Submission to the Grenfell Tower Inquiry: Building Safety

Sir Bernard Jenkin MP, Chair of the House of Commons Liaison Committee, was also Chair of the Public Administration and Constitutional Affairs Committee (PACAC) (previously known as the Public Administration Select Committee (PASC)) from 2010-2019. First elected MP in 1992, PPS to the Secretary of State for Scotland at the time of the Dunblane incident (1996). He also served as Shadow Transport Secretary at the time of the Ladbroke Grove rail disaster (1999) and the subsequent derailment due to a broken rail at Hatfield (2000).[1] Made a submission to the Cullen Inquiry recommending that there should be a new rail safety regulator and independent accident investigation branch of the Department of Transport.[2] This was the scheme recommended by the inquiry and adopted by the government. Following the inquiry chaired by Sir Robert Francis QC into the Mid Staffordshire NHS Foundation Trust, PASC recommended the government should set up an independent clinical investigation body.[3] Accepted by the government and the Healthcare Service Safety Investigation Branch of the Department of Health (HSSIB) is now operating in shadow form.[4] Draft legislation has been scrutinised by a joint Lords-Commons committee, chaired by Sir Bernard.[5] This is now included in the Health and Social Care Bill, which is now before Parliament.

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[1] https://en.wikipedia.org/wiki/List_of_rail_accidents_in_the_United_Kingdom
[2] Referred to in a speech to the House of Commons on 22 February 2000 - https://publications.parliament.uk/pa/cm199900/cmhansrd/vo000222/debtext/00222-07.htm
[3] PASC report, Investigating Clinical Incidents in the NHS, https://publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf, April 2015.
[4] https://www.hsib.org.uk/
[5] https://publications.parliament.uk/pa/jt201719/jtselect/jthssib/1064/106402.htm

Inspectors Register, 2013-21), the Tideway Reporting Group (2016-21) and Heylo Housing Registered Provider (2017 -21). He is President of the Town and Country Planning Association (since 2015) and has served on the Boards of the Fire Protection Association (2007-19) and Pocket Living (2013-21) and as Deputy Chair of Crossrail Ltd (2019-20).

Keith Conradi was RAF fast-jet pilot (1983-96), Virgin Atlantic Captain (1996-2002), Chief Inspector of Air Accidents Investigation Branch (2010-2016) and Chief Investigator of the Healthcare Safety Investigation Branch (2016-). He was President of the European Society of Air Safety Investigators (2011-2016), Vice-Chair of the European Network of Civil Aviation Safety Investigation Authorities (2010-2016) and Trustee of the Confidential Incident Reporting Programme (2010-2016). He is a Fellow of the Royal Aeronautical Society.

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The authors are submitting this evidence in a personal capacity, and not on behalf of any body or organisation.

1. Introduction

1.1 The Grenfell Tower disaster cost the lives of 72 people and impacted the lives of many more, principally the bereaved, residents and survivors. Additionally, many people still find themselves living in buildings that have been identified as at-risk and await remediation. They face huge uncertainty about the safety of their home and the potential costs of remedial works. If necessary, their ability to move elsewhere is hampered; restrictions apply to mortgage loans on buildings seen as at risk.

1.2 The objective of the Grenfell Inquiry is to address the concerns of the victims, the survivors, and the public. They want to be assured that there will be justice for those who were knowingly at fault and that there cannot be another similar disaster. Phase 2 of the inquiry will examine the causes of the events of the Grenfell disaster, including how Grenfell Tower came to be in a condition that allowed the fire to spread.

1.3 The remit of the inquiry includes "the scope and adequacy of the relevant regulations, legislation and guidance."[6] This refers in particular to paragraphs (i)(b) and (c) of the Terms of Reference proposed by Sir Martin Moore-Bick in his letter to the prime minister:

> (b) the design and construction of the building and the decisions relating to its modification, refurbishment and management;
> (c) the scope and adequacy of the building regulations, fire regulations and other legislation, guidance and industry practice relating to the design, construction, equipping and management of high-rise residential buildings…[7]

1.4 The Building Safety Bill[8] reflects, in large part, the recommendations of the Review commissioned by the government from Dame Judith Hackitt, 'Building a Safer Future', though the government has not accepted all her recommendations.[9] The Bill provides for the

[6] Terms of reference letter from the Prime Minister to Sir Martin Moore-Bick, 15th August 2017 https://www.grenfelltowerinquiry.org.uk/sites/default/files/inline-files/MMB_Letter_-_Grenfell.pdf
[7] Ibid.
[8] Draft Building Safety Bill. 2020. https://www.gov.uk/government/publications/draft-building-safety-bill ;
[9] Hackett Review, Building a Safer Future, May 2018: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/707785/Building_a_Safer_Future_-_web.pdf

establishment of a new Building Safety Regulator (BSR), based in the Health and Safety Executive (HSE).

1.5 The BSR will be responsible for a wide range of activities, including overseeing the safety and performance of all buildings and taking responsibility for building control approval on higher risk buildings, currently defined as buildings of a height of 18 metres or more or comprising more than six storeys.[10] It will also deal with residents' complaints, oversee a new competence regime for people working on buildings, advise on the need for changes to the Building Regulations and oversee and report on the performance of building control bodies.

1.6 In this submission, we have looked carefully at the Hackitt Review recommendations and how they have been interpreted by government. Section 2 of this submission focuses on the investigation of future major incidents. This was not included in the remit for the Hackitt Review. It outlines the flaws with the approach, which is implied by the government's present policy, whereby investigations will be carried out by the HSE or by new public inquiries. We recommend an independent building safety investigation body, based on the Rail Accident Investigation Branch of the Department for Transport, as proposed by Lord Cullen following the Ladbroke Grove crash. In rail and other sectors like aviation, this approach is much quicker, much less costly and more effective than public inquiries. Of critical importance, accident investigation bodies like RAIB command stronger public confidence at the outset than an ad hoc inquiry.

1.7 Section 3 focuses on the building control function. It outlines the lack of empirical data to assess the quality of building control and the legacy of the 1984 Building Act (the last time there was substantial reform). We build on the *Future of Building Control Report*, commissioned by the Ministry of Housing Communities and Local Government, which recommends that approved inspectors (private sector building control) and local authorities (public sector building control) together with the surveyors working in both private and public sectors, should be registered with an independent registration body, separate from the Building Safety Regulator (BSR), but subject to the same rigorous oversight. It recommends

[10] Ibid, paras 2.43-5 and Recommendation 2.11

that the new BSR conducts prosecutions under Section 35 and 36 of the Building Act for all types of buildings, not just high-risk residential buildings.

2. Shortcomings of the present proposals for investigating major incidents

2.1 The terms of reference of the Hackitt Review did not include the investigation function of the regulator. The Building Safety Regulator (BSR) will be part of the Health and Safety Executive (HSE). The relevant legislation is the 1974 Health and Safety at Work Act. Chapter 14 (2) states:

> The Executive may at any time—
> (a)investigate and make a special report on any matter to which this section applies; or
> (b)authorise another person to investigate and make a special report into any such matter.
>
> …The Executive may at any time, with the consent of the Secretary of State, direct an inquiry to be held into any matter to which this section applies.[11]

In practice, the HSE investigates incidents unless a given incident resulted in loss of life and police involvement, in which case there tends to be a public inquiry, which has to be set up for the purpose.

2.2 The Cullen Inquiry following the Ladbroke Grove Rail Accident questioned the suitability of HSE inhouse investigations. Lord Cullen concluded, "it was inappropriate for the safety regulator to carry out the function of investigation since it might be necessary for the investigation to examine the decisions and activities of the safety regulator itself."[12] Some might argue that this need ("for the investigation to examine the decisions and activities of the safety regulator itself") is the exception and not the rule; therefore, a separate and independent investigating body would not be necessary in most cases. However, it is not possible to make an objective judgement about whether the actions or omissions of the regulator played a role in the causes of an incident until the matter has been subject to an independent investigation.

Recommendation 1: The Inquiry should consider the potential for conflicts of interest which may arise if the HSE remains responsible for carrying out the investigation function for building safety in the event of a future major incident, particularly since the HSE board will be responsible for the governance of the Building Safety Regulator.

[11] Health and Safety at Work etc. Act 1974. https://www.legislation.gov.uk/ukpga/1974/37/contents
[12] Ladbroke Grove Rail Inquiry - Part 2 report. https://www.orr.gov.uk/media/10940

The HSE cannot know in advance of its investigation whether the failings of the Building Safety Regulator contributed to the incident in question.

2.3 The legislation enables intermediate forms of investigation between a full judicial inquiry and a standard HSE investigation. The HSE cites the investigation following the Buncefield fire as an example of best practice. After the Buncefield fire, the HSE established the Major Incident Investigation Board (MIIB) jointly with the Environment Agency, under an independent Chair, the late Lord Newton of Braintree. The HSE also established the Buncefield Standards Task Group (BSTG) to recommend urgent regulatory changes ahead of the MIIB Report.[13] The BSTG included representatives of the regulator, industry and trade union bodies. After publishing its report, BSTG became the Process Safety Leadership Group (PSLG), a permanent body. Unlike a public inquiry, where knowledge and experience gathered during the inquiry are subsequently lost, the PSLG maintained institutional knowledge from the investigation and continued to advise the government on future legislation.

2.4 The regulatory environment in residential and commercial property is complicated: different regulators are responsible for different aspects of building safety. Dame Judith Hackitt recommended that a Joint Competent Authority, comprising Local Authority Building Standards, the Fire and Rescue Service, and the HSE, oversee building safety, but the government did not accept this proposal.[14] There is a risk of siloed thinking, whereby each regulator investigates a major incident in isolation from parallel regulators. The Buncefield MIIB presents one way of resolving this cross-sectoral challenge. The MIIB made a series of recommendations regarding emergency planning and how industry and regulators work with the emergency services and other organisations as part of the wider civil response arrangements. [15]

2.5 The Buncefield investigation was politically fraught. The government and regulator resisted pressure for a full judicial inquiry. The regulators argued it was unnecessary because

[13] The Buncefield Major Incident. 11 December 2005. Ten years on A report by the COMAH Strategic Forum. https://www.hse.gov.uk/comah/buncefield/buncefield-10-years-on.pdf
[14] Hackitt Review, 22
[15] Emergency Response and Recovery Non statutory guidance accompanying the Civil Contingencies Act 2004 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/253488/Emergency_Response_and_Recovery_5th_edition_October_2013.pdf

there was no loss of life. The Buncefield MIIB was a compromise but had no formal powers, could not subpoena witnesses, or sequester evidence, and those who gave evidence were not under oath or legally protected in any way. The HSE and Environment Agency inspectors interviewed dutyholders; the MIIB used the evidence to determine the causes of the fire and the regulators to prosecute those responsible. [16] Other models of accident investigation separate these functions; HSE investigations do not. In an appendix to this paper, the local MP for Luton, who led on the Buncefield fire in Parliament, argues that it was inadequate and lacked independence from the HSE (appendix 1). The Buncefield inquiry is an exception that proves the rule: outside pressure forced the regulators to accept a degree of independence through the oversight of an independent chair, but as Sir Mike Penning MP argues, this did not provide sufficient confidence in the independence of the Buncefield inquiry. Other HSE investigations do not reflect the MIIB's cross-sectoral remit.

2.6 The Building Safety Bill defines a "major incident" as "an incident resulting in—(a) a significant number of deaths, or (b) serious injury to a significant number of people". The Grenfell tower fire would be classified as a major incident, as would the Lakanal House and Garnock Court fires, high-rise residential building fires discussed at length in Dame Judith Hackitt's interim report. However, the decision as to when to conduct an independent investigation requires greater consideration than may first appear necessary from such incidents. The number of deaths from fires in non-high-rise homes far exceeds the number who have died in high-rise buildings. Of the 213 fire-related fatalities in dwelling fires in 2016/17 in England, three were in purpose-built flats over ten storeys, 15 were in flats four-to-nine storeys; 195 (92 per cent) were in houses, bungalows, converted flats, or purpose-built flats that were one-to-three storeys.[17] The informal HSE rule, whereby there is an expectation of a full judicial inquiry when there is loss of life, does not, in this case, appear workable. Neither is it appropriate to assume independence from the regulator would only be required for high-rise buildings.

[16] "Chapter 2 Relationship between this report and any legal proceedings". *Buncefield Policy Procedure Report*, 9 https://www.hse.gov.uk/comah/buncefield/policyproceduresreport.pdf

[17] Fires in purpose-built flats, England, April 2009 to March 2017. 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/622114/fires-in-purpose-built-flats-england-april-2009-to-march-2017.pdf

Recommendation 2: The Inquiry should consider whether the HSE should continue to hold responsibility for investigating any major incident, in which it is also seeking to establish blame. The causes of major incidents are also likely to cut across multiple regulator's remits, requiring broader expertise than any single regulator can possess. Given that a far greater number of deaths from fires occurs in buildings not considered high risk, there should be no distinction in investigating major incidents in high-rise buildings and other major incidents that cause or risk serious injury or death.

2.7 As a result of the Cullen Inquiry, the government established the investigation function outside Her Majesty's Railway Inspectorate, under the HSE, with an independently staffed Rail Accident Investigation Branch (RAIB). Cullen drew on the success of the Air Accident Investigation Branch (AAIB) in civil aviation as best practise. In the 1980s, the Department of Transport established the Marine Accident Investigation Branch along the same lines.[18] RAIB improved public safety in the railways.[19] Following the success of these bodies the House of Commons and Public Administration and Constitutional Affairs Committee recommended the installation of a Healthcare Service Safety Investigation Branch (HSSIB). Draft legislation has been subject to pre-legislative scrutiny.[20] The HSSIB Bill passed second reading in the House of Lords in 2019 and is now part of the Health and Social Care Bill, which is before Parliament.

2.8 Like a public inquiry, an accident investigation branch establishes what caused a major incident and makes recommendations to the bodies responsible, usually the regulator. The regulator conducts a parallel investigation to establish responsibility and, if necessary, prosecutes those at fault. The regulator cannot force the accident investigation branch to reveal witness statements, except by High Court intervention. This creates a 'safe space' for those giving evidence, in which witnesses can be completely candid. Nobody can then exploit their openness and honesty against them in court. An accident investigation branch

[18] Marine Accident Investigation Branch. https://www.gov.uk/government/organisations/marine-accident-investigation-branch

[19] Since the Ladbroke Grove Rail Inquiry serious accidents have still occurred, such as the Tebay rail accident (2004: 4 fatalities, 3 injured); the Ufton Nevit collision (2004: 7 fatalities, 71 injured); and the Grayrigg intercity derailment (2007: 1 fatality, 88 injured). However, these incidents were addressed by the newly established machinery and there was little demand for public inquiries, which are much slower, more expensive, and have to acquire all their knowledge for the purpose of that inquiry

[20] Health Service Safety Investigations Bill. https://www.gov.uk/government/publications/health-service-safety-investigations-bill

does not protect witnesses from prosecution and is obliged to inform the police if it suspects any criminal activity, but thereafter plays no role in any subsequent judicial action. The establishment of an independent investigator in the field of building safety need have no impact on the powers and functions of the BSR. An independent investigator is an entirely additional but essential capability.

2.9 Unlike a public inquiry, an accident investigation branch already exists at the time of a major incident. Time is not wasted establishing an ad hoc arrangement, and gaining public acceptance of it, as for Buncefield, or for setting up a public inquiry such as this one. When compared with a public inquiry an accident investigation branch can investigate more incidents at far less cost.[21] After a civil aviation accident, a pilot, an aeronautical engineer, and a human factors analyst visit the scene of the crash, since understanding the causes of an air accident requires the fullest understanding of all three areas of expertise: flying, engineering, and human behaviour. These investigators would have been experienced practitioners in their discipline before joining the AAIB. They are given extensive training in investigation science following their recruitment. Appendix 2 discusses the history, budget and scope of UK accident investigation branches in more detail.

Recommendation 3: The Inquiry should recommend a new independent Building Safety Investigation Branch of the Ministry of Housing Communities and Local Government, to investigate the causes of major incidents without blame. It should have the power to investigate any incident or matter which it considers to be in the interests of building safety. This should draw upon the experience of established and trusted accident investigation bodies in other sectors, such as aviation and rail, which have proved to be an essential part of the safety management system.

2.10 The mechanism for making and responding to recommendations is the same in all accident investigation branches. The norm is to examine the consequences of major incidents as a whole rather than each regulator acting in isolation. It is mandatory for the body subject to recommendations to respond with the intended action or reasons for non-action. Investigation bodies can refer their recommendations up to the Secretary of State if the

[21] Carl Macrae and Charles Vincent. "Learning from failure: the need for independent safety investigation in healthcare". Journal of the Royal Society of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4224654/

response is considered unsatisfactory. Cullen cited "the lack of a co-ordinated system for the collation of recommendations and ensuring that they were followed up" as a major problem with the HSE approach. [22]

2.11 The accident investigation branch model can enable greater democratic scrutiny and transparency than HSE investigations, strengthening public confidence at moments of the most acute crisis. The pre-legislative scrutiny of governance and accountability of the proposed HSSIB for health investigations is instructive.[23] Schedule 1 of the Draft Health Service Safety Investigations Bill makes provisions concerning the membership of HSSIB's board, including the appointment of the chief investigator and its financial obligations. The Bill specifies that the Secretary of State will appoint the chair of HSSIB's board and at least four other non-executive members. The chief investigator will be appointed by the non-executive members, with the consent of the Secretary of State. The non-executive members will appoint the other members of the board.

2.12 There was, however, widespread agreement among the expert witnesses that there would be more confidence in HSSIB's independence were it to be accountable to Parliament rather than simply to the Secretary of State.[24] HSSIB will make an annual report on how it has exercised its functions, including the use of its financial resources. This report must be sent to the Secretary of State, who is required to lay it before Parliament. HSSIB must then publish it. At this stage, the select committee recommended that the Commons Health and Social Care Committee (HMCLG) scrutinise the quality of HSSIB's investigations and reports and their effect on patient safety.

Recommendation 4: Both the chair of the Building Safety Investigation Branch board and the non-executive members should be appointed by the Secretary of State. The non-executive members should appoint a chief investigator. The Housing, Communities and Local Government Committee should scrutinise the appointment of the chair of the board and the appointment of the chief investigator, as well as the annual reports

[22] Cullen Report. 166
[23] Draft Health Service Safety Investigations Bill. Chapter 2: Membership. https://publications.parliament.uk/pa/bills/lbill/2019-2019/0004/20004.pdf
[24] Draft Health Service Safety Investigations Bill: A new capability for investigating patient safety incidents. Governance and accountability of HSSIB. https://publications.parliament.uk/pa/jt201719/jtselect/jthssib/1064/106410.htm#_idTextAnchor168

published by the Building Safety Investigation Branch. This will establish the independence, accountability and public confidence in major incident investigations lacking from the current proposals.

3. Simplifying regulation and accountability of building control

3.1 Building control bodies are responsible for checking building work to verify that it complies with building regulations. Building control work can be carried out either by private firms, known as Approved Inspectors (AIs), or in-house by Local Authority Building Control bodies (LABCs), which have a statutory duty to provide building control services within their area. To be approved to provide building control services, AIs must be licensed by the Construction Industry Council Approved Inspectors Register (CICAIR Ltd.). AIs are subject to a code of conduct, regular auditing, and a complaints and disciplinary regime, leading to suspension of their licence if they are acting improperly or seriously underperforming. There is currently no licence regime or register for LABCs and no dedicated independent scrutiny or regulation of their service. CICAIR's subsequent representations to MHCLG advocated the same regulatory oversight for public and private building control bodies.[25] Local authorities were opposed to being subject to additional external oversight and CICAIR's recommendations have not been accepted by MHCLG.

3.2 There is limited data on the performance of building control bodies; certainly not enough to make a quantitative assessment of the relative performance of local authority and AIs. Cases of formal enforcement taken by the local authority under Section 35 and 36 of the Building Act are increasingly rare and the number of cases appears to have fallen by around 75 per cent in the last 10 years.[26] Where enforcement results in a prosecution, the published data makes no distinction between cases referred by AIs, who do not themselves have enforcement powers, and cases where local authorities carried out the building control function.[27] There is considerable informal enforcement activity by LABCs and AIs. The Hackitt Review concludes it "appears effective in most cases". It is difficult to judge how Dame Judith Hackitt came to this position because no data is published.[28]

3.3 CICAIR can take formal and informal action against AIs, to ensure the integrity of its register. There is an insufficient range of formal action and the "nuclear option" of removing an AI from the register is sufficiently rare that not enough published data is available to judge

[25] Letter from Nick Raynsford, Chair of CICAIR to Chandru Dissanayeke, Director of Building Safety Reform, MHCLG, 7 April 2020.
[26] Hackitt Review. 44
[27] Ibid. 60
[28] The inquiry may be able to obtain data from LABC, which is the national organisation that represents local authority building control bodies. They informed us that they would prefer to give data directly to the inquiry rather than via a third party.

CICAIR's effectiveness. There are no intermediate grades of competence, so AIs are licensed to carry out any building control work in all but a few cases. As already noted, the quality of service by LABCs is even less regulated. CICAIR publishes data on initial notices carried out by AIs, but no such data is available for local authorities. It is therefore difficult to get an accurate picture of capacity in the private and public sectors.[29]

Recommendation 5: The Inquiry should draw attention to the lack of empirical evidence on the relative performance of public and private building control. The new system should rectify this paucity of evidence. It is important not to repeat the mistake of the earlier reforms, whereby after nearly forty years, it is impossible to ascertain whether the reforms had any positive effect on the quality of building control. CICAIR provides a limited form of oversight of approved inspectors; it is difficult to determine any meaningful external oversight of local authority building control bodies.

3.4 Neither the Hackitt Review nor the draft Building Safety Bill adequately resolve oversight of building control. The new system proposed in the Building Safety Bill will create a separate regime for building control work on high-risk residential buildings (buildings over 18 metres or six stories in height). The regulator, BSR, will be responsible for carrying out this function. It will draw on a "building inspector register". Approved inspectors and surveyors from local authorities will have to apply and demonstrate sufficient competence to carry out such work.

3.5 There is some controversy over whether LABCs will be favoured over AIs in discharging this function. The Welsh White paper states this explicitly.[30] The government's response to the Hackitt Review strongly implies the same: "The skills, expertise and capacity of local authority building control will provide the main support for the new regulator and be

[29] Inside housing conducted research on which type of building control authority signed off flammable cladding on high-risk residential buildings. The sample size was limited. AIs carried out 63%, local authorities 37%. Experts say this is a relatively unsurprising picture, broadly reflecting the split between public and private for work of this kind – private inspectors carry out more complex work, such as tower blocks, than local authority inspectors do. Again, it is very difficult to draw firm conclusions without relying on anecdotal evidence.
[30] "in bringing forward changes we would intend to extend the current role of Local Authority building control to cover the additional regulatory regime for higher risk buildings. We would intend that Local Authorities will be responsible for building regulations functions under the regime for new, and the refurbishment of, higher risk buildings." Safer Buildings in Wales: A Consultation. 26 https://gov.wales/sites/default/files/consultations/2021-01/consultation.pdf

complemented by Approved Inspectors where required."[31] It is unclear why this decision has been taken. Building control surveyors often start their career in a local authority before setting up their own practise, but the most experienced building surveyors tend to be in the private sector. An LABC was responsible for the building control work on Grenfell tower, and the public will expect failings in LABCs to be fully addressed by any reform.

3.6 The legacy system of building control oversight will still apply to the vast majority of building control work. The proposed reforms have missed the opportunity for comprehensive reform within the building control sector. While the Building Safety Regulator will have oversight of all building control activity under the provisions of the Building Safety Bill, it will inevitably have to give priority to its work on high-risk residential buildings where it will itself be responsible for the building control function. This also creates a potential conflict of interest, as on high-risk residential buildings, the BSR will in effect be marking its own homework.

3.7 There is however an alternative option which would overcome both these problems. The Ministry of Housing, Communities and Local Government (MHCLG) commissioned the Future of Building Control Group (FBCG) early in 2020 to produce a report on the regulation of the building control profession. The group comprised all the leading bodies involved in building control activity, including professional institutions (RICS, CABE and CIOB), bodies representing both public and private building control (LABC and ACAI), the body currently designated by MHCLG for registering AIs (CICAIR), and other key players in the sector (CIC and NHBC). The report, submitted to MHCLG in summer 2020, recommended that the registration of all building control bodies and surveyors (whether in the public or private sectors) should be devolved to an independent registration body with a remit to register, monitor and oversee the activities of all building control bodies and surveyors within the statutory framework set by government. This would overcome the potential conflict of interest with the BSR marking its own homework, and also make it easier for the BSR to select appropriate building control inspection teams to work on high-risk buildings, based solely on criteria of appropriate competence.

[31] A reformed building safety regulatory system. Government response to the 'Building a Safer Future' Consultation. 11 https://www.gov.uk/government/consultations/building-a-safer-future-proposals-for-reform-of-the-building-safety-regulatory-system

3.8 The FBCG report details a graduated system of sanctions for building control bodies relating to the severity of the action in question.[32] The independent registration body should have the power to ensure the integrity of the register. This should include the imposition of appropriate sanctions where registration conditions are breached, up to a defined level. The regulator would have "step-in" powers to ensure the replacement of a seriously underperforming AI.

3.9 The challenge is how enforcement should work in the public sector (LABCs). It is imperative that there should be different but comparable provisions, which should apply to LABCs, since they have statutory responsibilities to perform the building control function, including enforcement. The Care Quality Commission (CQC) provides a good example of how to regulate public sector inspectors. Every care provider in healthcare undertaking "regulated activity", as defined in the Health and Social Care Act 2008, must be registered with the CQC. They use this registration to check that legal requirements particularly around quality and safety are met.[33] The CQC then monitors, inspects and rates the provider's service and can take action if the standard of care falls below acceptable levels.

Recommendation 6: The Inquiry should recommend equal oversight of both private and local authority building control bodies. This could be achieved through the recommendation of the Future of Building Control Group report to set up an independent registration body. It would administer two registers: 1) for all building control bodies (organisations); and 2) for all building control surveyors (individuals). The step-in powers for local authority and private building control bodies would be different; however, the regulator, or appropriate authority, should have the necessary powers to ensure the integrity of the register. The inquiry should recommend that the draft Building Safety Bill be clarified, so there is no doubt it is intended that competence should be the only criteria for selecting the building control function on high-risk residential buildings, or for any other type of building.

[32] Future of Building Control Group Report. 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/707785/Building_a_Safer_Future_-_web.pdf

[33] Health and Social Care Act. 2008. https://www.legislation.gov.uk/ukpga/2008/14/contents

3.10 The proposals present client choice as a factor that undermines the quality of building control work. The report states: "the ability for duty holders to choose their own regulator must stop and regulators must be able to enforce as regulators." There is a clear need to address what the Hackitt Review has identified as the casual relationship between contractors and building control bodies, which had come to rely more on box-ticking rather than certified assurances and physical inspection.[34] The BSR will carry out only building control work on high-risk residential buildings. For all other types of building control work, client choice is allowed to continue. In its pre-legislative scrutiny of the draft Building Safety Bill, the Commons Housing, Communities and Local Government Select Committee questioned why this direct role for BSR was not proposed as a safeguard extended to all buildings. Dame Judith Hackitt and the Housing Minister, Stephen Greenhalgh, pointed out that such an arrangement would create capacity problems in the safety regulator. The functions that the regulator should reserve are only loosely defined in the Hackitt Review and draft Building Safety Bill; it will be determined in secondary legislation.

3.11 The Hackitt Review argues that client choice in building control "appears unique across the UK regulatory environment". This is not the case and may reflect the HSE's limited experience in devolving inspection to a third party and then regulating that function: they have no experience except in the very specific and limited area of gas safety. In other matters, such as the recommendation for a Joint Competent Authority, Dame Judith Hackitt draws on the successful safety management regime in civil aviation. The role of inspection and certification of aircraft, aircraft parts, and pilots is regulated by the CAA. However, the CAA does not employ or appoint inspectors. They are employed by the airlines, the engineering companies responsible for aircraft maintenance, and the aircraft manufacturers. The confidence in the aviation inspection and certification system is assured by the way inspectors are licenced and regulated. The British Standard Institute (BSI) regulates medical devices in a similar manner.[35] Rather than inspectors being employed by the manufacturer, inspectors are employed by a third party known as a "notified body". The manufacturer contracts a notified body. The sign-off procedure depends on the device's risk profile being approved: high-risk devices like replacement knees have a particularly rigorous procedure.

[34] Hackitt Review. 5
[35] British Standard Institute website. https://www.bsigroup.com/en-GB/medical-devices/our-services/iso-13485/

Again, the BSI conducts a thorough auditing regime. If a notified body is found wanting, its future activities are audited more regularly.

Recommendation 7: The Inquiry should consider whether it is client choice that is the decisive factor which has determined the quality of building control work on high rise residential buildings, or whether it was other factors, such as the variability in the quality of building control inspectors, which contributed to the Grenfell disaster. The inquiry should examine other safety management systems that have maintained client choice and judge whether this has impacted the quality of inspection.

Recommendation 7A: The inquiry should reject the distinction between building control work on high-risk residential buildings and all other types of building control work. It is arbitrary and not based on evidence. The proposal for BSR to have reserved functions, where it takes over the choice of building control body for certain work does not address the fundamental problem of the regulation of the quality of building control in general.

3.12 The system of statutory enforcement of the building regulations currently resides with local authorities. Under Sections 35 & 36 of the Building Act they can prosecute persons undertaking building works and require them to remove or modify the works. Approved Inspectors have no statutory powers of enforcement; where they reach an impasse and cannot persuade clients and developers to comply with the regulations, they are required to revert the works back to the local authority. The Building Safety Bill proposes changes to the current enforcement system by introducing tougher sentencing parameters and compliance and stop notices. This is based on the system of improvement and prohibition notices used by HSE inspectors. The regulator can use these powers: they are responsible for prosecutions related to high-risk residential buildings. They can also be used by the local authority, who would remain responsible for enforcing regulations on all other building works under the Building Safety Bill.

3.13 Much like the oversight of building control, the new system for high-risk residential buildings, whereby the regulator carries out prosecutions, is not extended to all other types of building. The HSE have considerable experience in delivering successful prosecutions, both

in construction and the workplace. As already noted, local authority prosecutions have declined considerably in recent years; many local authorities have no recent experience at all. As of 2019, Oxford City Council's building control department had taken no enforcement action in the last ten years and had served only one statutory notice, back in 2018. HSE investigations have an effective mechanism to cover costs. In most instances the outcome of the investigations does not warrant a formal prosecution as the offending aspect is resolved through negotiation, but the clients and developers being investigated pay a fine which is the hourly rate of the inspecting officers time involved in reviewing the issue. Costs are cited as a major limiting factor undermining local authorities' capacity to enforce the building regulations.

Recommendation 8: Statutory enforcement of building regulations for all types of buildings, not just high-risk residential buildings, should be devolved to the new Building Safety Regulator, under the HSE. Given the failure of local authorities to take necessary enforcement action and hence their inexperience in taking such action, they are not the appropriate body to carry out this vital regulatory function.

4. **Recommendations**

Recommendation 1: The Inquiry should consider the potential for conflicts of interest which may arise if the HSE remains responsible for carrying out the investigation function for building safety in the event of a future major incident, particularly since the HSE board will be responsible for the governance of the Building Safety Regulator. The HSE cannot know in advance of its investigation whether the failings of the Building Safety Regulator contributed to the incident in question.

Recommendation 2: The Inquiry should consider whether the HSE should continue to hold responsibility for investigating any major incident, in which it is also seeking to establish blame. The causes of major incidents are also likely to cut across multiple regulator's remits, requiring broader expertise than any single regulator can possess. Given that a far greater number of deaths from fires occurs in buildings not considered high risk, there should be no distinction in investigating major incidents in high-rise buildings and other major incidents that cause or risk serious injury or death.

Recommendation 3: The Inquiry should recommend a new independent Building Safety Investigation Branch of the Ministry of Housing Communities and Local Government, to investigate the causes of major incidents without blame. It should have the power to investigate any incident or matter which it considers to be in the interests of building safety. This should draw upon the experience of established and trusted accident investigation bodies in other sectors, such as aviation and rail, which have proved to be an essential part of the safety management system.

Recommendation 4: Both the chair of the Building Safety Investigation Branch board and the non-executive members should be appointed by the Secretary of State. The non-executive members should appoint a chief investigator. The Housing, Communities and Local Government Committee should scrutinise the appointment of the chair of the board and the appointment of the chief investigator, as well as the annual reports published by the Building Safety Investigation Branch. This will establish the independence, accountability and public confidence in major incident investigations lacking from the current proposals.

Recommendation 5: The Inquiry should draw attention to the lack of empirical evidence on the relative performance of public and private building control. The new system should rectify this paucity of evidence. It is important not to repeat the mistake of the earlier reforms, whereby after nearly forty years, it is impossible to ascertain whether the reforms had any positive effect on the quality of building control. CICAIR provides a limited form of oversight of approved inspectors; it is difficult to determine any meaningful external oversight of local authority building control bodies.

Recommendation 6: The Inquiry should recommend equal oversight of both private and local authority building control bodies. This could be achieved through the recommendation of the Future of Building Control Group report to set up an independent registration body. It would administer two registers: 1) for all building control bodies (organisations); and 2) for all building control surveyors (individuals). The step-in powers for local authority and private building control bodies would be different; however, the regulator, or appropriate authority, should have the necessary powers to ensure the integrity of the register. The inquiry should recommend that the draft Building Safety Bill be clarified, so there is no doubt it is intended that competence should be the only criteria for selecting the building control function on high-risk residential buildings, or for any other type of building.

Recommendation 7: The Inquiry should consider whether it is client choice that is the decisive factor which has determined the quality of building control work on high rise residential buildings, or whether it was other factors, such as the variability in the quality of building control inspectors, which contributed to the Grenfell disaster. The inquiry should examine other safety management systems that have maintained client choice and judge whether this has impacted the quality of inspection.

Recommendation 7A: The inquiry should reject the distinction between building control work on high-risk residential buildings and all other types of building control work. It is arbitrary and not based on evidence. The proposal for BSR to have reserved functions, where it takes over the choice of building control body for certain

work does not address the fundamental problem of the regulation of the quality of building control in general.

Recommendation 8: Statutory enforcement of building regulations for all types of buildings, not just high-risk residential buildings, should be devolved to the new Building Safety Regulator, under the HSE. Given the failure of local authorities to take necessary enforcement action and hence their inexperience in taking such action, they are not the appropriate body to carry out this vital regulatory function.

Appendix 1: Mike Penning on the Buncefield Fire

Following the major incident in my constituency on the 11th December 2005 I had several meetings with the Rt. Hon John Prescott along with questions on the floor of the House about many issues, but the main early issues was that I felt we should have a full public inquiry.

I was told that that was out of the question as this was a HSE matter as there had been no fatalities and no police involvement for the same reasons.

I thought this to be an injustice; the HSE was responsible for the inspection and licensing of the site and if they were negligent how could they be responsible for the investigation? There were serious injuries but no police involvement.

I was eventually offered an independent chair (Lord Tony Newton) which was great but almost all of the reports which were published were presented by Mr Taff Powell from the HSE and even when Lord Newton wrote on the 11th July 2006 to present the initial report he wrote to Mr Bill Callaghan chair of the Health and Safety Commission.

In the final report Volume 1 forward Lord Newton wrote to the chair of the HSE Board (Judith Hackitt) and not to the Minister! In his first line he says, “In January 2006 her processor Sir Bill Callaghan appointed him and others” - the “others” being HSE staff.

So, the point I’m making is please don’t hold up the Buncefield Major Incident investigation as the way forward - that would be travesty. In 2021 we can’t allow those responsible for upholding safety to then also be the investigating body.

Finally, for those that are not aware of my previous responsibilities, I have been the Minister of State with the HSE in my Portfolio and a former Firefighter.

Appendix 2: Accident Investigation Branches in other sectors

SOURCE: Carl Macrae and Charles Vincent. "Learning from failure: the need for independent safety investigation in healthcare". Journal of the Royal Society of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4224654/

United Kingdom, Aviation: Air Accidents Investigation Branch (AAIB)

	2019	**2020**
Notifications	826	553
Field investigations opened	37	20
Field investigation reports published	29	30
Correspondence investigations opened	124	108
Correspondence investigation reports published	173	199
Overseas investigations	99	31
Budget	£8.0M	8.3

The AAIB operates as an independent branch of the Department of Transport and the Chief Inspector reports directly to the Secretary of State. The first Inspector of Accidents was appointed in 1915. The AAIB is charged with investigating accidents and incidents and making recommendations for improvement. It operates within a legislative framework that ensures that safety investigations are distinct from procedures to establish legal liability. This framework is shaped by internationally agreed conventions governed by the United Nations International Civil Aviation Organisation. High profile investigations include the engine fire on an Airbus A319 over London in May 2013 and the crash of a helicopter onto a London street in January 2013.

United Kingdom, Railways: Rail Accident Investigation Branch

	2019	**2020**
Notifications	381	457
Investigations commenced	13	14

Investigations published	17	16
Safety digests commenced	10	6
Safety digests published	10	8
Letters to coroners issued	6	4
Industry investigation reviews commenced	8	7
Budget	£5.2 m (2019/20)	£5.0 m (2020/21)

The RAIB was established in 2005 following an enquiry into the Ladbroke Grove rail accident of 1999. It is an independent branch of the Department of Transport and the Chief Inspector reports directly to the Secretary of State. The RAIB can direct recommendations to any organisation or person including railway and non-railway, private and public sector organisations. Investigations include the catastrophic derailment of an InterCity service in Cumbria in 2007 that caused one death and 30 serious injuries, and a fatal collision between a car and train on a level crossing near Taunton in March 2013.

United Kingdom, Maritime: Marine Accident Investigation Branch

Marine Accident Investigation Branch (MAIB)

	2019	**2020**
Notifications	1090	1217
Investigations Started	22	19
Reports published	20	24

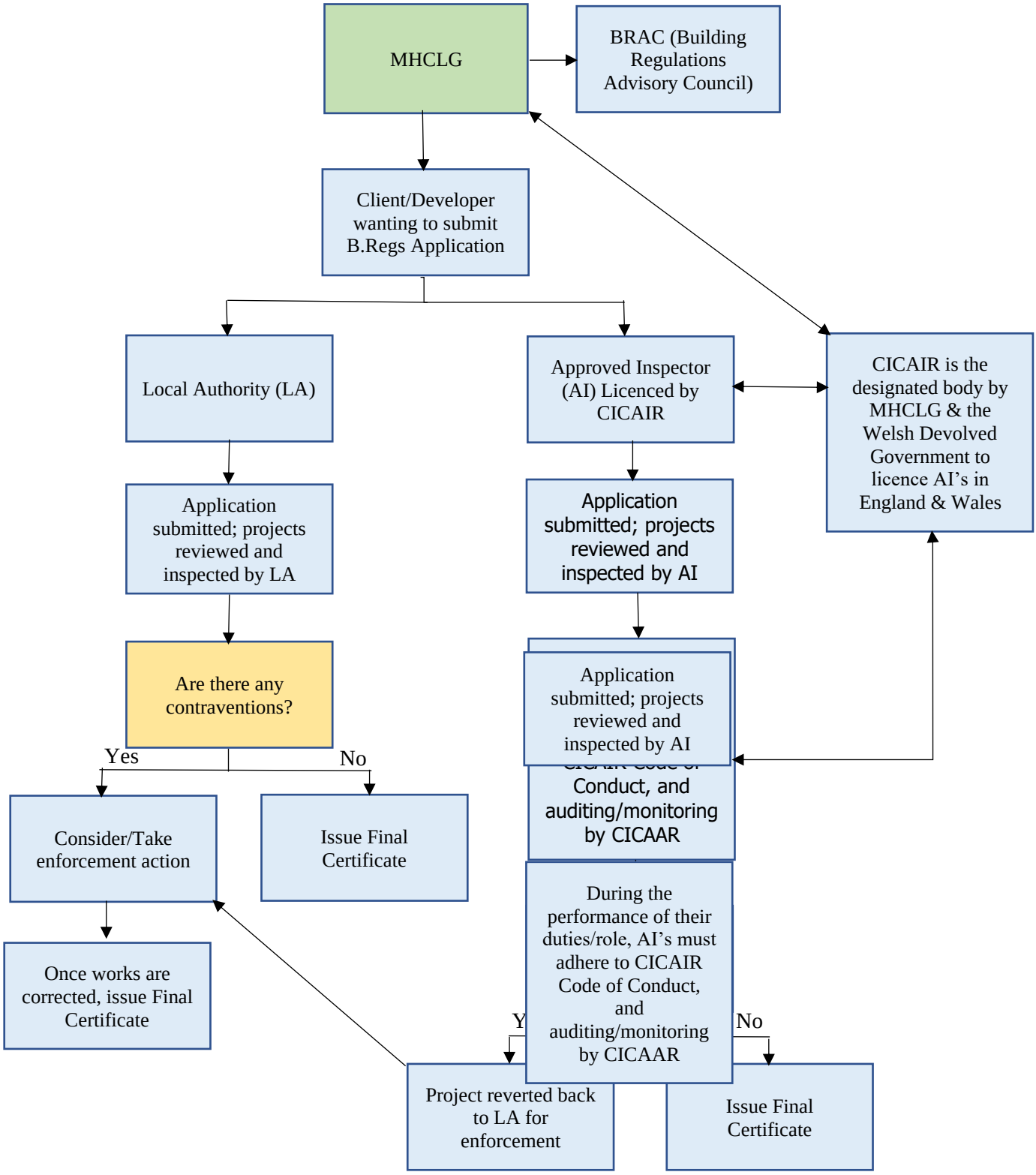
Our annual budget for 2020-2021 was 4.7 million
Our annual budget for 2021-2022 is 4.9 million

The MAIB was established in 1989 following the inquiry into the capsizing of the ferry Herald of Free Enterprise in 1987, which claimed 193 lives. The MAIB is a functionally and operationally independent branch of the Department of Transport and reports directly to the Secretary of State. It is a small organisation that conducts around 50 investigations each year. These include high profile cases such as the Marchioness disaster on the river Thames in August 1989 in which 51 people died.

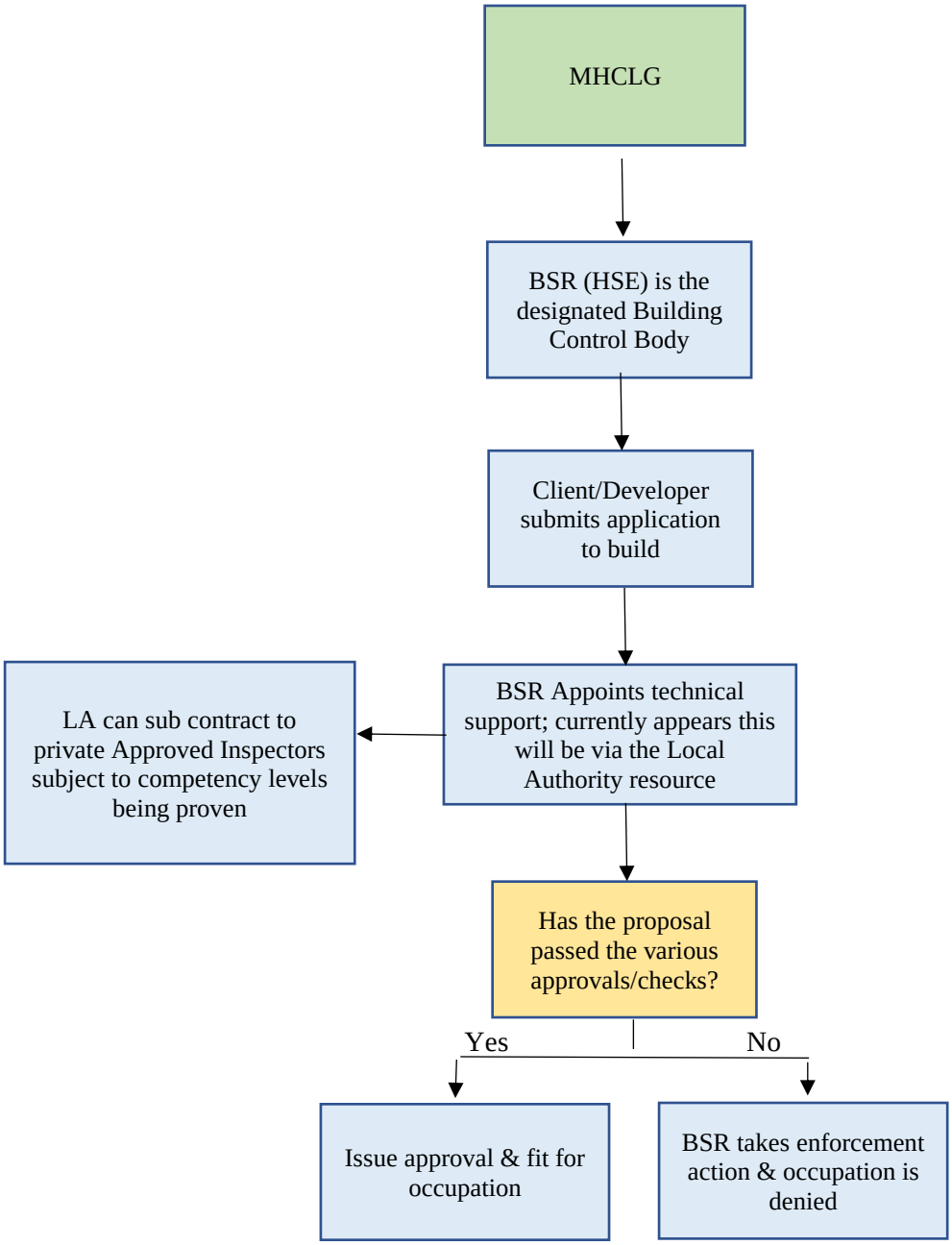
United States, Aviation: National Transport Safety Board, Office of Aviation Safety

The NTSB is an independent federal agency responsible for investigating accidents in all modes of transportation including aviation, roads and pipelines. The NTSB Office of Aviation Safety is responsible for investigating all domestic US air accidents – around 1750 each year. It is also responsible for participating in the investigation of international accidents that involve US airlines or US manufactured or designed equipment. This includes leading the investigation of the Boeing 777 crash at San Francisco in July 2013, and the investigation of battery-related issues that grounded the global Boeing 787 fleet in January 2013.

Appendix 3: Current Process for Obtaining Building Regulations Approval (Pre Building Safety Bill). Maintained for non-HRRBs under the new system.



Appendix 4. Current proposed Route to Obtain Building Regulations Approval for in Scope Work (HRRB's). Draft Building Safety Bill



Appendix 5. Reccomended Future Route to Obtain Building Regulations Approval for all Work Including In Scope Work