfell Tower which was not questioned, notwithstanding all the early indications that the building had suffered a total failure of compartmentation.
 - d. No systematic arrangements were made for information about the number and source of FSG calls to be communicated to the incident commanders. Similarly, information about the internal spread of the fire and the results of rescue operations was not effectively shared with incident commanders; pictures from the police helicopter were not available to them.
 - e. There were serious deficiencies in command and control. Although additional resources arrived swiftly, some senior officers failed to give sufficient practical support or inform themselves quickly enough of conditions and operations within the building.
 - f. Many of the physical or electronic communication systems did not work properly, such as the command support system (CSS) on the command units.

The LFB: in the control room

- 2.20 **Chapter 29** contains my findings about the operation of the control room. The control room staff faced an unprecedented number of 999 calls relating to the fire which posed a challenge wholly outside their long experience and training. Control room staff undoubtedly saved lives, but a close examination of the control room's operations has revealed shortcomings in practice, policy and training. In particular:
- a. LFB policy on handling FSG calls requires control room operators (CROs) to stay on the line with callers until they are rescued or can otherwise leave the building, but the number of FSG calls received during the fire far exceeded the number of CROs available, putting them in an invidious position.
 - b. Neither the application of the "stay put" policy nor the specific requirements that have to be followed if an FSG caller is to escape from a burning building are properly set out in the LFB policy documents.
 - c. CROs did not always obtain necessary information from callers, such as flat numbers, the number of people present, or whether people were disabled; nor did they always assess conditions at the callers' locations and hence the possibility of their escape.
 - d. CROs had not been trained to handle numerous simultaneous FSG calls, on the implications of a decision to evacuate, or on the circumstances in which a caller should be advised to leave the building or stay put. They were not aware of the danger of assuming that crews would always reach callers, which was one of the important lessons that should have been learnt from the Lakanal House fire. As a result, they gave assurances which were not well founded.
 - e. When the "stay put" advice was revoked and occupants were to be told to leave the building, the CROs did not all understand that they had to give that advice in unequivocal terms so that the caller would know that they had no choice but to leave the building.
 - f. Channels of communication between the control room and the incident ground were improvised, uncertain and prone to error. CROs did not therefore know enough about conditions in the tower or the progress of responses to individual FSG calls, so they lacked a sound basis for telling callers whether help was on its way.
 - g. Those on the incident ground did not have access to valuable information from the control room. The very fact that CROs had to terminate FSG calls in order to answer new calls ought to have alerted more senior control room officers to the fact that it had become impractical to give proper FSG advice.
 - h. There was no organised means of sharing information obtained from callers among the CROs, and little access to information from other sources. As a result, CROs had no overall picture of the speed or pattern of fire spread. Early on in the incident CROs told occupants that the fire was still confined to floor 4 when in fact it had reached the top of the tower.
 - i. Although the LFB has arrangements in place for handling a large number of 999 calls, routing them to other fire and rescue services, they do not provide for sharing information about conditions at the incident itself. Differing advice was given at important moments.
 - j. There were weaknesses in the supervision of control room staff. Supervisors were under the most enormous pressure, but the LFB had not provided its senior control room staff

with appropriate training on how to manage a large-scale incident with a large number of FSG calls.

- k. Mistakes made in responding to the Lakanal House fire were repeated.

The response of the other emergency services, RBKC and the TMO

2.21 The response of the other emergency services, RBKC and the TMO is considered in **Chapter 30**, which describes the standing arrangements and protocols for joint operations between London's emergency services. It is clear that although in some respects they were implemented successfully (for example, the management of the security cordon by the MPS), the response was unsatisfactory in other respects. The evidence does not show that any death or injury resulted from these failures but they contain important lessons for future major disasters in London. In particular:

- a. The MPS declared a Major Incident at 01.26 without telling the LFB or the LAS. The LFB declared a Major Incident at 02.06 without telling the MPS or the LAS; and the LAS declared a Major Incident at 02.26 without telling the LFB or the MPS. RBKC was not told about any of these declarations until 02.42. This lack of communication was a serious failure to comply with the joint working arrangements and protocols designed for major emergencies in London.
- b. The consequence of failing to share the declarations of a Major Incident meant that the need for a properly co-ordinated joint response between the emergency services was not appreciated early enough. That in turn led to a lack of shared understanding of the nature and effect of the fire. The conversations that should have taken place between the supervisors of the different control rooms did not happen.
- c. Communication between the emergency services on the night of the fire, both remotely and on the incident ground itself, did not meet the standards required by the protocols. A single point of contact in each control room and direct communication between control room supervisors should have been established.
- d. The heli-tele downlink (the communication link with the police helicopter overhead) failed to function, which adversely affected LFB operations.

2.22 RBKC is subject to certain obligations under the Civil Contingencies Act 2004 and had a formal "Contingency Management Plan" setting out what needed to be done in the event of an emergency. The TMO had no obligations under that plan. It had its own emergency plan, but it was not activated and was in any case fifteen years out of date. As RBKC's response to the fire relied on key information held by the TMO, its plan was in certain respects ineffective. One particular cause for concern is the delay in obtaining the attendance of a Dangerous Structures Engineer (DSE), despite numerous requests from the LFB; another is the delay in obtaining plans of the building, which were not on site, not on the LFB's ORD and not available to the LFB until around 08.00.

Shutting off the supply of gas to the tower

2.23 **Chapter 31** describes the steps taken to isolate the tower from the main gas supply. Gas was supplied to the tower by Cadent Gas Ltd (Cadent). Cadent had a legal obligation to help the LFB, and had reported to the incident ground before 05.00. Fortunately, a key Cadent engineer, Jason Allday, who knew the area well, subsequently arrived unprompted, took charge, and stayed for 24 hours. Shutting off the gas to the tower ultimately involved Cadent's

cutting and capping off three substantial pipes under nearby streets supplying gas to the whole area. The work was completed by 23.40 and the remaining flames in the tower died down almost immediately.

Part IV: Remembering those who died

2.24 **Chapter 32** contains a summary of the tributes paid to those who died in the fire at the commemoration hearings with which the Inquiry opened. The Inquiry started its Phase 1 hearings at the Millennium Gloucester Hotel in Kensington with commemorations of all those who died and a celebration of their lives. This part of the report names each of those who died and, drawing on the evidence given by loved ones and friends, provides a brief summary of their lives.

Part V: Recommendations

2.25 Although Phase 1 of the Inquiry has been limited to investigating the course of events during the night of 14 June 2017 and much work remains to be done, it has already become clear that some important steps need to be taken to improve fire safety, including the response of the LFB and other fire and rescue services to major disasters, including fires in high-rise residential buildings. **Chapter 33** therefore contains recommendations arising out of the evidence heard in Phase 1 and the findings of fact based on it. It would not be appropriate to make recommendations at this stage in relation to matters that have not been the subject of investigation, such as the regime surrounding the testing and certification of building materials, even though there are grounds for thinking that changes may need to be made.

2.26 Chapter 33 does not lend itself to being summarised. It should be read in full, because it sets out my recommendations in detail and explains the basis on which they are being made (or in some cases why certain recommendations are not being made). In summary, however, I make recommendations for change in relation to the following matters:

- a. The information made available to fire and rescue services about the materials and methods of construction used in the external walls of high-rise residential buildings.
- b. The arrangements made by the LFB to discharge its duties under section 7(2)(d) of the Fire and Rescue Services Act 2004.
- c. The availability of plans of high-rise residential buildings to local fire and rescue services and the provision of premises information boxes in high-rise residential buildings.
- d. The regular inspection and testing of lifts designed for use by firefighters.
- e. Communication between the LFB control room and the incident commander.
- f. The way in which fire and rescue services handle emergency calls.
- g. The LFB's command and control procedures and use of resources, in particular the capture of information from crews returning from deployments and the sharing of information between the LFB control room, the incident commander and the bridgehead.
- h. The communication equipment available to the LFB for use by crews deployed in firefighting and rescue operations in high-rise buildings.
- i. The evacuation of high-rise residential buildings, including the provision of equipment enabling firefighters to send an evacuation signal to the whole or a selected part of the building.

- j. The provision of fire safety information to residents of high-rise residential buildings and the marking of floor levels in lobbies and staircase landings.
- k. The inspection of fire doors and self-closing devices.
- l. Aspects of co-operation between the emergency services.

Part VI: Looking ahead to Phase 2

- 2.27 In Phase 2 the Inquiry will seek to answer the various questions set out in the List of Issues which appears on its website, but as a result of what has been learnt from the work done in Phase 1, some questions have assumed greater prominence than had previously been thought and others have receded in importance. Accordingly, in the final chapter of the report, **Chapter 34**, there is a pointer to those aspects of the Inquiry's investigations on which, in the light of Phase 1, particular attention will need to be focused in Phase 2.
- 2.28 The first matter concerns the deceased. An important element of Phase 2 will be to complete the investigation of the circumstances in which those who died in the fire met their deaths. Many of the findings that are required by the coroner have been made in this report, but there remains the need for an investigation into the wider circumstances that can only be satisfied by the evidence that will emerge during the proceedings in Phase 2. In due course there will be an opportunity for the bereaved to draw together the threads of the evidence relating to those who died in order to enable the necessary findings of fact to be made.
- 2.29 Other matters of particular concern include:
- a. The decisions relating to the design of the refurbishment and the choice of materials.
 - b. The regime for testing and certifying the reaction to fire of materials intended for use in construction.
 - c. The design and choice of materials.
 - d. The performance of fire doors in the tower, in particular, whether they complied with relevant regulations, their maintenance and the reasons why some of the self-closing devices do not appear to have worked.
 - e. The organisation and management of the LFB, in particular in relation to the formulation of policy in the light of experience, the arrangements for training firefighters and control room staff, and the arrangements for sharing information about the particular problems associated with fighting fires in high-rise buildings.
 - f. The warnings of potential fire hazards given by the local community.
 - g. The authorities' response to the disaster.
- 2.30 It has now become clear that some aspects of the building which were at one time thought to require careful investigation did not play a significant role in the disaster and will not therefore require further examination. They include:
- a. The width of the stairs.
 - b. The supply of gas.
 - c. The supply of electricity and the history of electrical surges.

1 Introduction

- 33.1 Phase 1 of the Inquiry has been concerned with investigating the cause of the fire, its subsequent development and the steps taken by the LFB and the other emergency services in response to it. In the course of it I have touched on the training given to the firefighters and CROs in relation to responding to fires in high-rise buildings and other incidents of a kind that may generate a significant number of calls from people seeking advice and assistance. Phase 2 will involve a more detailed examination of certain aspects of the management of the LFB (in particular its understanding of modern methods of construction and of the way in which some of the materials currently in use behave when exposed to fire) and the steps that were taken to train its officers to respond to fires in high-rise buildings. However, the evidence put before me in Phase 1 is already sufficient to demonstrate that a number of improvements can be made both in the way in which high-rise residential buildings are designed, constructed, approved and managed and in the way in which fire and rescue services respond to fires in such buildings.
- 33.2 The core participants and the experts who gave evidence in Phase 1 have suggested many steps which in their view can and should be taken to improve the safety of those who live in high-rise buildings and should therefore form the subject of immediate recommendations. However, they exhibited a wide divergence of views. It is important that any recommendations I make at this, or indeed any other, stage should be based firmly on the facts that have emerged from the evidence obtained by the Inquiry in the course of its investigations. I also think it important that they command the support of those who have experience of the matters to which they relate. Recommendations that are not grounded in the facts are of no value and recommendations that do not command the support of those who are experts in the field are likely to be ignored and, if not ignored, risk giving rise to adverse unintended consequences.
- 33.3 The recommendations set out below are therefore based entirely on the evidence I have heard in relation to the particular issues that were investigated in Phase 1 and on the findings and conclusions I have been able to reach in this report. They do not attempt to anticipate the evidence to be called in Phase 2 or the conclusions that may be drawn from it, and when deciding what recommendations should be made at this stage I have had regard in particular to their capacity for making a significant contribution to the safety of those who live in high-rise buildings. I am grateful to those of the core participants who made submissions on this subject, all of which I have considered carefully before making my recommendations. I refer to some of them in more detail in later paragraphs.
- 33.4 In England and Wales, high-rise buildings have conventionally been defined for the purposes of fire safety as buildings over 18 metres in height. In Scotland, however, the regulations have recently been changed so that the requirements relating to high-rise buildings apply to buildings over 11 metres in height. It is for consideration whether the position in England should now also be changed and, if so, what height should be adopted for that purpose. However, that question was not the subject of examination in Phase 1 and it is therefore not possible for me to make a recommendation about it at this stage. It is, however, a matter which will be examined in Phase 2.

33.5 When considering steps that might be taken to improve safety in relation to high-rise buildings generally it is important not to lose sight of certain matters. The first is that, although not unprecedented, fires of the kind that occurred at Grenfell Tower are rare. The widespread use of combustible rainscreen cladding panels and insulation on the exterior of buildings and the introduction of new kinds of building materials in external walls may have increased the risk of similar fires, but improvements in the regulations relating to fire safety and the requirements for testing and certification of materials, which will be a particular focus of attention in Phase 2, should be capable of mitigating that risk in the future. Effective compartmentation is likely to remain at the heart of fire safety strategy and will probably continue to provide a safe basis for responding to the vast majority of fires in high-rise buildings. However, in the case of some high-rise buildings it will be necessary for building owners and fire and rescue services to provide a greater range of responses, including full or partial evacuation. Appropriate steps must therefore be taken to enable alternative evacuation strategies to be implemented effectively.

2 Use of combustible materials

33.6 It is clear that the use of combustible materials in the external wall of Grenfell Tower, principally in the form of the ACM rainscreen cladding, but also in the form of combustible insulation, was the reason why the fire spread so quickly to the whole of the building. Surveys undertaken since the fire have established that external wall materials similar to those used on Grenfell Tower have been used on over 400 other high-rise residential buildings around the country. From the evidence put before me in Phase 1, two very important matters have come to light: first, that in its origin the fire at Grenfell Tower was no more than a typical kitchen fire; second, that the fire was able to spread into the cladding as a result of the proximity of combustible materials to the kitchen windows. It is not possible to say whether the same or a similar combination of design and materials is to be found on any other buildings, but it would be sensible for those responsible for high-rise buildings with similar cladding systems, if they have not already done so, to check whether the same or a similar combination exists. However, even if they do not, fires can occur in a wide variety of circumstances and in cases where the exterior walls of the building include combustible materials of a similar kind, might gain access to it by a variety of different routes. It is not surprising, therefore, that people living in such buildings are concerned for their safety. It is unnecessary for me to recommend that panels with polyethylene cores on the exterior of high-rise buildings be removed as soon as possible and replaced with materials of limited combustibility because it is accepted that that must be done. It is essential that it be done as quickly as possible and concern has been voiced publicly, most recently by the House of Commons Communities and Local Government Select Committee, about the apparently slow rate of progress in carrying out the work.¹ In the light of what has been learnt in Phase 1 about the behaviour of ACM panels with polyethylene cores when exposed to fire, I wish to add my voice to that of the committee in expressing the view that the programme of remedial work should be pursued as vigorously as possible. In view of the part played by the architectural crown in the spread of the fire at Grenfell Tower, particular attention must be paid to decorative features composed of combustible materials.

33.7 It has been suggested by certain core participants that I should recommend that no materials be permitted for use in the external walls of high-rise buildings that are not of Euro class A1 (the highest classification of reaction to fire in accordance with BS EN 13501-1). That is a matter on which views differ, however, and following a consultation the government has already prohibited the use on certain types of new buildings of materials whose classification

¹ <https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/2546/254602.htm>

of reaction to fire is lower than A2s1, d0. Having regard to the outcome of that consultation, and in the absence of any examination of the competing views, I do not think it appropriate at this stage for me to recommend any change to the regulations in this respect. Nor, for similar reasons, do I think it appropriate for me to recommend an immediate moratorium on the use of materials of Euro class A2 pending the outcome of Phase 2 of the Inquiry, despite the submissions pressed upon me by some of the core participants.

3 Testing and certification of materials

33.8 The regulation of the use of materials and products by reference to their fire classification depends to a large extent on the efficacy of the testing requirements and how they are interpreted by professionals. Early in Phase 2, the Inquiry will investigate the methods of testing and certifying materials for use in high-rise buildings. It will also investigate whether a prescriptive regime is the most effective way in which to ensure the safety of those who live and work in high-rise buildings and whether the current guidance on how to comply with the Building Regulations is sufficiently clear and reliable. None of those questions have been examined in Phase 1 and at this stage, therefore, I am not in a position to make any recommendations about any of those matters.

4 Fire and rescue services: knowledge and understanding of materials used in high-rise buildings

33.9 Although some senior officers within the LFB were aware of the dangers of cladding fires in high-rise buildings, the majority, particularly at the more junior levels, were unaware of them and were not trained to recognise the nature of the fire that occurred at Grenfell Tower. Moreover, the LFB was unaware of the combustible nature of the materials used in the cladding of Grenfell Tower and was therefore not in a position to formulate a contingency plan for a fire of this kind.

33.10 A sound understanding of the materials used in the construction of any high-rise building is essential if the fire and rescue service is to be properly prepared to carry out its function in relation to that building. The risk of fire of the kind that occurred at Grenfell Tower may be low, but knowledge is the key to proper planning and effective training. **I therefore recommend:**

- d. that the owner and manager of every high-rise residential building be required by law to provide their local fire and rescue service with information about the design of its external walls together with details of the materials of which they are constructed and to inform the fire and rescue service of any material changes made to them;
- e. that all fire and rescue services ensure that their personnel at all levels understand the risk of fire taking hold in the external walls of high-rise buildings and know how to recognise it when it occurs.

5 Section 7(2)(d) of the Fire and Rescue Services Act 2004

33.11 Section 7(2)(d) imposes a general duty on fire and rescue authorities to make arrangements for obtaining information needed for the purposes of extinguishing fires and protecting life and property. The LFB appears to have thought that it required nothing more than sending crews to inspect individual buildings in accordance with Appendix 1 to PN633. However,

this essential duty is not circumscribed in that way. Moreover, crews who visited Grenfell Tower during its refurbishment were not trained to carry out the inspections properly: see Chapter 27, paragraphs 24-27. **I therefore recommend:**

- a. that the LFB review, and revise as appropriate, Appendix 1 to PN633 to ensure that it fully reflects the principles in GRA 3.2;
- b. that the LFB ensure that all officers of the rank of Crew Manager and above are trained in carrying out the requirements of PN633 relating to the inspection of high-rise buildings.

6 Plans

33.12 No plans of the internal layout of the building were available to the LFB until the later stages of the fire. However, because each floor of the building above floor 3 was laid out in the same way, the LFB was not unduly hampered in its attempt to fight the fire and rescue occupants by the absence of those plans. In another case, however, the lack of floor plans might easily have far more serious consequences. It should be a simple matter for the owners or managers of high-rise buildings to provide their local fire and rescue services with current versions of such plans. **I therefore recommend** that the owner and manager of every high-rise residential building be required by law:

- a. to provide their local fire and rescue services with up-to-date plans in both paper and electronic form of every floor of the building identifying the location of key fire safety systems;
- b. to ensure that the building contains a premises information box, the contents of which must include a copy of the up-to-date floor plans and information about the nature of any lift intended for use by the fire and rescue services.

I also recommend, insofar as it is not already the case, that all fire and rescue services be equipped to receive and store electronic plans and to make them available to incident commanders and control room managers.

7 Lifts

33.13 When the firefighters attended the fire at Grenfell Tower they were unable to operate the mechanism that should have allowed them to take control of the lifts. Why that was so is not yet known, but it meant that they were unable to make use of the lifts in carrying out firefighting and search and rescue operations. It also meant that the occupants of the tower were able to make use of the lifts in trying to escape, in some cases with fatal consequences. The ability of fire and rescue services to take control of firefighting or fire lifts in a high-rise building is often key to successful operations. **I therefore recommend:**

- a. that the owner and manager of every high-rise residential building be required by law to carry out regular inspections of any lifts that are designed to be used by firefighters in an emergency and to report the results of such inspections to their local fire and rescue service at monthly intervals;
- b. that the owner and manager of every high-rise residential building be required by law to carry out regular tests of the mechanism which allows firefighters to take control of the lifts and to inform their local fire and rescue service at monthly intervals that they have done so.

8 Communication between the control room and the incident commander

- 33.14 The evidence shows that although both national policy and the LFB's policies call for a free flow of information between the control room and the incident commander, in practice that does not occur, at least when one or the other (or both) are operating under significant pressure. **I therefore recommend:**
- a. that the LFB review its policies on communications between the control room and the incident commander;
 - b. that all officers who may be expected to act as incident commanders (i.e. all those above the rank of Crew Manager) receive training directed to the specific requirements of communication with the control room;
 - c. that all CROs of Assistant Operations Manager rank and above receive training directed to the specific requirements of communication with the incident commander;
 - d. that a dedicated communication link be provided between the senior officer in the control room and the incident commander.

9 Emergency calls

- 33.15 Even allowing for the fact that the control room was operating under great pressure, it is clear that in many cases CROs failed to handle FSG calls in an appropriate or effective way. **I therefore recommend:**
- a. that the LFB's policies be amended to draw a clearer distinction between callers seeking advice and callers who believe they are trapped and need rescuing;
 - b. that the LFB provide regular and more effective refresher training to CROs at all levels, including supervisors;
 - c. that all fire and rescue services develop policies for handling a large number of FSG calls simultaneously;
 - d. that electronic systems be developed to record FSG information in the control room and display it simultaneously at the bridgehead and in any command units;
 - e. that policies be developed for managing a transition from "stay put" to "get out";
 - f. that control room staff receive training directed specifically to handling such a change of advice and conveying it effectively to callers.
- 33.16 The handling of emergency calls by other fire and rescue services was hampered by their lack of information about the nature of the incident and the way in which it had developed. Those who respond to emergency calls on behalf of the LFB need to have as much information as possible about the incident in order to be able to give appropriate advice. **I therefore recommend** that steps be taken to investigate methods by which assisting control rooms can obtain access to the information available to the host control room.

- 33.17 On occasions, MetCC operators and LAS CROs handled calls from people in the tower seeking FSG advice. Sometimes they gave advice that was not consistent with the advice that the LFB was giving or should have been giving in accordance with its policies. **I therefore recommend** that the LAS and the MPS review their protocols and policies to ensure that their operators can identify FSG calls (as defined by the LFB) and pass them to the LFB as soon as possible.

10 Command and control

- 33.18 The evidence of the way in which firefighters were deployed indicates that those in command exercised insufficient control over their actions to ensure that resources were used efficiently. Too often firefighters or junior officers acted on their own initiative, resulting in confusion and duplication of effort. In many cases instructions to crews deployed into the building were not carried out because firefighters came across people needing help and departed from their instructions in order to carry out what they regarded as a more important task. **I therefore recommend:**
- a. that the LFB develop policies and training to ensure better control of deployments and the use of resources;
 - b. that the LFB develop policies and training to ensure that better information is obtained from crews returning from deployments and that the information is recorded in a form that enables it to be made available immediately to the incident commander (and thereafter to the command units and the control room).
- 33.19 LFB policies recognise that regular communication between the control room and the incident commander and between the incident commander and the bridgehead are essential to successful firefighting and rescue operations, particularly when dealing with large-scale incidents. However, at Grenfell Tower there was no regular communication between the control room and the incident commander or between the incident commander and the bridgehead. **I therefore recommend** that the LFB develop a communication system to enable direct communication between the control room and the incident commander and improve the means of communication between the incident commander and the bridgehead.
- 33.20 The methods used for transmitting from the control room to the bridgehead information about people needing rescue were disorganised and the line of communication was too extended. The arrangements for receiving and recording that information at the bridgehead were prone to failure and there was little, if any, means of capturing and transmitting to the control room information about the results of deployments to specific flats. **I therefore recommend** that the LFB investigate the use of modern communication techniques to provide a direct line of communication between the control room and the bridgehead, allowing information to be transmitted directly between the control room and the bridgehead and providing an integrated system of recording FSG information and the results of deployments.

11 Equipment

- 33.21 Some of the equipment in use by the LFB, in particular the radio equipment, was unreliable or in some cases failed to work at all. **I therefore recommend:**
- a. that the LFB urgently take steps to obtain equipment that enables firefighters wearing helmets and breathing apparatus to communicate with the bridgehead effectively, including when operating in high-rise buildings;

- b. that urgent steps be taken to ensure that the command support system is fully operative on all command units and that crews are trained in its use.

12 Evacuation

33.22 There were no plans in place for evacuating Grenfell Tower should the need arise.

I therefore recommend:

- a. that the government develop national guidelines for carrying out partial or total evacuations of high-rise residential buildings, such guidelines to include the means of protecting fire exit routes and procedures for evacuating persons who are unable to use the stairs in an emergency, or who may require assistance (such as disabled people, older people and young children);
- b. that fire and rescue services develop policies for partial and total evacuation of high-rise residential buildings and training to support them;
- c. that the owner and manager of every high-rise residential building be required by law to draw up and keep under regular review evacuation plans, copies of which are to be provided in electronic and paper form to their local fire and rescue service and placed in an information box on the premises;
- d. that all high-rise residential buildings (both those already in existence and those built in the future) be equipped with facilities for use by the fire and rescue services enabling them to send an evacuation signal to the whole or a selected part of the building by means of sounders or similar devices;
- e. that the owner and manager of every high-rise residential building be required by law to prepare personal emergency evacuation plans (PEEPs) for all residents whose ability to self-evacuate may be compromised (such as persons with reduced mobility or cognition);
- f. that the owner and manager of every high-rise residential building be required by law to include up-to-date information about persons with reduced mobility and their associated PEEPs in the premises information box;
- g. that all fire and rescue services be equipped with smoke hoods to assist in the evacuation of occupants through smoke-filled exit routes.

13 Personal fire protection

33.23 It has been suggested by some core participants that every flat and every public space in a high-rise residential building should be equipped with a fire extinguisher and that a fire blanket should be present in every kitchen. It has also been suggested that hose reels and fire buckets containing water or sand should be kept in the public parts of all such buildings.

33.24 On the face of it there is much to be said in favour of householders obtaining fire blankets and fire extinguishers for their own use and if they live in high-rise buildings a strong argument can be made that such equipment, if appropriately used, may provide protection not only to the occupants of the flat in which a fire occurs but to the occupants of the building as a whole. However, the view of many is that people should not be encouraged to fight fires themselves but should leave the building as quickly as possible and call the fire and rescue service. None of the experts supported the provision of fire extinguishers, hose reels or fire

buckets, which, in my view, provide obvious potential for misuse. The government publishes advice on fire safety in the home and neither the evidence nor the scope of the investigations in Phase 1 provides a basis for the suggested recommendation.

14 Sprinkler systems

- 33.25 The coroner who conducted the inquests arising out of the Lakanal House fire heard evidence about the installation of sprinklers and recommended that the government encourage housing providers responsible for high-rise buildings containing multiple domestic premises to consider fitting them. It is not surprising, therefore, that some core participants have urged me to go a step further and to recommend that such systems be installed in all existing high-rise residential buildings.
- 33.26 Sprinkler systems no doubt have a very valuable part to play in the overall scheme of fire safety measures, but whether such a system would be likely to have suppressed the fire in Flat 16 or prevented it from escaping into the cladding before the firefighters could extinguish it is not something that was investigated in Phase 1. I have therefore heard no evidence about the use of sprinklers generally, their effectiveness under different conditions, or about the cost and disruption that would be caused by installing them in existing buildings. In those circumstances I cannot make any recommendation at this stage about the installation of sprinklers in existing buildings, although the government's response to previous recommendations will form an important part of the investigation to be carried out at Phase 2.

15 Internal signage

- 33.27 The landings in the staircase at Grenfell Tower were not clearly marked with the relevant floor number and where floor numbers were marked they did not reflect the additional floors created during the refurbishment. As a result, firefighters were unable to identify floors clearly when carrying out firefighting or search and rescue operations within the building. **I therefore recommend** that in all high-rise buildings floor numbers be clearly marked on each landing within the stairways and in a prominent place in all lobbies in such a way as to be visible both in normal conditions and in low lighting or smoky conditions.
- 33.28 The evidence put before me in Phase 1 indicates that many occupants of Grenfell Tower were unable to read or understand the fire safety instructions placed in the lobbies throughout the building. Such information is important because it helps to save lives. In the case of Grenfell Tower, fire safety advice was prominently displayed in the lobbies, but it was written only in English, despite the fact that many of the occupants were unable to read English easily or at all. These considerations apply to residential buildings of all kinds containing separate dwellings. **I therefore recommend** that the owner and manager of every residential building containing separate dwellings (whether or not it is a high-rise building) be required by law to provide fire safety instructions (including instructions for evacuation) in a form that the occupants of the building can reasonably be expected to understand, taking into account the nature of the building and their knowledge of the occupants.

16 Fire doors

- 33.29 In Phase 2, the Inquiry will investigate the extent to which at the time of the fire the entrance doors to the flats in Grenfell Tower complied with the relevant legislative requirements and, to the extent that they did not, will investigate the reasons for that failure. However, it has already become apparent from the evidence obtained in Phase 1 that ineffective fire doors allowed smoke and toxic gases to spread through the building more quickly than should have

been possible. One important reason why fire doors failed to perform their essential function was the absence of effective self-closing devices, some of which were broken or had been disabled or removed. Fire doors play an essential role in preventing or inhibiting the spread of smoke and toxic gases and in preserving effective compartmentation of buildings. In many cases they are critical to saving life. **I therefore recommend:**

- a. that the owner and manager of every residential building containing separate dwellings (whether or not they are high-rise buildings) carry out an urgent inspection of all fire doors to ensure that they comply with applicable legislative standards;
- b. that the owner and manager of every residential building containing separate dwellings (whether or not they are high-rise buildings) be required by law to carry out checks at not less than three-monthly intervals to ensure that all fire doors are fitted with effective self-closing devices in working order.

33.30 Effective fire doors are particularly important in those high-rise buildings that are exposed to an increased risk of fire because the external walls currently incorporate unsafe cladding. Among the experts, views differ about the desirability of requiring existing fire doors to be brought up to modern standards and if necessary be replaced with doors that comply with the requirements currently in force in relation to new buildings. However, the importance of fire doors in maintaining compartmentation and protecting parts of the building other than that in which a fire has occurred is plain and in my view justifies the expense that would inevitably be incurred. **I therefore recommend** that all those who have responsibility in whatever capacity for the condition of the entrance doors to individual flats in high-rise residential buildings, whose external walls incorporate unsafe cladding, be required by law to ensure that such doors comply with current standards.

17 Co-operation between emergency services

33.31 A point of concern that has emerged from the evidence heard in Phase 1 is that the emergency services failed to co-ordinate with each other and share information as intended, particularly during the early phases of the incident. Most seriously, each declared a Major Incident without immediately informing the others that it had done so. These failures represent weaknesses in the arrangements under which Category 1 Responders are to work together in response to a serious incident. **I therefore recommend** that the Joint Doctrine be amended to make it clear:

- a. that each emergency service must communicate the declaration of a Major Incident to all other Category 1 Responders as soon as possible;
- b. that on the declaration of a Major Incident clear lines of communication must be established as soon as possible between the control rooms of the individual emergency services;
- c. that a single point of contact should be designated within each control room to facilitate such communication;
- d. that a “METHANE” message should be sent as soon as possible by the emergency service declaring a Major Incident.

- 33.32 The MPS and the LAS have access to each other's CAD logs but neither was accessible to the LFB. Co-operation between the emergency services would be improved if the LFB had access to the CAD logs of the MPS and LAS. **I therefore recommend** that steps be taken to investigate the compatibility of the LFB systems with those of the MPS and the LAS with a view to enabling all three emergency services' systems to read each other's messages.
- 33.33 Although an NPAS helicopter was deployed to observe the development of the fire, the pictures it transmitted could not be viewed by the LFB because the encryption was incompatible with its receiving equipment. Incident commanders and CROs responding to emergency calls might have been assisted by seeing those pictures and in any event they should be available to fire and rescue services as a matter of routine. **I therefore recommend** that steps be taken to ensure that the airborne datalink system on every NPAS helicopter observing an incident which involves one of the other emergency services defaults to the National Emergency Service user encryption.
- 33.34 Many people had difficulty in establishing the whereabouts of friends and relatives who had been taken to hospital after escaping from the building. It is important that in the aftermath of a disaster people are able to ascertain as quickly as possible where their loved ones are and are able to make contact with them. **I therefore recommend** that the LFB, the MPS, the LAS and the London local authorities all investigate ways of improving the collection of information about survivors and making it available more rapidly to those wishing to make contact with them.

18 Other matters

- 33.35 Some of the core participants suggested that I should make recommendations on a range of other matters, including amendments to the Regulatory Reform (Fire Safety) Order 2005 to ensure that it applies to the external walls of residential buildings and the testing and certification of building materials. Although they are all matters of potential importance, none of them were examined in the course of Phase 1 and cannot therefore be the subject of recommendations in this report.

Chapter 34

Looking Ahead to Phase 2

1 Introduction

34.1 Having completed Phase 1 of the Inquiry it is useful to look ahead briefly to Phase 2 to identify some areas that will be of particular interest and importance and some that will not now call for investigation to the degree previously thought likely. Most of the questions on which attention will be focused closely relate to the building itself, but it is appropriate to begin with a reminder that important work remains to be done in order to complete the Inquiry's findings about the circumstances in which the deceased lost their lives.

2 The deceased

34.2 At the beginning of the Inquiry I expressed the hope that I would be able in due course to make sufficient findings about those who died and the circumstances in which they met their deaths to make it unnecessary for the coroner to resume the investigations which she opened in 2017. I had hoped to be able to make findings in this report in relation to all those matters, save for the wider circumstances that would in any event be the subject of investigation in Phase 2. However, although it has been possible for me to find many of the relevant facts, it has become clear that some aspects of the circumstances in which the deceased met their deaths require a more detailed examination of the evidence than has yet been possible. Within Phase 2 there will therefore be an examination of the evidence relating to the circumstances in which the deceased met their deaths generally with a view to making the findings which the coroner requires.

3 The remaining scope of Phase 2

34.3 I decided to begin the Inquiry with an investigation of the events which occurred during the night of the fire because only a detailed understanding of what had happened would enable me to identify effectively those aspects of the design, construction and management of the building that were primarily responsible for the disaster. As a result of the investigations carried out in Phase 1 it has become clear that some aspects of the building played a more significant role than others in bringing about the events which occurred on 14 June 2017.

34.4 Since the primary cause of the rapid spread of fire up, around and down the building was the use of ACM rainscreen panels with a polyethylene core, to which the use of combustible insulation contributed, the principal focus of Phase 2 will be on the decisions which led to the installation of a highly combustible cladding system on a high-rise residential building and the wider background against which they were taken. However, a number of other matters have emerged from the evidence gathered in Phase 1 which, although not yet fully explored (and therefore not capable of being the subject of findings at this stage), also give rise to significant concern and call for more detailed investigation. I identify below some of those that I consider particularly important, but must emphasise that it is not an exhaustive list.

4 Matters of particular concern

The London Fire Brigade

- 34.5 In the preceding chapters of this report I have referred to a number of respects in which the performance of the LFB fell below the standards set by its own policies or national guidance. In the case of the control room, there were signal failures to comply with policies that had been recently introduced or modified in response to criticisms of its performance in connection with the Lakanal House fire, giving rise to justified concern that the LFB as an institution had failed to learn or put into practice the lessons of that event. The need for regular active communication between the control room and the incident ground to exchange information about the development of the fire, although required by policies PN633 and PN790, appears to have been routinely ignored. There appears to have been a failure properly to understand the risk of cladding fires in high-rise buildings, despite the fact that by 2017 many buildings of a similar kind in other countries had suffered fires in cladding, some of which had been well publicised. Although some senior officers in the LFB had become aware of the risk, as appears from the *Tall Building Facades* presentation, there had been no attempt to disseminate the information to potential incident commanders and no attempt to equip them with the knowledge or skills needed to recognise and respond to such fires. Questions have also been raised about the LFB's understanding of the nature of the obligation imposed by section 7(2)(d) of the 2004 Act and its approach to discharging it. In that context, as in many others, there appears to have been a significant divergence between policy and practice.
- 34.6 These and other shortcomings described earlier in this report raise far-reaching questions about the LFB as an organisation. Some may question whether its training is adequate in the light of experience; others may question whether it is capable of learning from its mistakes. No conclusion can be reached on questions of that kind at this stage because there has been no examination of the way in which the LFB is managed and no opportunity to question those who are responsible at the highest level for its operations about these apparent shortcomings. However, they are matters of the greatest importance to all who live and work in the capital and will be an important aspect of Phase 2 of the investigation.

Testing and certification of materials

- 34.7 In the light of the expert evidence, in particular Dr Barbara Lane's supplemental report, there are already grounds for thinking that the current regime for testing the combustibility of materials and cladding systems, particularly those chosen for use in high-rise buildings, may be neither as rigorous nor as effectively enforced as it should be. Doubts have also arisen about the reliability of the certification of certain materials for use in high-rise buildings. Grave concern inevitably arises simply from the fact that it was possible for highly combustible materials to be used for the purposes of refurbishing and cladding a building like Grenfell Tower. How that was possible is a question that may be relevant to many aspects of the construction industry, including manufacturers of products currently widely available on the market. Pending further investigation it would clearly be sensible for anyone who is responsible for the fire safety of an existing building or who is considering the use of products on high-rise buildings to scrutinise the information about them provided by the manufacturers and exercise considerable care to ensure that they meet the required standards. These concerns extend to the adequacy of the regulations themselves, the quality of the official statutory and non-statutory guidance currently available, the effectiveness of the tests currently in use, the

arrangements for certifying the compliance of materials with combustibility criteria and the manner in which materials are marketed. They are questions that will lie at the heart of the Inquiry's investigations in Phase 2.

Design and choice of materials

- 34.8 A number of aspects of the design of the refurbishment and the choice of materials will need to be examined. The choice of ACM panels with a polyethylene core, the choice of combustible insulation and XPS window infill panels, a design which incorporated many vertical channels and the decision to incorporate an architectural crown composed of ACM fins, all of which made a major contribution to the extent of the fire, are just examples. An examination of the relevant building regulations and the guidance to the construction industry published by the government in support of them will form an important part of this aspect of the Inquiry's work.

Fire doors

- 34.9 In her supplemental report Dr Lane drew attention to serious questions that arise in relation to the fire doors throughout the tower, both the entrance doors to individual flats opening into the lobbies and the doors opening from the lobbies into the stairs. In Phase 2 it will be necessary to investigate whether those doors complied with the regulations and guidance applicable at the time they were installed, whether they were able to provide appropriate protection against the spread of fire and smoke and if not, why that was so. There is evidence that in many cases self-closing devices were broken or had been disconnected, rendering the doors useless if left open in an emergency. It will be necessary to investigate how that situation came about and why it was allowed to continue.

Window arrangements

- 34.10 As part of the refurbishment the windows were moved outwards so that they no longer sat flush with the original concrete wall but flush with the new cladding system. That alteration, together with the materials used in creating the window surrounds, created certain weaknesses to which Dr Lane and Professor José Torero drew attention. In particular, the use of uPVC in close proximity to combustible insulation and other materials of a combustible nature made it possible for the fire to escape into the cladding from its original location in the kitchen of Flat 16. The design of the window arrangements will therefore be another important focus of investigation in Phase 2.

Lifts

- 34.11 The lifts in Grenfell Tower appear to have been designed as "fire lifts" and lacked some of the protective features such as a secondary power supply, water ingress protection, or FD60 performance for the lift landing doors which would be present in "firefighting lifts".² They did, however, include a "fireman's switch", which should have enabled the firefighters to take control of them and prevent further use by the occupants of the building. In the event, the firefighters were unable to take control of the lifts, but they were able to use them in their normal mode of operation to take crew and equipment up to the bridgehead on floor 2.³ It does not appear, therefore, that their inability to take control of the lifts significantly affected their operations, but the lifts remained available for use by occupants, as described earlier, in

² Dr Lane explained the difference between a "firefighter lift" and a "fire lift" at p. 116 in her presentation on 18 June 2018. Refer also to [BLAS0000033] p. 7, 10 Figs. L1 and L2.

³ Dr Lane supplemental report [BLAS0000019] p. 25 19.5.71.

some cases with fatal consequences. Given the importance of such equipment to safety in a high-rise building, it is necessary in Phase 2 to investigate whether the lifts were appropriately maintained and, in particular, why the fireman's switch apparently did not work properly on this occasion.

Smoke extraction system

- 34.12 Suggestions have been made that the smoke extraction system failed to operate in accordance with its design and even contributed to the spread of smoke between different floors of the building. Systems of this kind are an integral part of the fire safety measures in most, if not all, high-rise buildings. Although the system at the tower was designed to operate on only one floor and was not intended to deal with smoke extraction on multiple floors at the same time, it is important to understand whether, in this case, it was capable of operating in accordance with its design and whether it did so. These questions will therefore form part of the investigation in Phase 2.

The warnings of the local community and the authorities' response to the disaster

- 34.13 From the outset members of the local community have said that they warned the TMO on many occasions about fire hazards, both those arising from the refurbishment and more generally. There is a strong feeling among them that their voices were ignored and that if attention had been paid to them the disaster could have been avoided. There is also a strong view in many quarters that in their response to the disaster the authorities failed the community by not providing adequate support in the days immediately following the fire. These are both important matters for further investigation in Phase 2, not least because they reflect what is said to be a general lack of concern on the part of the authorities for the residents of the tower and the wider community.

5 Matters no longer requiring investigation

Stairs

- 34.14 A question was raised about the width of the stairs, given that they provided the sole means of access to the upper floors of the tower for firefighters as well as the sole means of escape for the occupants. However, the stairs appear to have complied with requirements of the legislation in force at the time of their construction and the expert evidence supports the conclusion that they had sufficient capacity to enable all the occupants of the building to escape within a reasonable time. This aspect of the building will not, therefore, be the subject of further investigation in Phase 2.

Gas

- 34.15 It was thought at one time that the supply of gas to the tower might have played a significant part in the outbreak and development of the fire, but as a result of the investigation carried out in Phase 1 it has become clear that that was not the case. Although the supply of gas allowed fires within individual flats to continue to burn until it was shut off at 23.40 that day, its contribution to the fire which consumed the tower appears to have been minimal. However, some works associated with the installation of the new gas riser were incomplete and may have contributed to the spread of smoke. In those circumstances it will be necessary at Phase 2 to consider whether the installation of the gas services complied with the relevant regulatory regime, but the focus of those investigations can be relatively narrow.

Electricity

- 34.16 There was a widespread suspicion, based on events that were said to have occurred in 2013, that the fire had been caused by a surge in the supply of electrical power to the building. In the event, no evidence has emerged to support that suspicion and I am confident that the true cause of the initial outbreak of fire has been correctly identified in Chapter 21. As a result, I do not think it necessary to undertake any further investigation into that aspect of the matter.

Grenfell Tower Inquiry

UPDATED LIST OF ISSUES

GENERAL NOTE

This list is intended as a guide to the issues on which the Inquiry's investigations will focus. It is not a prescriptive list and is not to be understood as a pleading or statement of case. The Inquiry's investigations may uncover the need to address further issues within its terms of reference but not contained in this list. Accordingly, the issues in this list may be subject to revision during the course of the Inquiry.

THE ISSUES

1) Grenfell Tower's original design, construction, composition (completed 1974)

- (a) What was its design, construction and composition?
- (b) What were the relevant contemporaneous building regulations, fire regulations, other legislation, guidance and industry practice?
- (c) Did Grenfell Tower, as originally constructed, comply with all such relevant regulations, legislation, British Standards, guidance and industry practice?
- (d) What assessments and decisions were made about such compliance and by whom?

2) Subsequent modifications prior to the most recent

- (a) In respect of each relevant later modification:
 - (i) What was the nature and extent of the modification?
 - (ii) What was the purpose of the modification?
 - (iii) What was the design and construction of the modification?
 - (iv) What were the relevant contemporaneous building regulations, fire regulations, other legislation, guidance and industry practice?

- (v) Did Grenfell Tower, as modified, comply with all such relevant contemporaneous regulations, legislation, British Standards, guidance and industry practice?
- (vi) What assessments and decisions were made about such compliance and by whom?

3) Modifications to the interior of the building 2012-2016

- (a) What modifications were made to the inside of the building?
- (b) Who made these modifications?
- (c) What was the reason for the modifications?
- (d) What were the regulations, legislation, British Standards, guidance etc. that applied to the modifications throughout the period from initial design to completion and approval.
- (e) Were the modifications compliant with such regulations, legislation, British Standards (including testing requirements), guidance etc.
- (f) If so, were any of those inadequate and if so in what respects?
- (g) If not, what elements or aspects of the interior of the building at the time of the fire failed to comply with what elements or aspects of what regulations, legislation, British Standards, guidance, industry practice, and in each case to what extent?
- (h) Why did each such failure occur?
- (i) Who was responsible for such failures?
- (j) To what extent did the design and construction of the modifications to the interior of the building take account of the design and construction of the modifications to exterior of the building? If it did not, in what respects did it not and why not?
- (k) What advice or information was available, and what assessments were made, about the components that comprise the interior of the building, their fire safety, fire-resistance and compliance with safety standards (including information or advice from manufacturers of relevant components)?
- (l) Was specific consideration given to the combination of the interior components (e.g. fire-doors, other fire-breaks, ventilation systems, dry or wet risers or the absence of the same, stairways and access) and the fire safety, fire-retardancy and compliance with safety standards of the same?

- (m) What decisions about the interior of the building were made, by whom and when?
- (n) What was the chain of decision-making, communication and responsibility about those matters?
- (o) What factors or motives influenced the decisions about the interior of the building?
- (p) What if any assessments were carried out to balance such factors or motives with the safety of the residents?
- (q) If such assessments were carried out, who carried them out, when and what did they conclude?

4) Modifications to the exterior of the building 2012-2016 (including cladding and insulation)

- (a) What was the purpose of the cladding/insulation to the exterior of the building?
- (b) What was its design, manufacture, composition and method of fixing to the building?
- (c) To what extent did the design and construction of the modifications to the exterior of the building take account of the design and construction of the interior of the building? If it did not, in what respects did it not and why not?
- (d) Was the exterior of the building (including the cladding, insulation, fixings and windows) compliant with relevant building regulations, fire regulations, other legislation, British Standards (including testing requirements), guidance and industry practice?
- (e) To the extent that it was compliant with such regulations, legislation, British Standards, guidance etc. were any of those inadequate and if so in what respects, so far as relevant to the nature and immediate causes of the fire and its spread?
- (f) If not compliant in any respect, what elements or aspects of the exterior of the building at the time of the fire failed to comply with what elements or aspects of what regulations, legislation, British Standards, guidance, industry practice, and in each case to what extent?
- (g) Who was responsible for such failures?
- (h) What advice or information was available, and what assessments were made, about the components that comprised the exterior of the building, their fire

- safety, fire-resistance and compliance with safety standards (including information or advice from manufacturers of relevant components)?
- (i) Was specific consideration given to the combination of the exterior components (e.g. cladding, insulation, windows, and methods of fixing) and the fire safety, fire-retardancy and compliance with safety standards of the same?
 - (j) How commonly used are:
 - (i) these particular cladding panels;
 - (ii) this type of insulation;
 - (iii) any other relevant parts of the exterior e.g. fixings/windowsin the UK and elsewhere and are there relevant lessons to be learned from the use/regulation of such matters elsewhere?
 - (k) What decisions about the exterior of the building (i.e. cladding, insulation, fixings and windows) were made, by whom and when?
 - (l) What was the chain of decision-making, communication and responsibility about the cladding, insulation, windows and fixings?
 - (m) What factors or motives influenced the decisions about the exterior of the building?
 - (n) What if any assessments were carried out to balance such factors or motives with the safety of the residents?
 - (o) If such assessments were carried out, who carried them out, when and what did they conclude?

4A. Testing, certification and classification – exterior wall materials

- (a) What testing and/or certification and/or classification had occurred in respect of the exterior wall materials at Grenfell Tower, including the cladding and insulation?
- (b) Was any such testing and/or certification and/or classification adequate and appropriate?
- (c) Is the testing, certification and classification regime for external wall materials fit for purpose?

5) The fire and safety measures within the building at the time of the fire

To the extent that the following issues are not covered by the issues set out under Section 4 above:

- (a) What were the fire resistance, prevention, mitigation, evacuation and other fire safety measures (“fire safety measures”) in place at the time of the fire?
- (b) Were the fire safety measures compliant with relevant building regulations, fire regulations, British Standards, other legislation, guidance and industry practice?
- (c) To the extent that the fire safety measures were compliant with such regulations, legislation, British Standards, guidance etc. were any of those inadequate and if so in what respects, so far as relevant to the nature and immediate causes of the fire and its spread?
- (d) If the fire safety measures were not compliant, what elements or aspects of the fire safety measures in place in the building at the time of the fire failed to comply with what elements or aspects of what regulations, legislation, British Standards, guidance, industry practice, and in each case to what extent?
- (e) Why did each such failure occur?
- (f) Who was responsible for such failures?
- (g) What fire risk assessments had been made in relation to Grenfell Tower in the period January 2012-June 2017, including specifically at all times during the most recent modifications?
- (h) What reports or conclusions are available concerning the same and what do they say?
- (i) In what ways was the building intended to be resistant to the spread of fire?
- (j) What was assumed (if anything) about the resistance of the building to the spread of fire?
- (k) Were any checks or assessments or inspections made as to whether the actual condition of the building matched any assumptions made?
- (l) What was the nature of such checks or assessments or inspections and who carried them out?
- (m) What decisions about fire safety measures were made, by whom and when?
- (n) What was the chain of decision-making, communication and responsibility about those matters?
- (o) To what extent did the relevant persons or organisations responsible for the fire safety of occupants of Grenfell Tower communicate with one another about their knowledge of the building and the decisions they were making?
- (p) Was any consideration given to the evacuation of disabled and other vulnerable residents, and if so, was adequate provision made for them?

- (q) What factors or motives influenced the decisions about the fire resistance, prevention, mitigation and safety measures?
- (r) What if any assessments were carried out to balance such factors or motives with the safety of the residents?
- (s) If such assessments were carried out, who carried them out, when and what did they conclude?
- (t) What advice was given to those responsible for fire safety in Grenfell Tower and how did they respond to that advice?

6) Inspections

- (a) What fire and other relevant inspections (including building control inspections) were carried out:
 - i. During the recent renovations; and
 - ii. Between the completion of the recent renovations and the fire?
- (b) What were the relevant conclusions/reports from those inspections and by whom were they carried out?
- (c) Pursuant to what criteria were such inspections carried out, how frequently and by what personnel?
- (d) Were the inspections compliant with all relevant standards?
- (e) Were the fire and other safety inspections system (including any criteria applied) reasonably fit for purpose?
- (f) Who carried out the inspections, how were they trained and were they competent to do so?
- (g) What was the system for implementing conclusions/recommendations following such inspections?
- (h) Was that system operated properly or at all?

7) Governance/Management

- (a) What was the legal relationship between the different persons and organisations who were responsible for fire safety at Grenfell Tower as at 14 June 2017?
- (b) As at that date how did the relationships between the different persons and organisations who were responsible for fire safety at Grenfell Tower work in practice?

- (c) As at that date had any other fires taken place at Grenfell Tower or other similar buildings under the authority of RBKC?
- (d) If so, were any investigations, reports or lesson-learning exercises carried out? What did they conclude?
- (e) Were any recommendations made? If so, were they implemented? If they were not implemented, who was responsible for that decision and what reasons did they have?

8) Communications with residents

- (a) What system was there, if any, for residents to express their concerns and views about fire safety?
- (b) What channels of communication did it provide?
- (c) Was there a formal system for recording concerns and addressing them?
- (d) What concerns, warnings and other statements were expressed about the fire safety of Grenfell Tower by its residents or any other person before, at the time of or after the recent renovations?
- (e) How and to whom were any such complaints expressed?
- (f) What was done in response to such expressed concerns?
- (g) What provisions, if any, were put in place to ensure that those with language or other special needs could send and receive communications to and from the TMO and the Council about matters of fire safety or safety more generally?

9) Fire advice to residents 2012 to 14 June 2017

- (a) What advice was given to residents about fire precautions?
- (b) How was that advice communicated and by whom?
- (c) What provisions were in place to ensure that that advice had been received and understood by residents?
- (d) What was the basis of the advice?
- (e) Was the advice appropriate and consistent with the then current fire safety standards and practice for high-rise residential buildings in general, and in particular where used for social housing?
- (f) Was the advice periodically reviewed and if so by whom and on what basis?
- (g) What were the conclusions resulting from any such review and were they implemented?

- (h) Were there any evacuation plans in place and, if so, what were they?
- (i) Who drew them up?
- (j) Were they independently reviewed, and if so, by whom, when and with what conclusions?

10) Response to Recommendations

- (a) What recommendations, including from inquiries, inquests, investigations, experts, professional and trade bodies and Parliamentary Committees were relevant to the risk of fire at Grenfell Tower as at 14 June 2017 given its composition and occupancy?
- (b) Were appropriate steps taken by central and local government and other relevant bodies to act upon such recommendations insofar as they were relevant to the risk of fire in high-rise residential buildings?
- (c) Specifically, what steps were taken by the Ministry of Housing, Communities and Local Government and the London Fire Brigade or any other body to implement the recommendations of the coroner following the Lakanal House inquest?
- (d) If and to the extent that any such recommendations were not implemented, what were the reasons for not implementing them?
- (e) To what extent did any failure to implement any of these recommendations cause or contribute to the manner and speed of the spread of the fire at Grenfell Tower, the extent of the damage and the number of casualties?

11) The fire

- (a) What was the cause and seat of the fire?
- (b) How did the fire progress and what contribution to its progress was made by
 - (i) the construction of the exterior walls and surfaces, openings to them and internal structures abutting them,
 - (ii) the internal structure and condition of the building (including, for example, stairwells, shafts, vents, cavities, fire-stopping, and pipework), or
 - (iii) other factors, including the effectiveness or lack of effectiveness of fire safety measures?
- (c) What information can be obtained from the experience of fires in high-rise residential buildings in other countries? In particular

- (i) Have there been comparable fires in high-rise buildings in other countries?
- (ii) If so, what was the nature of the construction of those buildings?
- (iii) Did the extent of the loss of life or damage to property in those cases differ?
- (iv) If so, why?

12) The response of the emergency services

- (a) What plans and strategies did the fire and rescue service have for dealing with a major fire in a high-rise residential building?
- (b) What training and equipment did fire officers have for dealing with a major fire in a high-rise residential building?
- (c) Did the fire service have adequate access to the building?
- (d) What actions were taken on the night of 14 June 2017 to fight the fire, including:
 - (i) First calls and responses;
 - (ii) Assembly of strategy, command and control;
 - (iii) Co-ordination with occupants of Grenfell Tower and other services during and immediately after the fire, including the establishment of radio communication channels;
 - (iv) The application of any “stay-put” policy and any change to a “get out and stay out” policy;
 - (v) The methods of rescuing individual residents;
 - (vi) Steps taken to communicate with residents in the Tower.
- (e) Were the fire services hampered in their fire-fighting plans and strategies, and if so by what and to what extent? In particular, to what extent was water pressure adequate to allow the LFB to fight the fire effectively?
- (f) What, if any, aspects of the access to and construction and fire prevention features of Grenfell Tower affected the proper execution of the (or any) fire-fighting, rescue and evacuation strategy?
- (g) The adequacy of the LFB’s actions (including the application of the “stay-put” policy) respectively referred to in (a), (b) and (d) above.

13) The aftermath

- (a) What policies, procedures and plans were in place on the part of the Tenant Management Organisation, central and local government for dealing with a major emergency such as the Grenfell Tower fire?
- (b) What was the response of the Tenant Management Organisation, central and local government by way of the provision of emergency relief in the days immediately following the fire?
- (c) Was the response adequate and if not, in what respects was it inadequate?

Dated September 2019

Briefing Note

Title: Private Tower Blocks in Wolverhampton

Date: 23 January 2020

Prepared by: Jagtar Singh Job Title: Programme Manager

Intended Audience: Internal Partner organisation Public Confidential

1. Purpose or recommendation

Provide an update on fire safety matters relating to the privately-owned tower blocks in Wolverhampton.

2. Overview

In May 2018, the MHCLG issued a directive to local authorities to monitor and manage housing conditions in their area, with a specific focus on fire safety in public and privately-owned high-rise residential buildings over 18m in height.

The directive mandated all local authorities to:

- Maintain records of high rises over 18m and notify the MHCLG
- Review fire safety of all high-rise buildings, including carrying out inspections and hazard assessments
- Take enforcement action on private bodies and keep records of actions taken

Within Wolverhampton there are 42 residential high-rise blocks falling within the directive and/or National Building Safety Programme. 36 of these blocks are owned by City of Wolverhampton Council (CwC) (freehold) and managed by Wolverhampton Homes. Of the remaining six, five are privately owned and one is owned by CwC (freehold) and on long-term lease management arrangement to Sanctuary Housing Group.

The response of the Council to the MHCLG directive has been significant, based on feedback from building owners and managing agents, many of which own or manage high rise blocks in several different local authority areas, Wolverhampton is ahead of other Councils in its work to ensure the safety of those living in high rise buildings. The Programme Team leading the work has been complimented on its proactive approach by a key external stakeholder.

High-rise fire safety is planned and overseen by the Safer High-Rise Homes Group established in May 2018, the group has coordinated a programme of fire safety inspections of the privately-owned blocks. This has involved close collaboration with West Midlands Fire Service to ensure that there is a coherent approach to planning of any enforcement action, carrying out remedial works and communication with the various stakeholders including residents.

A Programme Manager has been appointed to provide coordination of the group. The Safer High-Rise Homes Group reports into the Fire Safety Compliance Group, Housing and Assets Leadership Team and provides updates to the Leader, Members and SEB as required.

3. Background and context

The table below provides an outline of the status of fire safety inspections in each of the privately-owned blocks.

High Rise Details	Status of Fire Safety Inspection and Follow on Activity
<p>Liberty Heights Blocks A, B and C Culwell Street, Wolverhampton, WV10 0JT</p> <p>Built circa 2009 Purpose built student accommodation, concrete and steel frame modular building system.</p> <p>The student accommodation is spread across 3 blocks (A, B and C) with a total of 657 en-suit bedrooms formed into 142 cluster flats with shared kitchen/Lounge and 3, 4 or 5 bedrooms per flat.</p>	<p>Fire safety inspection report issued August 2019. The Property Services Team of the freeholder has carried out a site visit to consider the inspection findings, awaiting its plan for carrying out remedial actions.</p> <p>WMFS carried out a routine visit in December and found no areas for concern.</p>
<p>The Studios 24 Birch Street, WV1 4HY</p> <p>Former office block, under refurbishment.</p>	<p>Fire safety inspection report issued April 2019. The Business Manager has advised that the remedial actions have been carried out. Will be arranging a follow-on inspection.</p>
<p>Hampton View Woden Road, Heath Town, WV10 0PE</p> <p>Built circa 1960, 22 floors, single staircase, comprising 107 flats no gas within block. CwC owned, on long term lease to Sanctuary Housing.</p>	<p>Sanctuary Housing is in process of carrying out extensive refurbishment which has included replacement of fire doors, installation of sprinkler system is planned.</p> <p>A review of the works carried out to date will take place during the spring.</p>
<p>St. Cecelia's Okement Drive, Heath Town, WV11 1XE</p> <p>Built circa 1970, 20 floors, single staircase. Comprising of 114 flats and gas services with block.</p>	<p>Fire safety inspection report issued December 2018, number of issues found.</p> <p>The Council has been liaising closely with WMFS to plan remedial works. This has involved meetings between CwC, WMFS and the managing agent.</p> <p>CwC has commissioned specialist legal guidance to identify liability for costs for fire safety works between the building freeholder, leaseholders and Right to Manage Company.</p> <p>CwC has used its regulatory powers to carry out and fund urgent fire safety works and has agreed with WMFS a schedule for the works which will commence in February and</p>

	complete during the Spring. These works will provide an interim solution until a detailed assessment is complete of the building.
Market Square Apartments Market Square, Wolverhampton WV3	WMFS visiting 28 January with representatives from the council to carry out an initial fire safety audit.

Proposal/Options

Next Steps

1. Continue to work with building freeholders and managing agents at each of the privately-owned blocks to implement the findings of the fire safety inspection reports.
2. To instigate enforcement action against responsible person(s) where there is insufficient progress with remedial works.
3. Ensure that that the Safer High-Rise Programme has an effective stakeholder engagement and communications plan so that residents are informed of the background to the inspection programme, its findings and implications for them as leaseholders, freeholders or tenants.
4. Consider the implications for the privately-owned blocks of the Grenfell Tower Phase 1 report and develop the appropriate plans in readiness for regulatory and legislative developments that will follow.

This page is intentionally left blank