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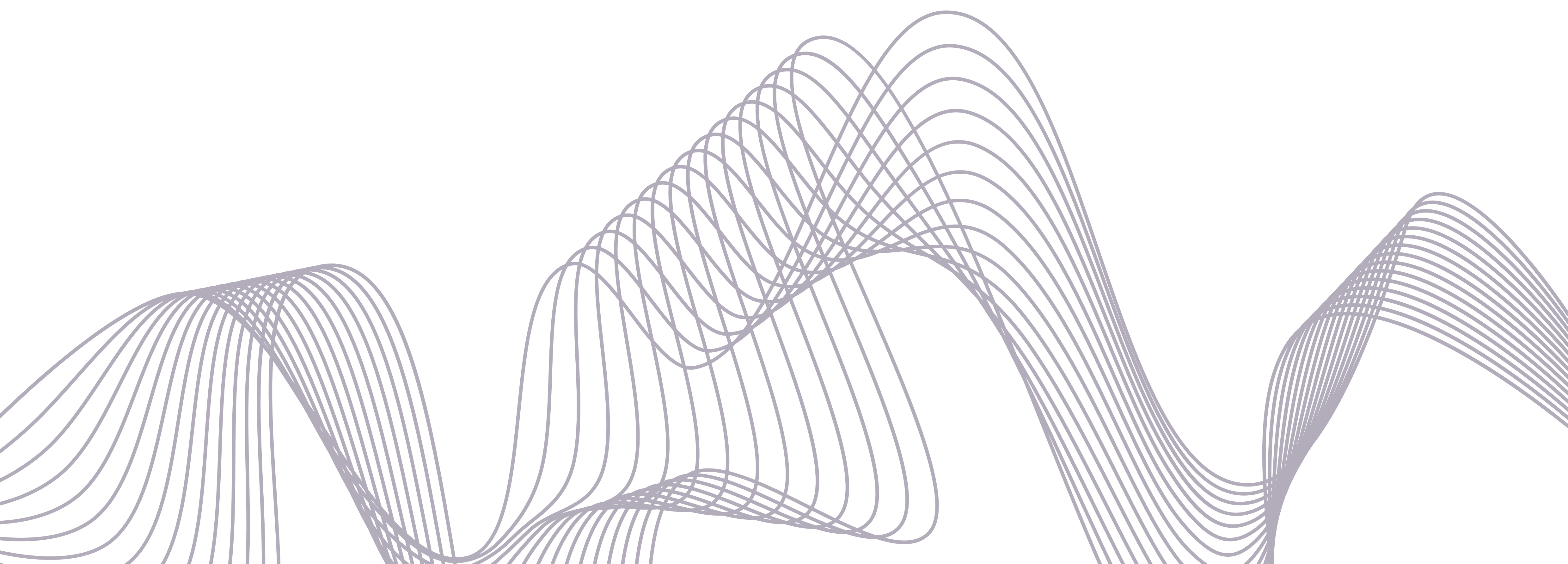
The Buildings We Left Behind: Why Hotels, Student Accommodation and Hospitals Fall Outside the Building Safety Act

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In the aftermath of Grenfell, the political and regulatory response was necessarily focused. Higher-risk residential buildings. Combustible cladding. Accountable persons. The safety of people in their homes.

That focus was right. But three years on from the Building Safety Act receiving Royal Assent, it is worth asking an uncomfortable question: why are the occupants of hotels, student accommodation blocks, and hospitals afforded less regulatory protection than the residents of a qualifying residential building? When, on almost any measure of vulnerability, their risk profile is equal or worse?



Who The BSA Protects, And Who It Doesn't

The higher-risk building regime under the BSA applies to residential buildings of 18 metres or more. The definition of residential (for these purposes) is effectively buildings containing flats, the permanent homes of people who live there, pay service charges, and rely on their freeholder or managing agent to keep the building safe.

Hotels fall outside that definition. Student accommodation, purpose-built student accommodation specifically, which now accounts for hundreds of thousands of beds across the UK, falls outside it. NHS hospitals and private healthcare facilities, many of which are clad in the same HPL and ACM systems that triggered the post-Grenfell regulatory response, also fall outside it.

Each of these building types is subject to its own regulatory framework. Hotels and hospitals operate under the RRO 2005, managed through fire risk assessments carried out by their operators. Student accommodation sits in a similar position, with additional obligations under housing legislation in some cases.

None of them are subject to the BSA's safety case regime. None require registration with the BSR. None carry the PAP obligation, the mandatory occurrence reporting requirement, or the external wall assessment framework that the BSA created for residential buildings.

The Vulnerability Argument

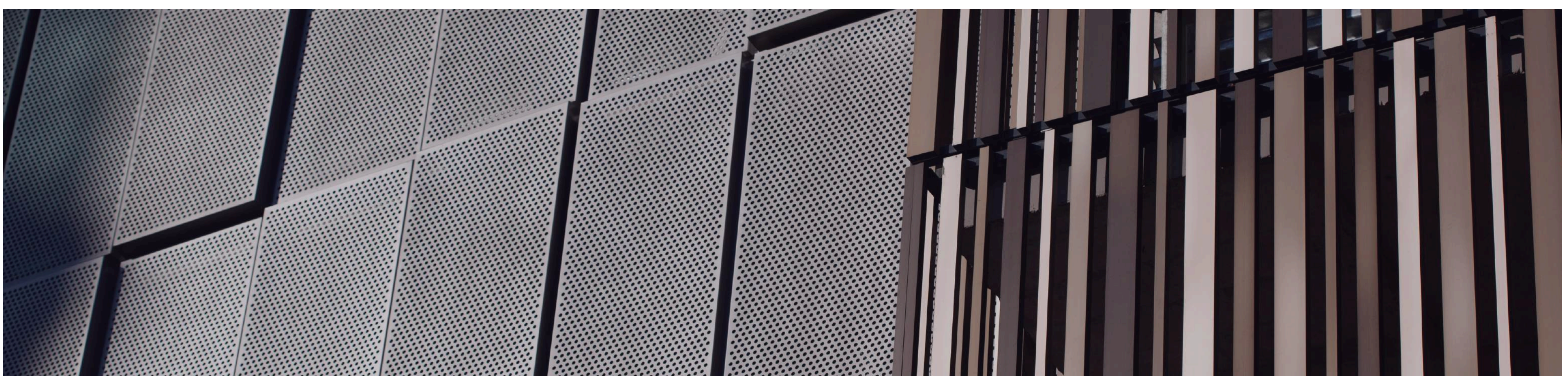
The BSA's residential focus was justified, in part, on the basis that permanent residents (particularly those in social housing) face barriers to exit and advocacy that transient occupants do not. They cannot easily move. They cannot easily challenge. They are dependent on others to manage the risk on their behalf.

That argument has merit in the residential context. It does not hold when examined against the actual occupant profile of the buildings left outside scope.

Consider student accommodation. Purpose-built student blocks routinely exceed 18 metres. Many were constructed during a period of rapid expansion in the 2000s and 2010s, when cladding systems were selected for cost and appearance rather than fire performance. The occupants are overwhelmingly 18 to 21 year olds, frequently living away from home for the first time, often in buildings they don't fully understand. A drinking culture is a documented feature of student life, and with it comes elevated risk at night, reduced awareness in the early hours, and evacuation behaviour that cannot be predicted or managed in the way a residential building with known occupants might allow for. The assumption that a student in a PBSA block is better placed to manage fire risk than a leaseholder in a residential building is not one I would care to defend.

The hospital argument is, if anything, more stark. A significant number of NHS and private hospital buildings, particularly those constructed or refurbished between 1990 and 2015, are clad in HPL or ACM systems installed primarily for their visual appearance and ease of maintenance. The occupants of those buildings at any given moment include people who are sedated, people who are physically incapacitated, people in intensive care, people recovering from surgery. The evacuation of a hospital in a cladding fire scenario is not a managed, orderly exit. It is one of the most complex and high-consequence emergency scenarios imaginable. And yet the external walls of those buildings carry no FRAEW obligation, no PAP accountability, and no BSR oversight.

The combustibility of a cladding system does not know what the building is used for.



Why The Drafters Drew The Line Where They Did

The exclusion of these building types was not accidental or unconsidered. The BSA's architecture is built around the concept of the Principal Accountable Person: the entity with a legal interest in the building who carries the safety case obligation. That concept maps cleanly onto the leasehold structure of residential high-rise blocks, where the freeholder or head leaseholder has both the legal interest and the ongoing management relationship with residents.

Hotels, student accommodation, and hospitals typically have single freehold ownership and operational management under one roof. The theory is that a well-managed hotel or hospital operator already has safety management obligations under existing fire safety, health and safety, and sector-specific regulatory frameworks that provide equivalent protection.

The theory is not entirely wrong. Some operators are exemplary. The difficulty is that the BSA's power lies not in its existence but in its enforcement architecture. The BSR, the safety case requirement, the mandatory occurrence reporting, the registration obligation. None of that applies to the buildings left outside scope, regardless of how well or poorly they are managed. A framework that relies on operator goodwill rather than regulatory accountability is not a safety regime. It is an aspiration.

The Question The Sector Should Be Asking

This is not an argument that the BSA was wrong to focus on residential buildings first. The scale of the remediation challenge in the residential sector alone is enormous, and the regulatory infrastructure to manage a wider scope did not exist at commencement. But it is an argument that the current boundary is a starting point, not a resting point.

The occupants of a 22-storey student block clad in HPL panels deserve the same quality of external wall assessment, the same management accountability, and the same regulatory oversight as the residents of the building next door. The patient in a hospital ward surrounded by an unverified cladding system deserves better than a fire risk assessment framework designed for buildings where everyone is ambulatory and awake.

A risk-based regulatory regime, as Dame Judith Hackitt envisaged, would follow the risk, not the tenure model. Hotels, student accommodation, and hospitals represent a significant cohort of higher-risk buildings that currently sit outside the scope of the most significant building safety legislation this country has produced in a generation.

That is not a sustainable position. And when the conversation about scope extension begins in earnest, as it will, the organisations already operating to the standard the BSA demands will be well placed. Those that treated their exclusion from the current regime as a permanent exemption will not.

The risk does not stop at the boundary of the legislation. The legislation needs to catch up with the risk.



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