



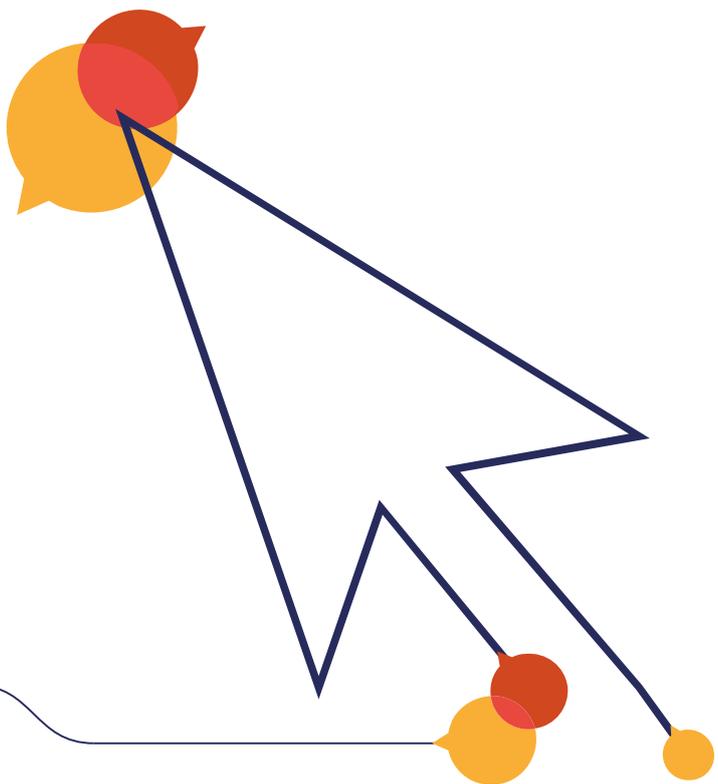
accidents don't have to happen

# Terms of Reference of the Grenfell Tower Inquiry

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Views of the Royal Society for the Prevention of Accidents

July 18, 2017



# 1. Background

The Royal Society for the Prevention of Accidents (RoSPA) is a registered charity that has been at the heart of safety and health in the UK, and indeed around the world, since our inception during the First World War. We are unique within the UK's health and safety community in that we take a whole person, whole life approach to accident prevention with our influence and activities covering safety at home, at work, on the road, at leisure and in schools and colleges.

We play a leading role to support, champion and co-ordinate safety and health activities at a national level, including through various committees that bring together top-level experts within particular fields, and which include the National Home Safety Committee and the National Occupational Safety and Health Committee.

We are currently marking our centenary year, not only focusing on the achievements of the past 100 years – such as the significant reductions in death and injury on the roads and in workplaces – but also focusing on the challenges that remain within accident prevention. Total accidental deaths and injuries are on the rise, especially in homes and during leisure, and the most vulnerable – the very young, older people and the poorest – are affected disproportionately.

Everyone at RoSPA was absolutely horrified by the extent and severity of the fire at Grenfell Tower, which is the worst we can recall seeing. Our heartfelt thoughts are with everyone affected by the horrific incident.

Since the fire, we have sought to put our expertise to good use, including producing simple fire safety messages for the public who may be freshly-concerned about their safety in light of Grenfell ([www.rospa.com/lets-talk-about/](http://www.rospa.com/lets-talk-about/)) and also joining with other health and safety organisations to contribute to the debate about the general context of deregulation.

On the wider issue of what happened and why it happened, as we witnessed the terrible scenes at Grenfell Tower on the morning of June 14 our immediate thoughts were that this appalling tragedy should not be happening in one of the safest countries in the world; that something must have gone terribly wrong; and that safety decision-making must have broken down.

There must be an inquiry that digs deep enough and goes wide enough so that not only this event but similar tragedies cannot happen again.

With these thoughts in mind, we welcome the opportunity to respond to the consultation on the Terms of Reference (ToR) of the Grenfell Tower Inquiry.

## 2. Purpose and scope of the inquiry

At RoSPA, we stress constantly that accidents don't have to happen. But we also caution that, in their detail, they are rarely simple phenomena. For accidents to happen, several errors and weaknesses have to come together to produce an unplanned adverse outcome. Conversely, for safety to work well, several layers of safety have to be in place to stop errors and weaknesses turning into tragedy. Safety is multi-layered.



## Terms of Reference of the Grenfell Tower Inquiry: RoSPA views

The role of inquiries into disasters is to establish clearly not just what happened, when, where, how and with what consequences, but crucially to ask “why?” Asking “why” enough times and at each stage of the inquiry process is necessary to understand both the *immediate* and *root* causes, and to address what needs to be done to prevent a recurrence.

For it to be able to go deep enough, it will be important that the Grenfell Tower Inquiry’s ToR are not too restrictive and that suitable technical assessors are appointed.

And, if the negative atmosphere surrounding health and safety created by more than a decade of deregulation and “light touch” risk management and enforcement played a significant part in this awful tragedy, then the inquiry should not shrink from examining this in some detail and laying bare the facts.

While not being used for party political advantage, the inquiry must look at the policies of government, councils, professional bodies and other organisations to identify whether these had weaknesses that caused poor decision-making, leading to the tragedy. And if the inquiry reveals a formulaic, “tick box” compliance approach in the chain of safety decision-making around Grenfell Tower, it will need to delve deeply into this issue and identify the extent to which corporate and public risk committees were, and indeed are, really taking their responsibilities seriously.

Too often in the past, inquiries have failed to dig deep enough to uncover the organisational, institutional and cultural reasons why hazards were not identified and risks properly controlled. A superficial “fly, crash, fix, fly” approach to safety improvement misses the opportunity presented by each new disaster to find out why safety failures were not anticipated and stopped in their tracks before people were harmed. (See Annex 1 for RoSPA’s broader views on “transformative inquiries” and Annex 2 for a list of previous tragedies and the subsequent inquiries/investigations).

We all owe it, not just to the victims of Grenfell Tower but also to the countless others who could well be harmed by accidents due to the same underlying “safety pathogens”, to get this inquiry right.

## 3. Issue-specific questions

What follows are questions that RoSPA believes must be asked in order to establish fully the causes of the Grenfell Tower tragedy. They relate specifically to the situation regarding Grenfell Tower itself, but clearly have implications for practices across the wider local authority area, in other parts of the country and, indeed, in sectors wider than just housing.

### 3.1. Fire safety responsibilities, risk assessments and systems

- What were the fire safety responsibilities of the landlord (the local authority)?
- What were the fire safety responsibilities of the management company?
- What access to competent professional advice did both the landlord and the management company have? Was it adequate? If not, why not?
- Who carried out the fire safety risk assessments? How competent were they?
- What was the frequency, depth and quality of fire safety risk assessments? What upgrades were identified? What was the implementation shortfall? Why? What upgrades were implemented? Which, if any, were delayed and why?



## Terms of Reference of the Grenfell Tower Inquiry: RoSPA views

- Were sprinkler systems ever considered as part of the fire safety risk assessments? If they were, why were they not adopted?
- How were the residents involved/consulted in fire safety risk assessments? What issues had they raised previously and what had been the response from the management company?
- What was the design basis of the fire safety case in the original build of Grenfell Tower?
- How was the overall design for the refurbishment agreed? What was the consideration of fire safety in the design/planning for the re-furb?
- What was the standard of materials procurement/workmanship? Is there evidence of cost-saving that compromised fire safety?
- What information from other high-rise etc. fires was taken into account from around the world?
- Who were the architects? Who was the CDM lead? Who was advising the principal contractor? Were any issues about fire safety raised at review?
- What was the involvement of the local authority building control?
- What was the safety and health culture within the local authority, the management company and the various other bodies involved in the refurbishment and ongoing management of Grenfell Tower? Was safety and health led effectively from the top? Is there evidence of a “tick box” approach to risk management in these organisations and, if so, what factors contributed to this approach being adopted?

### 3.2. The provision and maintenance of smoke alarms and fire safety information

- What types of smoke alarms were installed in communal areas and individual flats? Was a hard-wired system in place (which is best practice) or were the alarms battery operated, either with a 10-year battery (which is good practice) or with “normal” batteries that require changing regularly? Why were the particular alarms selected?
- Were smoke alarms fully linked (meaning that they would all sound in the event of a fire) or semi-linked (meaning that residents in close proximity to the seat of a fire could evacuate quickly)? Why was the system chosen?
- Who was responsible for testing and maintaining the smoke alarms (including changing batteries, where required)? If it was the residents’ responsibility, had they been advised sufficiently of this?
- How frequently were smoke alarms checked?
- Were carbon monoxide (CO) alarms installed? If not, why not? Given the suggestion that many of the deaths were due to CO poisoning, could the installation of CO alarms have provided earlier warning of the need to evacuate?
- Did the local authority work with the local fire service in the provision of fire safety information? Free home fire safety checks are available in many areas – were these promoted to residents?
- What information was provided to new and existing residents on an ongoing basis about fire safety and home safety in general? Was this information made available in different languages/formats (e.g. pictorial)?
- Did residents have clear information about what to do if a fire broke out in their own flat?
- Did residents have clear information regarding the fire escape plan for individual flats and for the building as a whole?

### 3.3. White goods

- Were white goods, such as fridges, freezers, washing machines and tumble dryers, provided for residents or were residents responsible for providing their own? If provided by the local authority, did the local authority register the appliances at [www.registermyappliance.org.uk](http://www.registermyappliance.org.uk) so that it would be



## Terms of Reference of the Grenfell Tower Inquiry: RoSPA views

notified of any recalls/safety information? If residents were responsible for providing their own, did the local authority encourage residents to register them using this service?

- If white goods were provided centrally, was there a regime in place for testing/upgrading appliances?
- Did the local authority housing department work with the authority's own trading standards team with regard to recalls of faulty white goods?

### 3.4. Maintenance and structural issues with regard to personal safety

- Was a concierge/caretaker on site to deal quickly with issues of maintenance (including with fire doors, clutter in stairwells, fire escapes, fire alarms etc.)? If there was no one on site, were residents aware of the reporting procedure and how quickly were reported problems attended to?
- Were fire doors in place and fully operational (meeting the relevant standards, not being broken and not being propped open)?
- Given that the "stay put" advice in the building was apparently based on the view that fire should be contained within the flat where it began, were there any structural reasons, besides the much-publicised issue of the cladding/external insulation, which led to the fire spreading so quickly?
- Has the fire investigation identified any factors that contributed to the spread of poisonous fumes (e.g. insulation, furniture within homes etc.)?

### 3.5. Cladding standards

- How did the cladding of the type used on Grenfell Tower and similar buildings get an Agrément Certificate from the BBA (British Board of Agrément)?
- To what standards was the cladding tested and how were these standards developed, both here in the UK and at a European level via CEN (the European Committee for Standardization)? Who were the members of the relevant technical committees? Which organisations did they represent? What was their competence and background? Were they mainly drawn from manufacturers? Was there any consumer or regulatory representation?
- What were the modelling assumptions and data on which the standards were based?
- Where these standards and any associated test methods constructed to enable compliance by the lowest-end producers?
- Did all other (non-cladding) aspects of the refurbishment of Grenfell Tower comply with the current Building Regulations?

### 3.6. Wider considerations

- To what extent were the important lessons of the Lakanal House fire taken on board? Which department of Government was responsible for following them through? If they were not fully implemented, why not? Which Minister was ultimately responsible? Did the delay in reviewing Building Regulations and the promulgation of relevant advice contribute in any way to the tragedy?
- Are there differences in how safety in general, and fire safety in particular, is promoted and managed in the social housing sector compared to the private rented sector? If so, why?
- Health and safety has, for a number of years, been derided in some quarters as an unnecessary "burden", with deregulation being promoted as a way of freeing-up businesses from red tape. Is there any evidence that this has contributed to the lowering of safety standards within the housing sector?
- The general duty of care in common law and the use of risk assessment at the planning stage should be sufficient to avoid the creation of unacceptable risks, whether or not these risks are covered by



## Terms of Reference of the Grenfell Tower Inquiry: RoSPA views

explicit regulations or guidance. Is there any evidence from the wider context of safety and health management in the UK that organisations feel free to do anything unless it's specifically prohibited by regulations?

## 4. Conclusion

In answering the questions outlined above, it is clear that a huge amount of evidence will be required. At this point, we would urge that in making an assessment of organisations' entire safety and health management systems and cultures, and whether these contributed to the tragedy, it will be crucial to look beyond the individual policies that may exist within organisations. Having a number of policies covering specific aspects of safety management does not add up to a positive safety system or culture and it will be important for the inquiry to delve deeper into attitudes towards safety and health management from the top down.

Given the huge sensitivity surrounding the tragedy, we understand that time is of the essence in producing an interim report. We would recommend that this interim report focuses on whether any swift changes need to be made to housing stock across the country that could save lives and prevent injuries in other incidents, for example with regards to cladding, smoke alarms, sprinklers etc.

The awful scenes of the Grenfell Tower disaster have focused attention on the prevention of catastrophic fires in high-rise buildings, but we should also remember that any lessons learned through the inquiry into this tragedy could apply more widely. In 2015/16, 191 people died in accidental dwelling fires in England in, up from 167 in 2014/15 ([www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/611182/fire-statistics-england-1516-hosb0517.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/611182/fire-statistics-england-1516-hosb0517.pdf)). While the general trend in accidental fire deaths has been downwards in recent decades, the scale of the tragedy at Grenfell Tower shows that there is absolutely no room for complacency.

## 5. Contact details

This submission has been contributed to by colleagues across RoSPA, notably:

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## Annex 1: transformative inquiries

In setting up the inquiry, RoSPA feels that Sir Martin and his colleagues in the Lord Chancellor's Department could usefully look back at the way in which transformative inquiries into previous disasters, particularly from the 1980s onwards, led to wider safety regime change in the sectors affected, if not wider. Contrast, for example, the 1974 inquiry into the Flixborough fire, which was very much engineering based, with the later inquiries into Piper Alpha, Zeebrugge and Kings Cross, which were not just technically very competent but which asked much more searching questions, particularly about standards of safety regulation and corporate risk management.

RoSPA is concerned that, if its ToR are too restrictive and the focus is purely technical, the inquiry will not be transformative because it will not be able to track back down the chains of safety decision-making to identify systemic weaknesses that on this occasion led to a catastrophic fire but that equally could have led to other disasters too.

Effective disaster inquiries should enable not just "single loop" safety learning (tackling immediate causal factors) but "double loop" (tackling underlying factors) or even "triple loop" safety learning (safety culture) – and they can thereby help to strengthen disaster prevention in other domains, often well beyond the circumstances in which the original tragedy occurred.

### Looking at public safety more broadly

Fire, however horrendous, is only one threat to public safety. It must be remembered that large-scale, simultaneous loss of life can occur – and has occurred – in many different contexts where members of the public are present in large numbers such as: civil air transport; rail transport; underground transport; coach transport; river transport; ferries; railway stations; shopping malls; sports stadia; pedestrianised areas in towns and cities; churches, mosques, synagogues; tower blocks and other multi-occupation domestic premises; work premises such as warehouses, major hazards plants; nuclear sites; factories, offshore installations, tunnels and underground chambers; large offices, hospitals, medical centres etc.; schools/colleges; theatres, cinemas and night clubs; race circuits and motor rallies; music festivals and outdoor events, demonstrations; crowds at celebrations; flood-plain housing; shows/exhibitions, theme/leisure parks, attractions and exhibitions; even at fun runs or in restaurants.

The full list is very long.

Reflecting on the above settings, it is true to say that memories of numerous preventable tragedies in the last half of the last century are still raw in the nation's consciousness. So it is important, in setting up the Grenfell Tower Inquiry, that the lessons learned from the way other disaster inquiries have been conducted over the last 50 or so years are reflected. Collective memories about how to do these things well may have become diluted as the Civil Service has evolved and key people have moved on. At an appropriate point there is a strong case for an "inquiry into inquiries" to see how the approaches to the common challenges which these important exercises have to confront, have evolved over time, particularly as our understanding of error – both individual and organisational – has developed. Such a review could look at the selection and role of technical assessors and the level of professional support provided to inquiries – and it could also compare and contrast the response by authorities – and by Society generally – to the implementation of important safety recommendations that they have made.



## Terms of Reference of the Grenfell Tower Inquiry: RoSPA views

### Policies, politics and “hindsight bias”

Assessing the preventability of major tragedies has always been the most uncomfortable challenge at the heart of the public inquiries that followed them. Understanding and taking into account “hindsight bias” is crucial. Most tragedies however – even those that seemed wholly novel and unprecedented – on closer examination tend to be shown to have been eminently preventable, even without the wisdom of hindsight. Yet there is a worrying acceptance that it still takes major loss of life to jolt authorities to take action to prevent recurrence. And the scope for learning lessons in an open way to save lives in the future is too often limited because the atmosphere surrounding these disasters is poisoned by individual and corporate fears about criminal and civil liability and loss of reputation.

It has to be accepted therefore that inquiries that go wide and deep and which seek out facts without fear or favour, can produce findings that are uncomfortable for everyone, particularly those in positions of power authority. But this is where courage and leadership are required from our political leaders.

Inquiries raise all kinds of questions about policies, about which different people have different views (politics) but it is not their job to pass political judgments. Not just politicians on all sides but safety professionals too (and in this we include ourselves) need to be humble enough to admit that we have all failed to some degree, and that until we get to the real roots of tragedies such as the Grenfell Tower fire, more people will suffer in the future – perhaps not in the same way – but in tragedies that will turn out to have been eminently preventable.

## Annex 2: previous tragedies, inquiries and investigations

**Aberfan** (October 21, 1966, 116 children and 28 adults died) – Tribunal chaired by Lord Justice Edmund Davies.

**Summerland fire** (1973, 51 dead) – Public inquiry that ran from September 1973 to February 1974 with Denis Cowley QC acting for the Douglas Corporation.

**Flixborough** (June 1, 1974, 28 killed) – Court of Inquiry set up by the Secretary of State for Employment to establish the causes and circumstances of the disaster and identify any immediate lessons to be learned, and also an expert committee to identify major hazard sites and advise on appropriate measures of control for them.

**Abbeystead** (May 23, 1984, 8 killed) – Section 14 inquiry report by the Health and Safety Executive.

**Bradford City football stadium fire** (May 11, 1985, 56 died) – Mr Justice Popplewell (1986), Final Report of the Committee of Inquiry into Crowd Safety and Control at Sports Grounds.

**Manchester aircraft fire** (August 22, 1985, 57 dead) – Air Accident Investigation Branch investigation.

**Zeebrugge** (March 6, 1987, 193 killed) – Mr Justice Sheen (1987), M.V.Herald of Free Enterprise, Report of the Court.



## Terms of Reference of the Grenfell Tower Inquiry: RoSPA views

**King's Cross** (November 18, 1987, 31 died) – Desmond Fennel QC (1988), Investigation into the King's Cross Underground Fire.

**Piper Alpha** (July 6, 1988, 167 people died) – The Hon Lord Cullen (1990), The Public Inquiry into the Piper Alpha Disaster established under the Offshore Installations (Public Inquiries) Regulations 1990.

**Clapham rail collision** (December 12, 1988, 35 died) – Anthony Hidden QC, Investigation into the Clapham Junction Railway Accident (1989).

**Kegworth air disaster** (January 8, 1989, 47 died) – Air Accident Investigation Branch Report Report No: 4/1990: Report on the accident to Boeing 737-400, G-OBME, near Kegworth, Leicestershire on 8 January 1989.

**Hillsborough** (April 15, 1989, 96 died) – Rt Hon Lord Justice Taylor (1990), The Hillsborough Stadium Disaster, Interim Report.

**Marchioness/Bowbelle disaster** (August 20, 1989, 51 people) – Lord Justice Clarke (between 1999-2001), Thames Safety Inquiry Formal Investigation under the Marine Accident Investigation Branch.

**M40 minibus crash** (November 18, 1993, 12 children and 1 adult died) – Investigation by police.

**Dunblane school killings** (March 13, 1996, 18 died) – The Hon Lord Cullen (1996), The Public Inquiry into the Shootings at Dunblane Primary School on 13 March 1996.

**Southall rail collision** (September 19, 1997, 7 died) – Prof John Uff QC (2000), The Southall Rail Accident Inquiry Report, Health and Safety Commission.

**Ladbroke Grove (also known as Paddington) rail collision** (October 5, 1999, 31 killed) – The Hon Lord Cullen and Prof John Uff QC: 1) Ladbroke Grove Rail Inquiry 2) The Joint Inquiry into Train Protection Systems (2001). Part 1 was concerned with issues relating to the Ladbroke Grove train crash and Part 2 was related to wider issues of safety management and the regulatory regime.

**Potters Barr train crash** (May 10, 2002, 7 died) – Investigations by British Transport Police, Health and Safety Executive, Rail Standards and Safety Board.

**Barrow-in-Furness Legionella outbreak** (August 2, 2002 onwards, 7 died) – Coroner's inquiry.

**ICL Plastics factory explosion** (May 11, 2004, 9 people died) – Health and Safety Executive investigation.

**South Wales E.coli outbreak** (September 16 onwards, 2005, 1 person died) – Prof Hugh Pennington, Public Inquiry into the September 2005 Outbreak of E.coli O157 in South Wales, March 2009.

**Suicide bombings at four locations around London** (three underground trains and one aboveground bus, July 7, 2005, 56 died including four bombers) – Report of July 7 Review Committee 2006. Home Office Report on lessons from the emergency response 2006.

**Buncefield fire** (December 11, 2005, 0 persons died) – Joint Health and Safety Executive and Environment Agency inquiry.



Terms of Reference of the Grenfell Tower Inquiry: RoSPA views

**Grayrigg rail accident** (February 23, 2007, 1 person died) – Report by Railway Accident Investigation Branch.

**M5 multiple crash** (November 4, 2011, 7 people died) – Police investigation.

**Grenfell Tower fire** (June 14, 2017, estimated that about 80 people died) – Public Inquiry to be chaired by Sir Martin Moore-Bick.





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