Safer and Stronger Communities Board
12 November 2019

Building Safety Update

Purpose of report

For information.

Summary

This report updates the Safer and Stronger Communities Board on the building safety developments since its last meeting.

Recommendations

That members note and comment on the LGA's building safety related work.

Actions

Officers to action any matters arising from the discussion as appropriate.

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Building Safety Update

Background

1. Since the Board's last meeting the LGA has continued to support the work of councils and fire and rescue services to tackle the remediation of a variety of fire safety issues that have become apparent following the fire. The LGA has also continued to work closely with the Government on the reform of building safety.

2. The most important developments since the Board's meeting in September has been publication of the Grenfell Tower Inquiry's Phase 1 report, and consideration of London Fire Brigade's (LFB) own review of its response to the fire by the London Assembly.

Grenfell Tower Inquiry Phase 1 report

3. The Phase 1 report from the Grenfell Tower Inquiry, which was established in the immediate aftermath of the fire, was published on 30 October. It is divided into four volumes, with six parts and covers nearly 1,000 pages. Part I of the report contains an introduction to the events on 14 June 2017, a description of Grenfell Tower itself and the organisation of LFB. Part II contains a detailed narrative description of the fire and the steps taken to respond to it. Part III contains Sir Martin Moore-Bick's conclusions about the origin and development of the fire and an analysis of the response from LFB and the other emergency services. A summary of the tributes paid by the friends and family of the victims is set out in Part IV. Part V contains recommendations arising from the findings made earlier in the report and Part VI set out the areas the Inquiry will concentrate on in Phase 2.

Findings in the report

4. In the report Sir Martin arrives at a number of conclusions:

    4.1. The fire was caused by an electrical fault in a fridge-freezer in the kitchen of flat 16.
    4.2. The fire then spread to the aluminium composite material (ACM) cladding panels before firefighters opened the kitchen door in flat 16 for the first time.
    4.3. The reason the fire spread so rapidly up and down the external surface of the building was the presence of the ACM panels, along with combustible foam insulation behind the panels, which contributed to the rate and extent that the flame spread.
    4.4. Compartmentation in Grenfell Tower failed because the heat from the fire caused the glass in the windows to fail, and to deform and dislodge extractor fans in kitchens providing a point of entry for the fire back inside the building.
    4.5. A number of key fire protection measures inside the tower failed, including some of the fire doors, as a number were left open because the self-closing devices did not work.

4.6. There is compelling evidence the walls of the building failed to comply with requirement B4(1) in the 2010 Building Regulations as they did not adequately resist the spread of fire.

4.7. LFB's planning and preparation for a fire like that at Grenfell was gravely inadequate:

4.7.1. There had been no training for the incident commanders and senior officers present about the dangers of combustible cladding even though at a senior level LFB was aware of similar fires.

4.7.2. LFB commanders had received no training on how to recognise the need for an evacuation or how to organise one.

4.7.3. There was no contingency plan for the evacuation of Grenfell Tower.

4.7.4. Key information held by LFB about the tower was wrong, or out of date, or missing altogether.

4.8. Although the firefighters at the scene displayed extraordinary courage and selfless devotion to duty, the first incident commanders, who were of relatively junior rank were faced with a situation they had not been properly prepared for:

4.8.1. They seem not to have been prepared for the possibility there might be a general failure of compartmentation and that might then require a mass evacuation.

4.8.2. Once it was clear there was a failure of compartmentation a decision should have been taken earlier to organise the evacuation of the tower.

4.8.3. There were no systematic arrangements for information from emergency calls to the control room to be passed to incident commanders, and similarly information on the internal spread of the fire and the results of rescue operations was not effectively shared with incident commanders.

4.8.4. There were deficiencies in command and control, with some senior officers failing to inform themselves quickly enough of conditions and operations on the ground.

4.8.5. Many of the physical or electronic communication systems did not work properly.

4.9. LFB control room staff faced an unprecedented number of fire survival guidance (FSG) calls which posed a challenge outside their experience and training. While they undoubtedly saved lives there were shortcomings in practice, policy and training:

4.9.1. LFB policy on handling FSG calls from residents of the tower required them to stay on line until they were rescued or left the building. However the number of these calls far exceeded the number of staff trained to handle them.

4.9.2. LFB policy documents do not properly set out how the stay put policy is applied or how a caller from a burning building is to escape.

4.9.3. Control room staff did not always record necessary information from callers such as flat numbers, the number of people present or whether people were disabled.

4.9.4. Control room staff had not been trained on what a decision to evacuate meant or the circumstances in which a caller should be advised to stay put or leave the

building. They were not aware of the dangers of assuming crews would always reach callers, which was one of the important lessons from the Lakanal House fire in 2009.

4.9.5. When the decision to evacuate was made the control room staff did not understand they had to give advice to callers in unequivocal terms that they had to leave the building.

4.9.6. Communications between the control room and the incident were improvised, uncertain and prone to error. Control room staff therefore had no sound basis for telling callers help was on its way.

4.9.7. Those at the incident did not have access to valuable to information from the control room, and there was no organised means of sharing information from callers among the control room staff so they had no overall picture of the speed and pattern of fire spread.

4.9.8. LFB's arrangements for handling large volumes of FSG calls with other control rooms did not allow for the sharing of information about conditions at the incident itself.

4.9.9. Senior control room staff had not been trained on how to manage large scale incidents with a large number of FSG calls.

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

4.10. While the standing arrangements and protocols between the London emergency services and the local authority were implemented successfully, there were lessons for the handling of future emergencies as all three bluelight services declared major incidents at different times without telling the other services they were doing so or telling the local authority. As a result the need for a properly co-ordinated joint response was not appreciated early enough, which meant information on the nature and effect of the fire was not passed on. In addition communication between the emergency services did not meet the standards required by the protocols.

4.11. The Royal Borough of Kensington and Chelsea's own emergency plan relied on key information from the Tenant Management Organisation (TMO), but the TMO had no obligations under the council's plan, and did not activate its own emergency plan which was fifteen years out of date.

Recommendations in the report

5. Although the scope of Phase 1 of the Inquiry was limited to investigating the events of the fire, as it was clear there were steps that needed to be taken to improve fire safety, including the response from LFB and other fire and rescue services to major fires, the report contains a number of recommendations. In the report Sir Martin Moore-Bick also sets out why he has not made recommendations in some areas. In making recommendations, Sir Martin limited himself to making ones that were based on the facts that emerged from the evidence heard by the Inquiry and had the support of those with experience of the matters to which they relate. It is worth noting that Sir Martin states that "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."

6. The recommendations fall broadly into three categories:

   6.1. Those that all fire and rescue services will need to consider. For example the recommendation that all services ensure 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.
   6.2. Those that will inform the work the Government is doing supported by the LGA and others to reform the system of buildings safety. For example the recommendation 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.
   6.3. Those that are specific to LFB. The LGA has no view on these operational matters.

7. The recommendations in the report, along with an explanation of why Sir Martin has not made recommendations in some areas are listed below:

   7.1. In light of what Sir Martin has learnt about the role played by the ACM cladding system in the spread of the fire he adds his voice to that of the Housing, Communities and Local Government Select Committee about the need to pursue the programme to remediate buildings with ACM cladding as vigorously as possible.
   7.2. Core participants had urged Sir Martin to recommend that only Euro class A1 products be permitted for use on the external walls of high-rise residential buildings, but as the Government has banned the use of materials that do not meet the A2 standard, Sir Martin did not think it was appropriate at this stage to recommend any change to the regulations.
   7.3. A sound understanding of the materials used in the construction of high-rise buildings is necessary for fire and rescue services (FRSs) to be properly prepared to fight fires in those buildings so Sir Martin recommends:
      7.3.1. The owner and manager of every high-rise residential building be required in law to provide their local FRS with information on the design of its external walls and details of materials used in construction, and to inform the FRS of any material changes.
      7.3.2. All fire and rescue services ensure their personnel at all levels understand the risk of fire taking hold in the external walls and how to recognise when it occurs.
   7.4. Under s7(2)(d) of the Fire and Rescue Services Act 2004 fire and rescue authorities are required to make arrangements to obtain information needed to help fight fires and protect life and property. The report recommends LFB review its procedures for inspecting buildings under s7(2)(d) including ensuring it is in line with national guidance, and that officers from crew manager and above are trained in carrying out the inspections.

7.5. No plans of Grenfell Tower were available to LFB until the later stages of the fire, but as the floors were laid out in the same way this did not hamper the fire fighting. As this lack of plans might have more serious consequences in other circumstances the report recommends:

7.5.1. that the owner and manager of every high-rise residential building be required by law:

7.5.1.1. 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;

7.5.1.2. 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.

7.5.2. 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.

7.6. The ability for firefighters to control and access firefighting lifts in a high-rise residential building is important so the report recommends 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, to carry out regular tests of the mechanisms that allow firefighters to take control of the lifts and to report the results of such inspections and tests to their local fire and rescue service at monthly intervals.

7.7. There was not a free flow of information between the control room and incident commanders at Grenfell so the report recommends :

7.7.1. that LFB review its policies on communications between the control room and the incident commander;

7.7.2. 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;

7.7.3. that all control room staff of Assistant Operations Manager rank and above receive training directed to the specific requirements of communication with the incident commander;

7.7.4. that a dedicated communication link be provided between the senior officer in the control room and the incident commander.

7.8. As LFB's control room staff were unable to handle the number of calls being received from residents of the tower the report recommends a range of measures including:

7.8.1. amending LFB policies to draw a clearer distinction between callers seeking advice and those who need rescuing;

7.8.2. that all FRSs develop policies for handling large volumes of FSG calls simultaneously; and

7.8.3. policies be developed for managing a transition from stay put to get out.

7.8.4. The report also recommends that steps be taken to investigate methods by which assisting control rooms can obtain access to the information available to the host control room, and that London Ambulance Service and the Metropolitan Police Service review their protocols and policies to ensure that their operators can identify FSG calls (as defined by LFB) and pass them to LFB as soon as possible.

7.9. To address the command and control failures identified in the report LFB develops policies and training to ensure better control of deployments and better information is obtained from crews returning from deployments; that LFB develop a system to enable direct communication between the control room and incident commanders; and LFB investigate use of modern communication techniques to provide a direct line of communication between the control room and the bridgehead.

7.10. As some of the LFB equipment was unreliable the report recommends it obtains equipment to enable firefighters in helmets and breathing apparatus to communicate with the bridgehead effectively.

7.11. The report recommends the lack of plans in place for evacuating Grenfell Tower are addressed by:

7.11.1. the Government developing national guidelines for carrying out partial or total evacuations of high-rise residential buildings;

7.11.2. that fire and rescue services develop policies for partial and total evacuation of high-rise residential buildings and training to support them;

7.11.3. 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;

7.11.4. 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;

7.11.5. 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);

7.11.6. 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;

7.11.7. that all fire and rescue services be equipped with smoke hoods to assist in the evacuation of occupants through smoke-filled exit routes.

7.12. It was suggested by some participants to the enquiry the report should recommend that every flat and public space in a high-rise residential building should have a fire extinguisher and there should be a fire blanket in every kitchen, but Sir Martin rules out making such a recommendation as experts did not support it.

7.13. The report also rules out making recommendations about installing sprinklers at this stage on the basis that the Inquiry has not looked at whether a sprinkler

system might have suppressed the fire in flat 16 or stopped it getting into the cladding, and it has heard no general evidence on their cost and effectiveness.

7.14. The lack of clear numbering of the floors in Grenfell Tower meant firefighters were unable to clearly identify floors, and additionally residents were in many cases unable to read or understand the fire safety instructions in the lobbies so the report recommends:

7.14.1. 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.

7.14.2. 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.

7.15. The failure of the fire doors in Grenfell meant they were unable to prevent the spread of smoke and toxic gases through the building. The report therefore recommends:

7.15.1. 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;

7.15.2. 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.

7.15.3. 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.

7.16. Given the lack of co-ordination between the emergency services the report recommends the arrangements under which the emergency services are to work together are amended to make it clear:

7.16.1. that each emergency service must communicate the declaration of a Major Incident to all other Category 1 Responders as soon as possible;

7.16.2. 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;

7.16.3. that a single point of contact should be designated within each control room to facilitate such communication;

7.16.4. that a message to the other emergency services should be sent as soon as possible by the emergency service declaring a Major Incident.

7.16.5. that steps be taken to investigate the compatibility of LFB systems with those of the Metropolitan Police Service and the London Ambulance Service with a

view to enabling all three emergency services' systems to read each other's messages.

7.16.6. that steps be taken to ensure that the airborne datalink system on every National Police Air Service helicopter observing an incident which involves one of the other emergency services defaults to the National Emergency Service user encryption.

London Fire Brigade's review of its response to the Grenfell Tower fire

8. In addition to the publication of the Phase 1 report by the Grenfell Tower Inquiry, London Fire Brigade's own internal review of its response on the night of the fire was considered by the London Assembly on 16 October. In addition to highlighting the exceptional nature of the fire in terms of its scale and rapidity caused by the complete failure of the buildings fire safety measures, the review makes over 40 key observations and 13 recommendations, many of which are relevant to other FRSs. The recommendations covered the following areas that have implications for all services in fighting fires in high-rise residential buildings:

8.1. LFB should press for improvements to the regulatory regime to prevent a similar fire occurring in the future.
8.2. LFB should continue to campaign for the provision of sprinklers in high-rise residential and other types of buildings.
8.3. LFB should review its policies and training packages relevant to conducting visits to buildings under s7(2) of the Fire and Rescue Services Act 2004, which are carried out to obtain information relevant to firefighting and protecting life and property in that building.
8.4. LFB should consider how information on identified fire safety deficiencies in a premises are made available to operational crews.
8.5. LFB should consider whether to retain its own incident control framework or move to the decision making process set out in National Operational Guidance.
8.6. LFB should consider the extent to which human factors affecting command and control are addressed in policy and training.
8.7. LFB should consider how it can most effectively raise awareness of and reinforce the requirements to record decisions at incidents.
8.8. LFB should review whether measures can be introduced to improve the accuracy of information about people self-evacuating or being rescued from buildings.
8.9. LFB should consider to what extent recognition that a building is behaving unpredictably in a fire is addressed in policy and training.
8.10. LFB should review the role played by policy, training and human factors in issues related to the use of breathing apparatus, identification of floor numbers, the handling of the number emergency calls and the resulting volume of information, and the compromising of the single escape route by fire and smoke.
8.11. LFB should consider how situational awareness in the control room in the event of a large scale incident of this nature could be improved.

8.12. LFB should consider whether any improvement in policy and training is needed to address issues resulting from the volume of hand held radio traffic, the booking in of senior officers at the incident due to the high volume of radio traffic, the flow of information to and from the control room, and the lack of ability to communicate with all residents in a building to provide advice or instruct an evacuation.

9. As might be expected there is considerable overlap between the issues identified by LFB's review and the Phase 1 report, and the work underway in LFB to respond to the review will address many of the recommendations addressed at LFB in the Phase 1 report.

LGA response to the Grenfell Tower Inquiry Phase 1 report

10. The LGA statement issued in response to the report is at **Appendix A**. While accepting that there are important lessons for the fire brigade nationally, and LFB individually, to learn from the fire, the LGA argued that the report had made a fundamental error by focussing on the fire brigade's response to the fire before examining the causes of the fire.

11. Lord Porter made a number of media appearances to make this point and also spoke in the House of Lords debate on Thursday 31 October. Our lines received extensive media coverage.

12. Speaking in the House of Lords, Lord Porter noted that:

12.1. "I was with some of the families of the victims and a couple of the survivors yesterday morning, and universally they had nothing but good words to say about the report. So Sir Martin has delivered a report in tragic circumstances in a way that has gone down well with the people who are most affected by it."

Next steps in response to the Phase 1 report

13. The Government has already indicated it will accept the recommendations in the Phase 1 report directed at it. These have wide ranging implications for both FRSs and councils. The LGA's Grenfell Task and Finish Group will be considering the Phase 1 report ahead of the Board's meeting, and Fire Services Management Committee was due to consider both the Phase 1 report and LFB's own internal review from a fire and rescue authority perspective at its meeting on 6 December, but we are looking to reschedule the meeting due to the General Election. FSMC is now likely to consider the two reports and what actions the LGA needs to take with the National Fire Chiefs Council (NFCC) to respond to the recommendations in January 2020.

14. A preliminary consideration of the Phase 1 recommendations suggests there may be issues for councils and FRSs in implementing some of the proposals in practice. The

requirement on building owners to carry out checks every three months on fire doors to ensure the self-closing devices are in working order, may be difficult to enforce where leases or tenancy agreements make no provision for this unless legislation allows for this.

15. It is also unclear for example how extensive Sir Martin envisaged the requirement to ensure up to date information is kept in the premises information box about persons with reduced mobility and their associated personal emergency evacuation plans. Councils often struggle to identify who is living in leasehold flats in their blocks, especially where the flat may have been let. If the expectation is that councils have to provide up to date information on all persons with reduced mobility in their blocks, irrespective of tenure, then consideration will have to be given to how councils can obtain this information from leasehold properties.

16. Other recommendations may also have costs implications for building owners and FRSs, or also potentially duplicate what might emerge from the work to reform the fire safety regulatory framework in line with the recommendations from Dame Judith Hackitt's report. Producing up-to-date plans in both paper and electronic form for high-rise buildings, which in some instances may be over 50 years old, will require time and resource and should be considered alongside the recommendations from the Hackitt report for the production of a safety case for each building including a digital record of the building as built.

17. Where the Phase 1 report's recommendations are not covered by existing building safety work, we will be seeking views from member authorities on the recommendations and any issues arising from implementing them. These views will then inform the LGA's engagement with the Ministry of Housing, Communities and Local Government and the Home Office as they consider the Phase 1 recommendations and how they will be taken forward by Government. Any initial views from Board members would assist in shaping the LGA's approach going forward.

Future direction of the Inquiry (Phase 2)

18. The principal focus of Phase 2 of the Grenfell Tower Inquiry 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. The LGA has already expressed the view that these are the areas that should have been dealt with in Phase 1.

19. Phase 2 will also consider the way LFB is managed and questioning those responsible at the highest level for its operation. Given the findings made in the Phase 1 report it is understandable why this should be a focus for the next stage of the inquiry, but there is the risk that in doing so less attention is paid to identifying why combustible cladding was installed on Grenfell Tower and hundreds of other high-rise residential buildings, hotels and public buildings, and what needs to be done to prevent this happening in the future.

Remediation

Progress

20. Progress continues to be made in carrying out remediation to the 158 social sector residential blocks with combinations of aluminium composite material (ACM) cladding and insulation that have been found not to meet the building regulation standards. The statistics published by the Ministry of Housing, Communities and Local Government (MHCLG) on 12 September show that, as of 31 August, remediation has finished on 60 of these blocks. Of those which have not yet been remediated, work has started on 81 of these blocks, and a further 17 have plans in place. Funding for the remediation of 144 of these 158 buildings is provided from the Government's social sector ACM cladding removal fund. Remedial works for the remaining 14 buildings are being funded through existing funds and litigation action.

21. The latest statistics from MHCLG show that remediation work has been completed on 13 high-rise, private residential buildings. A further 168 buildings are yet to be remediated; of these, 24 have begun remediation, 76 have a plan in place, 46 have plans in development, and 22 buildings remain with unclear remediation plans. There are still four buildings where the cladding status is yet to be confirmed.

Funding

22. Following the Government's decision to provide funding for the owners of private high-rise residential buildings with ACM cladding to remediate them, the MHCLG Secretary of State has warned that where owners had not applied the Government was considering naming and shaming them. He also indicated that the Government was considering what other measures could be taken where building owners did not come forward and apply for funding.

Joint Inspection Team

23. One option to encourage building owners tom come forward would be for councils to take enforcement action against owners who do not apply for the funding. As members will recall the LGA is hosting the Joint Inspection Team (JIT) to support councils' use their enforcement powers under the Housing Act and the Housing Health and Safety Rating System. The team has so far supported two local authorities to take enforcement action following a full site inspection on a small number of buildings, and has provided initial advice to a number of others. A further inspection is due to be carried out for a third local authority in the week of the Board meeting, and the team is in discussion with a number of other authorities about more inspection to be conducted over the coming months.

Fire Protection Board

24. A new Fire Protection Board is being established, chaired by the NFCC, with Home Office, MHCLG and LGA representation. The Board's Terms of Reference are being finalised, but its initial priority will be to provide assurance around the interim fire safety measures in place in buildings with dangerous ACM cladding. Fire and Rescue Authorities (FRAs) have already been written to directly by the Home Office about this following a pilot process which concluded recently, and we expect FRAs will now be in the process of putting in place preparations for carrying out the assurance process.

Fire Doors

25. As members will recall from previous meetings, MHCLG identified systemic issues with glass-reinforced plastic (GRP) composite fire doors' ability to meet the necessary 30 minute standard. We continue to hold regular meetings with MHCLG officials, along with London Councils, the National Housing Federation and a number of local authorities, to discuss the issues created by this.

26. Members will also recall from previous updates that this resulted in a remediation plan drafted by the fire doors industry, setting out how they intend to cover the costs of remediating sub-standard GRP fire doors. The LGA and its members have previously expressed several concerns with this plan relating to manufacturers' ability to cover costs, and the exclusion of several high risk categories of buildings.

27. We had anticipated that MHCLG would produce advice for building owners on the identification of fire doors that needed remediation before the end of the year, but this is likely to be delayed until after the general election. Our concerns around the usefulness of the manufacturers' remediation plan remain, and we expect discussions about the plan to resume after the general election.

Reform

Joint Regulators Group

28. As members will recall from previous meetings, MHCLG has been progressing development of policy and legislative options for implementation of changes to the new regulatory framework through the Joint Regulators Group. The LGA, along with the Health and Safety Executive, Local Authority Building Control, and the National Fire Chiefs Council are members of this group, and there have been a range of workshops and working groups meeting regularly since the last Board meeting to continue to flesh out the detail of Government's policy proposals, and make practical arrangements for their implementation.

29. The Government is working with the Health and Safety Executive to set up the new building safety regulator they are proposing in shadow form. The LGA continues to lobby

to ensure that the views of local regulators (both councils and FRAs) are taken into account when devising the new body, as we expect enforcement and inspection to continue to be delivered locally. The Government had intended to respond to the "Building a Safer Future" consultation by the end of the year, but again this is unlikely to happen due to the timing of the general election.

Automatic Fire Suppression Systems (AFSS)

30. The Government is consulting on changes to fire safety regulations for new-build blocks of flats. The headline change in this consultation is the proposal to lower the height at which sprinklers are required in new build blocks of flats. The LGA - in conjunction with the National Fire Chiefs Council - has already called for this change and our response will reflect the conclusions of the Fire Service Management Committee's working group on AFSS, which have been endorsed by the LGA's Executive. The LGA has already called on the Government to make funding available for councils to retrofit sprinklers and deliver the same safety standards to those living in ageing tower blocks as it requires in new build housing. The consultation, which is linked to wider changes planned for Approved Document B and also covers signage and evacuation alert systems, closes on 28 November.

Implications for Wales

31. Building regulations and fire and rescue services are devolved responsibilities of the Welsh Assembly Government, and the main implications arising from the recommendations of the Hackitt Review and the government's response to it are on building regulations and fire safety in England. However the Welsh government has announced that it will be making the changes recommended in the report to the regulatory system in Wales, and the LGA has been keeping in contact to ensure the WLGA is kept informed of the latest developments in England.

Financial Implications

32. Although the LGA has set up the Joint Inspection Team, the cost of doing so is being met by MHCLG. Other work arising from this report will continue to be delivered within the planned staffing budget, which includes an additional fixed term post in the safer communities team to support the LGA's building safety work

Next steps

33. Officers to continue to support the sector's work to keep residents safe and reform the buildings safety system, as directed by members.

Appendix A – LGA Statement

LGA RESPONDS TO GRENFELL TOWER INQUIRY REPORT

Responding to the publication of the Grenfell Tower inquiry report today, Lord Porter, building safety spokesman at the Local Government Association, said:

“The tragedy that unfolded at Grenfell Tower and claimed at least 72 lives in such an unimaginable and heart-breaking way, must never be allowed to happen again.

“There are undoubtedly lessons that can be learned about how the fire service responded on that tragic night as it faced the worst fire in this country for more than half a century. However, the inquiry has made a fundamental error by examining the response to the fire before examining its causes. The consequence of this is to scapegoat the fire service while those responsible for the fire have yet to be exposed or held to account.

“It is clear that the fire was caused by a catastrophic failure of the building safety system in England. This has been proven by the number of public and private buildings with flammable material and the number of modern buildings which are behaving in unexpectedly dangerous ways when they catch fire. Reform of this broken system cannot come soon enough.

“Government has to ensure any new regulatory system not only covers high-rise residential buildings, but extends to any building where vulnerable people sleep like hospitals, care homes and residential schools. Those who live in, work and visit high-rise and high-risk buildings must be safe. We look forward to continuing to work with the Government at pace to deliver the much-needed reform to ensure residents are safe and feel safe.”

NOTES TO EDITORS

The LGA represents more than 350 councils in England and Wales and all fire and rescue authorities.

ENDS