Grenfell Tower Public Inquiry Phase 2 report

National Housing Federation briefing

October 2024

Introduction

The Grenfell Tower Public Inquiry published its second and final report on 4 September 2024. The first phase of the Inquiry established the course of events on the night of 14 June 2017, and the second phase was dedicated to establishing how a building had come to be in the condition that such a tragedy could occur.

In its Phase 2 report, the Inquiry has made recommendations that aim to further regulate the construction industry, clarify the requirements of the building regulations, improve the testing regime for construction products, strengthen the role of building control, ensure the competence of fire risk assessors, and ensure effective management and operation of the fire and rescue services, among other things. In a statement made on the day the report was published, the Inquiry acknowledged the scale of change that had already taken place in the last seven years but urged that more had to be done.

This briefing does not summarise all of the findings and recommendations. It focusses on those for housing associations to consider in particular.

A public inquiry makes recommendations, and it is the government’s decision as to if, or how, the recommendations will be implemented. On the day the report was published, the Prime Minister said that the government will respond in full within six months. The government has already announced its intention to bring forward proposals in response to a key recommendation from the Phase 1 report – which was reiterated in the Phase 2 report – relating to the evacuation of vulnerable people during an emergency. The NHF will engage with members on these proposals once they are published.

The NHF is committed to working with our members, the government and other stakeholders, to learn the lessons from the fire at Grenfell Tower, so that such a tragedy can never happen again. When the Inquiry’s report was published, we wrote to the Prime Minister and the Building Safety Minister to reaffirm this commitment.

If you have any questions about this briefing, please contact Victoria Moffett, Head of Building and Fire Safety Programmes.

The Tenant Management Organisation

[Part four](https://www.grenfelltowerinquiry.org.uk/sites/default/files/CCS0923434692-004_GTI%20Phase%202%20Volume%203_BOOKMARKED_0.pdf) of the Inquiry’s report details the failings of the Tenant Management Organisation (TMO) in its responsibility to ensure the health and safety of residents at Grenfell Tower. While we have set out the key lessons from this part of the report below, we recommend that those who work in social housing, and particularly those who are responsible for resident safety, read this part in full, so that we all have a clear understanding of how the TMO failed in its duties to residents. Part four identifies various themes in the TMO’s failings, including around organisational culture, competence, transparency, governance and its relationship with residents.

Part four begins by setting out the governance arrangements at the TMO, describing them as ‘satisfactory.’ Despite this, one of the key points the Inquiry raises is around the ‘culture of concealment’ at the TMO. On a number of occasions, the TMO’s board and the Royal Borough of Kensington and Chelsea’s (RBKC’s) scrutiny panel were not provided with information by the executive about the TMO’s approach to fire safety. This included concerns raised by the London Fire Brigade (LFB) about the TMO’s approach to fire safety, deficiency notices issued by the LFB, and breaches of the Fire Safety Order identified by a third party contracted to carry out fire risk assessments in light of the LFB’s concerns.

The Inquiry identified an over-reliance on the judgement of one relatively junior member of staff as to whether an issue should be disclosed to the board. But importantly, after identifying multiple occasions when the CEO himself did not disclose important information to the TMO’s board, the Inquiry states that it “can only conclude that he (Robert Black, the CEO of the TMO) and the executive team failed to make even the most basic disclosure to the board of the widespread systemic failings in the TMO’s management of fire safety.” Because of this, the Inquiry concludes that the TMO board was deprived of the ability to take corrective action.

The Inquiry also refers to the governance arrangements between the TMO, which managed Grenfell Tower, and the RBKC, which owned Grenfell Tower. It highlights that there was confusion at the executive level of the TMO as to its independence from RBKC, that the performance reviews of the TMO written by RBKC were written with information from the TMO that was not independently verified, and that an audit of the TMO’s work did not take place despite this being part of an annual performance agreement. The Inquiry also states that the prompt completion of actions relating to fire safety in fire risk assessments was not a key performance indicator.

Part four also details the relationship between the TMO and the residents of Grenfell Tower. It identifies occasions when the TMO sought to silence residents and their representatives, and that proposed means of engaging with residents were directed at giving information to residents rather than hearing from them. It identifies that some of those involved in the refurbishment were nervous of particular residents and they allowed it to be a barrier to proper engagement.

On this topic, the Inquiry concludes that relationships between residents and the TMO were “characterised by distrust, dislike, antagonism and anger on both sides, but that the TMO had the responsibility to ensure that the relationship was maintained.” The Inquiry regards the fact that it didn’t do this as “a serious failure to recognise its basic responsibilities”.

The Inquiry hasn’t made any recommendations specifically in response to the failings of the TMO referenced in this part. It states that this is because the Social Housing (Regulation) Act 2023 enables the Regulator of Social Housing to “play a more active role in setting appropriate standards and ensuring they are met.” However, the Inquiry states that those ‘responsible for the management of social housing should give…careful consideration (to the criticisms of the TMO) and take appropriate action accordingly.’ The NHF will be considering the Inquiry’s findings, and we will be creating engagement opportunities for our members to reflect on the themes identified.

The management of fire safety at Grenfell Tower

[Part five](https://www.grenfelltowerinquiry.org.uk/sites/default/files/CCS0923434692-004_GTI%20Phase%202%20Volume%203_BOOKMARKED_0.pdf) of the report examines the legal obligations of those responsible for the management of residential buildings, and the steps taken by the TMO to comply with them in the years leading up to the fire. It also examines the role of the Royal Borough of Kensington and Chelsea, given it was responsible for overseeing the TMO’s arrangements for protecting the health and safety of residents. It identifies a series of failings and missed opportunities by different parties, over many years, to effectively manage fire safety at Grenfell Tower.

The Fire Safety Order

In relation to meeting the requirements of the Fire Safety Order, the Inquiry found that there was confusion between the TMO and the RBKC on their respective responsibilities. It found that all parties should be clear on their responsibilities under the Fire Safety Order and while the Order seeks to identify a single ‘responsible person’ for each premises, this does not exclude other parties from being subject to the same duties.

Fire safety management at the TMO and the development of fire safety strategies

The Inquiry criticised the length of time it took for the TMO to review and sign off a fire safety strategy. A strategy to address a failing identified in 2009 was not taken forward until 2013 and the process to formalise it was confused and not completed. A fire in another building managed by the TMO in October 2015 prompted a review of the fire safety strategy, but this was still under way well into 2017. The Inquiry said that “the delay speaks to an absence of proper expedition to make sure that a policy, which touched on the health and safety of residents, was completed expeditiously and kept up to date to reflect any changes in circumstances or regulatory requirements.”

Fire risk assessments and the response to them

The Inquiry criticised the relationship between the TMO and Carl Stokes – its sole fire risk assessor from 2010 until the fire in June 2017. It found that “Mr Stokes’ willingness to be an advocate for the TMO in disagreements with the LFB was a material factor in the decision to appoint him”. It also found that he was appointed to work on higher-risk properties without a new tender, which was “not a proper or safe way for the TMO or RBKC to seek to discharge their duties under the Fire Safety Order”*,* and“created a risk that the standard of the fire risk assessments produced as a result might not meet the statutory requirement”. The TMO placed “an undue amount of trust and confidence” in him and failed to monitor or audit the quality of his fire risk assessments.

The Inquiry also criticised Mr Stokes’ competence, and his fabrication of relevant qualifications and experience. It details some unacceptable behaviours on his part, such as copying and pasting information from previous assessments of other buildings (which it criticised the TMO for not noticing), being selective about his use of guidance, and bowing to pressure put on him by the TMO.

The Inquiry also criticised the TMO’s role in responding to the findings of fire risk assessments, identifying that it kept “no reliable or comprehensive record of what remedial work Mr Stokes thought it particularly important to complete,” and for its attempts to persuade Mr Stokes to recategorise the priority of actions identified in fire risk assessments.

The replacement, inspection and maintenance of entrance doors

This chapter confirms the failures of the wider fire door testing system, as well as the TMO’s failure to specify the doors that it needed to meet regulatory requirements. It found that the TMO also failed to assure itself that the doors it received corresponded with the test certificates supplied.

It details the TMO’s failure to implement a required system of inspection, servicing and maintenance for fire doors, which led to a failure to address instances when self-closing devices were removed. It found that those responsible did not understand the importance of self-closing devices, and did not raise issues gaining access to flat front doors with managers so that they could be installed or fixed.

Fire safety information

The Inquiry found that fire safety advice given to tenants was inadequate. There was no process for ensuring or recording that new tenants received fire safety letters, the tenant handbook went out of stock and was not replaced, the website information depended on residents accessing this themselves and fire safety articles were extremely inconsistent in tenant and leaseholder magazines and not building specific.

It also found that the TMO failed to follow guidance on placing fire action signs in communal areas for seven years and only acted on this and on the provision of information to residents following resident complaints, or a deficiency notice from LFB.

The smoke ventilation system

The Inquiry found that the smoke ventilation system at Grenfell Tower had been in an inadequate condition for many years, and that this was known about even prior to a fire in April 2010, when the smoke ventilation system allowed smoke to leak into lobbies. A contractor quoted for work to remedy the issues, but there is no clear evidence that this was ever carried out. The TMO assured the LFB that interim measures would be put in place while the system was being repaired, but there is no evidence that this happened either. When leaseholders complained following the fire, they were not told about the defects, or that remedial work was needed.

Fire risk assessments over successive years recommended that confirmation be provided that the system was being regularly tested and maintained, but this confirmation was not provided. When evidence was available that the smoke ventilation system was not working appropriately, fire risk assessments failed to reflect this. When a deficiency notice was issued by the LFB, it was not followed up on. Finally, when there was action to modernise the system, the time between publishing a tender document and carrying out the work was four and a half years, and the LFB was not kept regularly informed.

Lifts

This section relates to the maintenance of fire control switches and the use of generic drop keys which weren’t compatible with the switches. Firefighters were found to be ordering keys from Amazon or eBay because delivery was quicker than through LFB procurement, which in turn led to keys with an incorrect pattern being in circulation.

Emergency planning

This chapter of the Inquiry focused on the TMO’s approach to planning for an emergency. It found that the TMO had not updated the emergency plan for Grenfell Tower in 15 years, and changes as a result of the refurbishment had not been reflected. It also found that fire risk assessments for the building didn’t refer to whether there was an emergency plan and included incorrect statements about who would be responsible for an evacuation. The Inquiry found that a fire in another TMO-managed building in 2015 alerted the senior management team to the need to review and revise its emergency plans, but no steps were taken towards this.

Vulnerable residents

In this section, the Inquiry looks at the TMO’s approach to identifying and providing support to residents who wouldn’t be able to evacuate in an emergency. It describes the TMO’s failure to understand where residents of Grenfell Tower would need support to evacuate as “a basic neglect of its obligations in relation to fire safety.”

The report references the Fire Safety Order and makes two clarifications on its contents. Firstly, that the responsibilities it sets out cannot just apply to buildings where there are staff present to help with evacuation. Secondly, that these regulations around evacuation apply to everyone lawfully in the premises - residents and visitors - regardless of their 'physical or mental capabilities'.

The Inquiry makes it clear that the TMO failed to meet these existing requirements. Namely, that those responsible should take steps to identify anyone who would need support to evacuate, that escape routes should be assessed for their suitability for those people, and that reasonable steps should be taken to ensure that a disabled person could realistically use the premises.

The Inquiry highlights that the LFB raised concerns about “the failure of the TMO to make adequate provision for disabled people to escape from its buildings” in 2009. The same year, the TMO commissioned a third party to carry out a review of its approach to fire safety, which also identified that the absence of a procedure to ensure the safety of disabled people constituted a breach of fire safety requirements. The Inquiry also found that there was no evidence that the TMO shared information about any vulnerable residents with its fire risk assessor. Fire risk assessments that highlighted the need to understand and make arrangements for people who needed support to evacuate went unacted upon.

The TMO also didn’t make residents aware that they could request support to evacuate. Where information about residents’ needs was recorded, usually at the beginning of a tenancy, it was not recorded consistently and developments meant it ended up being recorded in three different systems. There was no established procedure at the TMO for identifying circumstances that would result in the consideration of a Personal Emergency Evacuation Plan (PEEP). The Inquiry stated that the TMO ought to have had a readily accessible system for collecting and maintaining information about residents’ vulnerabilities – both to decide whether a PEEP was necessary, and to assist during emergencies. Between 2010 and 2017, only two residents were assessed for PEEPs by the TMO.

The Inquiry states that it believes that people who can’t evacuate independently should be provided with a PEEP, but that the content of it will depend on what is practicable in each case. The Inquiry states that as far as reasonably practicable, people who are vulnerable should have a means of escape which is as good as that available to those that do not share their particular vulnerability. This was a recommendation in its Phase 1 report and the Inquiry has repeated this recommendation in its second report. The previous government had consulted twice on proposals to bring forward this recommendation, but the response to the second consultation had not been published prior to the election. The current government has announced it will bring forward proposals in autumn 2024, which had not been published at the time of writing this briefing.

The refurbishment of Grenfell Tower

[Part six](https://www.grenfelltowerinquiry.org.uk/sites/default/files/CCS0923434692-004_GTI%20Phase%202%20Volume%204_BOOKMARKED_0.pdf) of the report examines the refurbishment of Grenfell Tower from inception to completion, highlighting how various actors carried out their legal duties, and what this meant for decision making that affected the course of the refurbishment. It also covers the selection of the external wall materials and the failure of the building control process to identify and correct the errors in the design and choice of materials. Overall, it finds that there were failings across multiple actors, particularly in relation to a failure to understand and communicate responsibilities for compliance with the building regulations, demonstrating a lack of competence across the board.

For the purposes of this briefing, we will focus on the responsibilities of the TMO and how these were carried out. The Inquiry states that responsibility for the dangerous condition that Grenfell Tower was in following refurbishment primarily rests with those who designed, constructed and approved the work, as well as those who manufactured and sold the materials used. But “the TMO itself must take a share of the blame for the disaster.”

The procurement of competent professionals

The first error identified is that the TMO failed to give proper attention to the appointment of the architect for the project, instead going along with the RBKC’s desire to engage the team already working on another nearby project, to save time and cost. This meant that there was no competitive process, and no assessment of its competence to carry out the work. This was despite an existing requirement for clients under the CDM Regulations 2007 to take reasonable steps to ensure that any designer, principal contractor or contractor appointed is competent to take on the role. The Inquiry states that there is no evidence of the TMO being aware of that obligation, and, when a resident asked whether the architect had sufficient experience of working on tower blocks, there is no evidence that he ever received an answer.

On a similar theme, the Inquiry highlights a decision taken by the TMO to perform the role of client design adviser, and that it would approve all design decisions. This is a role that could have been provided by the TMO’s employer’s agent, Artelia, but the Inquiry believes the decision was driven by commercial considerations, and an unrealistic view of the expertise available within the TMO.

Avoiding the procurement rules

To avoid having to carry out a competitive procurement procedure, the TMO insisted that the architect’s fees be capped at an amount that would be insufficient to cover the provision of tender documents needed to appoint a principal contractor. To get around this, part of the fee was deferred until after the principal contractor was appointed. This meant that the TMO ‘deprived itself of the opportunity to select an architect from a wider range of applicants, some of whom might have had more relevant experience.’

In addition, the TMO conducted discussions with the principal contractor, Rydon, prior to the procurement process completing, which allowed Rydon to amend its price in advance of being awarded the contract. The TMO had received advice from its solicitors that a meeting of this nature was not permissible.

The Inquiry found other evidence of the TMO seeking to manipulate the procurement process with a view to value engineering. Though it also notes Rydon’s role in failing to disclose a costing error in its original tender, meaning that the TMO later did not have a full understanding of Rydon’s financial interest when it recommended the use of the ACM cladding. The Inquiry also notes that it would have been reasonable for the TMO to have considered asking RBKC to increase its budget for the refurbishment in light of the tender price, instead of value engineering, particularly as RBKC had previously agreed to increases in the budget for the project.

Failure to notice that Exova’s work was incomplete

Exova was employed by the TMO as fire engineer, to produce fire safety strategies for Grenfell Tower in connection with the refurbishment. It produced a draft outline fire safety strategy for Grenfell Tower, but this was not completed. The Inquiry notes that it was principally the TMO’s responsibility to ensure this work had taken place, and that there were instances where it should have noticed that the work hadn’t been completed. However, it also notes that the employer’s agent, Artelia, should also have alerted the TMO to the omission, and others involved in the refurbishment had responsibilities that they also didn’t carry out in relation to the fire safety strategy.

Failure to challenge Rydon’s decision not to appoint a fire safety consultant

Once Rydon was appointed principal contractor, it was responsible for making sure sufficient expertise and resources were made available to the project and that the work carried out by external consultants was satisfactory. However, Rydon failed to take any action to contact Exova about the fire safety strategy. This was because it didn’t usually do this, assuming instead that the safety of the design had been established before its appointment. The Inquiry finds multiple examples of where Rydon failed to properly define the terms of contracts, or issue them at all.

The Inquiry is also critical of the TMO for failing to sufficiently challenge this. It did ask in multiple meetings, but after a certain point it stopped asking. Instead, the TMO retained the services of Exova in an unstructured way and on ill-defined terms.

Failure to resolve fire safety concerns

While the TMO raised questions with Rydon about the fire performance of the ACM cladding, the Inquiry found that it didn’t receive a satisfactory response and did not insist on one. It also criticises Rydon for not following up with the query, given its significance.

Failure to involve residents

The Inquiry notes that it was particularly important for residents to be engaged on the refurbishment, given that it was taking place while the building was occupied. However, the Inquiry found that residents’ involvement in the process was largely symbolic, with their views during the procurement stage diluted and their attendance at meetings an afterthought. The TMO did not carry out its duties under the management agreement and residents were given no opportunities to question or challenge key decisions.

The Inquiry has not made any recommendations to address the failings of the TMO as a client, in terms of not being aware of its full responsibilities. It says that this is because of the new requirement under the Building Safety Act 2022 for the client to make or approve a statement of compliance with the building regulations, to be provided as part of a building control application.

Recommendations

The Inquiry made a range of recommendations in response to its findings. In its statement when the report was published, it urged those responsible to go further than the regulatory changes that have already taken place. We have summarised some of the recommendations in this briefing, but you can read them in full on [the Inquiry’s website.](https://www.grenfelltowerinquiry.org.uk/sites/default/files/CCS0923434692-004_GTI%20Phase%202%20Volume%207_BOOKMARKED.pdf)

The construction industry

Its recommendations for the construction industry focus on improving the regulatory arrangements, in terms of bringing the responsibility for construction and safety regulation into one government department and recommending a Chief Construction Adviser, and on improving competence of individuals working in construction by requiring licenses to work on higher-risk buildings. It also makes recommendations around improving the reliability of fire performance tests, and the clarity of construction products’ certification process.

Legislation, regulation and guidance

In terms of improving existing regulation and guidance, it recommends that the definition of higher-risk for the purposes of the Building Safety Act is urgently reviewed, stating that it is arbitrary to consider risk in relation only to a building’s height. It also recommends that Approved Document B be reviewed and redrafted, so that there can be a high degree of confidence that the requirements have been met. In particular it recommends that the guidance draw attention to the need to make a calculation of likely fire spread and evacuation timeframes, so that these can be used in a fire safety strategy. It also recommends that the revision of Approved Document B considers that the existence of effective compartmentation is a questionable assumption. It also recommends that the academic community be involved in the membership of any bodies advising on changes to guidance.

Fire safety strategies

In terms of fire safety strategies, the Inquiry recommends that the fire safety strategy consider the needs of vulnerable people, including the additional time they may require to leave a building or reach a place of relative safety, and any additional facilities necessary to ensure their safety. It also recommends that there is a statutory requirement for a fire safety strategy produced by a registered fire engineer to be submitted as part of a building control application for a higher-risk building (Gateway two), whether for the construction of a new building or refurbishment of an existing building, and for it to be reviewed and re-submitted on completion (Gateway three).

Fire engineers and fire risk assessors

It also makes recommendations to ensure high standards among fire engineers, given the importance of their role in designing safe buildings. It recommends the fire engineering profession be recognised and protected by law, and that the government take steps to increase the number of places on high-quality master's level courses. It also recommends the government convene an appropriate group to set out a statement of the knowledge and skills expected of a fire engineer.

For fire risk assessors, the Inquiry recommends that the government establish a system of mandatory accreditation to certify the competence of fire risk assessors.

Response and recovery

It also makes a range of recommendations aimed at improving the response to emergencies such as the fire at Grenfell Tower, some of which may affect housing associations. This includes a recommendation that local authorities make reasonably practicable arrangements to enable them to place people in temporary accommodation at short notice, which should, as far as possible, involve local providers of social housing.

The Inquiry also makes a raft of recommendations aimed at fire and rescue services and others with a role in constructing and managing buildings.

Next steps

On the day the Inquiry’s report was published, the Prime Minister addressed Parliament, setting out the government’s response. You can read his full speech [here](https://www.gov.uk/government/speeches/prime-ministers-statement-on-grenfell-tower-inquiry-final-report-4-september-2024).

In his speech, the Prime Minister said that the government will look at all of the Inquiry’s recommendations in detail and will respond in full within six months. The NHF is engaging with officials on this, and we understand that a response is expected in March 2025.

The Prime Minister also set out his view that the speed at which buildings with unsafe cladding are being addressed is too slow. The government is planning to publish a remediation action plan in autumn 2024, which the NHF has also been feeding into. We expect this to identify specific barriers and solutions to increasing the pace of remediation and we will ensure there are ongoing opportunities for our members to shape this work.