

THE JOSHUA TEST

A White Paper and Draft Legislative Proposal for the Inspection and Safety Assurance of Residential Fall-Protection Structures in England

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No More Falls – Josh's Legacy



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Policy Submission Cover Sheet

THE JOSHUA TEST

A White Paper Proposing a Statutory Duty to Demonstrate the Continuing Safety of Residential Fall-Protection Structures

An initiative of the No More Falls Campaign

POLICY SUBMISSION COVER SHEET

Classification Official – Policy Proposal

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Proposed for Ministry of Housing, Communities and Local Government (MHCLG)

Purpose Proposal for Government Consultation

Decision Requested

Consideration of a public consultation on legislation establishing The Joshua Test and the proposed Joshua Duty

Prepared and Submitted by

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Executive Purpose

This White Paper presents a policy proposal for the introduction of The Joshua Test—a new statutory framework requiring those responsible for residential fall-protection structures to demonstrate, through proportionate inspection, structural verification and documented evidence, that such structures remain capable of preventing the fall they were installed to prevent.

The proposal seeks to complement existing building safety legislation by addressing an identified gap in the continuing assurance of life-critical residential fall-protection structures.

It is submitted to support consideration of a Government consultation on potential legislative reform.

Policy Objective

To establish a clear statutory duty requiring responsible persons to demonstrate the continuing structural safety of residential fall-protection structures throughout their operational life.

Key Recommendation

That the Government consult on legislation establishing:

- The Joshua Principle
- The Joshua Duty
- A proportionate framework for inspection, structural verification and record keeping
- A statutory system designed to reduce preventable deaths and serious injuries

These proposals are intended to reduce preventable deaths and serious injuries arising from the failure of residential fall-protection structures.

Guiding Principle

"No residential fall-protection structure should ever be relied upon to protect life unless those responsible can demonstrate that it remains capable of performing the function for which it was installed."

Disclaimer

This publication is an independent policy proposal prepared and submitted by Fiona Jane Garrett MCIPR, Founder of No More Falls – Josh's Legacy and Joshua Robbins' mother on behalf of the No More Falls Campaign. It is not an official publication of His Majesty's Government, the Ministry of Housing, Communities and Local Government, or any public authority. References to government departments, legislation and regulatory bodies are included solely to identify the intended recipients and policy context for the proposals set out in this White Paper.

Foreword

Every significant improvement in public safety has begun with someone asking whether a tragedy could have been prevented.

This White Paper is born from that same question.

On 29 January 2026, my son, Joshua Conor Robbins, stepped onto the communal walkway outside his home while waiting for a food delivery. He leaned on a guardrail designed to prevent a fall. The barrier failed, and Joshua fell to his death.

No parent imagines they will ever receive that phone call.

No parent imagines they will then spend almost seven weeks waiting for their child's body to be released while police and forensic examinations continue.

No parent imagines being asked to consent to a post-mortem examination that requires their child's organs and tissues to be removed and examined, or to decide whether they wish their child's body to be reconstructed before it is finally released into their care.

Those are decisions that stay with you forever.

Behind every preventable death lies not only the loss of a life, but a family left to endure experiences that no parent should ever face. They are the unseen consequences of tragedy; the moments that never appear in statistics, policy papers or court documents, yet remain with families for the rest of their lives.

There is one moment that has stayed with me more than any other.

On 20 March 2026, after Joshua's body had finally been released and he had been cremated, I sat beside the River Thames with a coffee before returning home to Northern Ireland.

London carried on around me.

People hurried to work. Tourists wandered along the river. The city was alive with its usual rhythm.

Joshua wasn't beside me.

Everything that remained of my beautiful son was contained in a small navy blue box, inside a black rucksack resting quietly beside me.

That was all I had left.

When it was time to leave, I lifted the rucksack onto my shoulders and carried Joshua through the busy streets of London, through the airport and home to Northern Ireland.

The weight I carried was not the weight of the ashes.

It was the weight of losing my son.

It was the weight of almost seven weeks spent waiting to bring him home.

It was the weight of knowing that no parent should ever have to make the decisions that had been placed before us.

As I walked through the airport that day, I realised something.

The heaviest burden was not the rucksack.

It was the weight of knowing how easily ordinary families can become overwhelmed when tragedy strikes.

Families living in social housing.

Families struggling simply to make it from one month to the next.

Families without wealth, influence or the resources to navigate lengthy investigations, complex legal processes and powerful institutions.

Too often, they carry not only unimaginable grief, but the burden of trying to find answers at the same time.

This White Paper is for them as much as it is for Joshua.

Since Joshua's death, one question has continued to shape every conversation, every meeting and every page of this document.

How do we know that the structures designed to prevent fatal falls remain capable of performing the function for which they were installed?

The United Kingdom has made significant advances in building safety. The Building Safety Act 2022, the introduction of Awaab's Law and wider reforms following the Grenfell Tower tragedy demonstrate Parliament's commitment to learning from the past and strengthening protections for residents.

This White Paper does not seek to diminish those achievements.

Nor does it seek to interfere with, influence or pre-empt the outcome of any ongoing criminal investigation, inquest or future legal proceedings arising from Joshua's death. Those processes must follow their proper course, and this document makes no findings regarding individual responsibility or liability.

Instead, it asks a broader question of public policy.

Should the law require those responsible for residential fall-protection structures to be able to demonstrate, through proportionate inspection, structural verification and documented evidence, that those structures remain capable of protecting life throughout their operational life?

This proposal has become known as The Joshua Test.

The Joshua Test is not about blame.

It is about prevention.

It is about ensuring that the structures people instinctively trust every day are not simply assumed to be safe, but can be shown to be safe.

At the time of writing, I have still not been able to lay Joshua to rest.

The trauma of losing him so suddenly, combined with the grief that has followed, has left me unable to make that final decision. Every time I think about scattering or burying his ashes, it feels as though I am losing him all over again.

So Joshua remains with me.

Every morning, when I wake, I see him.

His ashes are a quiet but constant reminder of the life that was taken, the future that was lost and the reason I continue this work, even on the days when it feels impossible.

People sometimes ask how I have found the strength to continue.

The truth is that I don't see it as strength.

I see it as a promise.

A promise that Joshua's life will mean something beyond the circumstances of his death.

A promise that another family should never have to carry their child home in a small box because a structure intended to protect life failed to do the very job it existed to do.

If this White Paper contributes, even in the smallest way, to preventing one future tragedy, then Joshua's legacy will not be defined by how he died.

It will be defined by the lives that are saved because he lived.

This White Paper begins with Joshua's story.

I hope it ends with his legacy.

Fiona Jane Garrett MCIPR

Founder, No More Falls Campaign

Author of The Joshua Test

Acknowledgements and Independent Contribution

This White Paper has been informed by discussion with professionals and stakeholders across housing, law, engineering and public policy. Responsibility for the analysis, recommendations and any remaining errors rests with the author.

Wayne Hughes, HQN

Wayne Hughes reviewed earlier barrier-safety and cost-analysis papers from an asset-management, regulatory and practical perspective. He expressly did not provide forensic structural-engineering advice. His review informed the sector-wide framing of the proposal and, in particular, the financial-planning treatment used in Chapter 14.

His financial contribution was to emphasise that programme costs should be planned by block, barrier system and risk rather than simply by dwelling; that specialist structural work, access equipment and temporary protection can materially increase costs; that inspection and assurance budgets should be separated from remediation; that remediation may substantially exceed the inspection programme; and that early estimates should include contingency and be market-tested before being presented as formal costs.

Acknowledging this contribution does not imply that Wayne Hughes or HQN endorses the final White Paper, its legislative recommendations or any site-specific engineering conclusion.

Executive Summary

This White Paper proposes legislation creating a statutory framework requiring responsible persons to demonstrate the continuing safety of residential fall-protection structures through documented inspection, structural verification, competent certification, record keeping and appropriate regulatory oversight.

It builds on existing law while addressing a gap: current legislation imposes duties to manage and maintain safety but does not create a universal statutory requirement for recurring structural verification of residential balconies, balustrades and communal railings.

The Joshua Test: At a Glance

The Problem

Millions of residents rely every day on guardrails, balustrades, balconies, communal walkways and other fall-protection structures. These structures may remain in service for decades while exposed to weather, moisture, corrosion, repeated loading, alterations and ordinary deterioration.

Existing law contains important duties relating to housing conditions, building safety, repairs and risk management. However, those duties do not presently form a single, nationally consistent system requiring every relevant residential fall-protection structure to undergo proportionate, competent and documented structural verification throughout its operational life.

The central question is therefore:

How can residents, landlords and regulators know that a structure designed to prevent a fatal fall remains capable of doing so?

The Current Legal Framework

Building Safety Act 2022

Part 4 of the Building Safety Act 2022 establishes an enhanced in-occupation safety regime for higher-risk residential buildings in England. In general, these are occupied buildings containing at least two residential units that are either at least 18 metres high or have at least seven storeys.

Accountable Persons for these buildings must assess and manage defined “building safety risks”. The current statutory definition principally concerns risks arising from the spread of fire and structural failure. Official explanatory material indicates that structural failure is intended to capture a failure in the structural integrity of the building that poses a risk to people, likely manifesting as the collapse of part or all of the building.

This is a significant advance in residential building safety, but the enhanced occupation regime:

- is principally limited to buildings meeting the statutory height or storey threshold;
- concentrates on fire spread and structural failure as legally defined;
 - does not expressly establish a universal inspection and testing cycle for every guardrail, balustrade or fall-protection system; and
- does not provide equivalent coverage for all lower-rise residential buildings.

A residential building below 18 metres and fewer than seven storeys is not a higher-risk building for the purposes of the Part 4 occupation regime, irrespective of the presence of residential units or potentially serious fall hazards.

Housing Act 2004 and the HHSRS

The Housing Health and Safety Rating System provides a risk-based mechanism for assessing hazards in residential premises. It covers 21 potential hazards and is used by local authorities to assess risks to occupiers. Councils must take enforcement action where a Category 1 hazard is identified and have powers to act in relation to Category 2 hazards.

Relevant HHSRS hazards include:

- falls between levels, including risks associated with defective or insufficient guarding;
 - structural collapse and falling elements.

The HHSRS is therefore highly relevant to unsafe railings and balustrades. However, it is primarily a hazard-identification and enforcement framework. It does not itself establish a universal programme under which all residential fall-protection systems must be structurally tested or verified at prescribed intervals before a defect becomes apparent or a complaint is made.

Social Housing Regulation

The Regulator of Social Housing's Safety and Quality Standard requires registered providers to take all reasonable steps to ensure the health and safety of tenants in their homes and associated communal areas. Providers must maintain an accurate, current and evidenced understanding of the condition of their homes, based on physical assessments, and provide effective repairs and maintenance services.

The Neighbourhood and Community Standard also requires registered providers to work with tenants and relevant organisations to take all reasonable steps to ensure the safety of shared spaces.

These are important regulatory obligations. However, they are expressed predominantly as outcomes that landlords must achieve. They do not prescribe a nationally uniform engineering methodology, inspection interval, load-testing requirement or certification regime specifically for residential fall-protection structures.

Regulatory context at publication: the Regulator of Social Housing published revised consumer standards and a revised Consumer Standards Code of Practice in July 2026, with the new Competence and Conduct Standard and revised requirements due to take effect on 1 October 2026. References in this White Paper should therefore be read alongside that transition.

Awaab's Law

Awaab's Law currently requires social landlords in England to investigate and address emergency hazards and significant damp and mould hazards within specified timeframes.

From 30 November 2026, Phase 2 will extend the significant-hazard requirements to a wider range of hazards, including falls between levels and structural collapse and falling elements.

This extension is an important development. It will strengthen tenants' rights when a relevant hazard is known, reported or identified. Nevertheless, Awaab's Law is principally a hazard-response and repair-timescale regime. It does not create a universal requirement for periodic structural testing of all railings and balustrades regardless of whether a defect has already been reported or recognised.

It also presently applies to qualifying social housing tenancy arrangements in England, rather than creating an equivalent universal duty across all residential tenures and building types.

Health and Safety at Work etc. Act 1974

The Health and Safety at Work etc. Act 1974 provides strong protection in relation to work activities.

Section 2 concerns duties owed by employers to their employees. Section 3 extends beyond employees by requiring employers and self-employed persons to conduct their undertaking so that people who are not their employees are not exposed to health and safety risks, so far as is reasonably practicable.

This means the Act is not confined to injuries suffered by workers inside a conventional workplace. A resident, visitor or member of the public may potentially fall within section 3 where:

- there is an employer or self-employed dutyholder;
- the person exposed is not that dutyholder's employee;
- the risk arises from the conduct of the dutyholder's business or undertaking; and
- the necessary connection and degree of control are established on the facts.

However, section 3 is not a dedicated residential building-inspection regime. Its application depends on the relationship between the risk and the conduct of a business undertaking. It does not impose an express, universal statutory timetable requiring every residential landlord or building owner to commission periodic structural verification of every fall-protection system.

The Gap

The current system contains multiple layers of protection, but each has a different scope, trigger and enforcement route.

The result is a fragmented framework in which:

- enhanced Building Safety Act duties principally apply to higher-risk buildings meeting statutory height or storey thresholds;
- the HHSRS assesses hazards and supports local-authority enforcement, but does not require universal scheduled testing;
- social-housing standards impose important safety and stock-condition outcomes but do not prescribe a uniform fall-protection verification methodology;
- Awaab's Law is primarily activated by the awareness, reporting or identification of a hazard and is limited to relevant social-housing arrangements;
- health and safety legislation may protect non-employees, but only where the risk arises from the conduct of a relevant undertaking and the statutory conditions are satisfied; and
- no single duty clearly requires all responsible persons to prove, at proportionate intervals, that residential guardrails and balustrades remain capable of withstanding the loads and foreseeable use for which they exist.

The gap is therefore not that residential safety is completely unregulated.

The gap is that continuing structural integrity may be assumed from appearance, maintenance records or historic compliance rather than demonstrated through a consistent, competent and documented process of lifecycle assurance.

The Proposal

The Joshua Test would establish a clear statutory duty requiring the person responsible for a residential fall-protection structure to demonstrate that it remains capable of performing its life-safety function.

The duty would apply to structures including:

- guardrails and guarding;
- balustrades;
- balcony barriers;
- communal walkway barriers;
- parapets and protective barriers; and
- comparable systems intended to prevent falls from height.

Compliance would be proportionate to the age, design, material, exposure, condition and risk profile of the structure.

The regime could require the following core elements:

1. an initial documented condition and risk assessment;
2. inspections at defined, risk-based intervals;
3. intrusive investigation where corrosion or concealed deterioration is reasonably suspected;
4. engineering verification or load testing where appropriate;
5. assessment by suitably competent persons;
6. prompt remediation of identified defects;
7. retention of inspection, testing and repair records;
8. clear responsibility where ownership or management is divided; and
9. access to relevant safety information for residents, regulators and investigators.

The Benefits

The Joshua Test would:

- identify deterioration before it results in death or serious injury;
- move the system from reactive repair towards preventative assurance;
- provide landlords with clear and consistent expectations;
- improve the quality and comparability of inspection records;
- reduce reliance on superficial visual inspection alone;
- support regulators and investigators with a documented safety history;
- increase resident confidence;
- protect residents regardless of income, tenure or housing status; and
- create a nationally recognised standard for residential fall-protection safety.

The proposal would complement the Building Safety Act 2022, the Housing Act 2004, Awaab's Law, social-housing consumer standards and the Health and Safety at Work etc. Act 1974. It would not displace those protections.

Who It Would Affect

The proposed duty should be considered for application across residential tenures, including:

- housing associations;
- local-authority landlords;
- private landlords;
- freeholders;
- resident management companies;
- right-to-manage companies;
- commonhold associations;
- managing agents acting on behalf of responsible persons; and
- Accountable Persons and Principal Accountable Persons under the Building Safety Act, where applicable.

The obligation should attach to whoever possesses the legal responsibility and practical control necessary to inspect, maintain, repair or replace the structure.

Residents should not receive weaker protection merely because their building falls below an arbitrary height threshold or because they live in one tenure rather than another.

Next Steps

This White Paper asks Government to:

1. open a formal consultation on residential fall-protection safety;
2. commission a cross-departmental review of current legal coverage and enforcement;
3. consult structural engineers, corrosion specialists, regulators, housing providers, insurers and residents;
4. develop a statutory definition of residential fall-protection structures;
5. establish proportionate inspection and verification standards;
6. determine competency and record-keeping requirements;
7. assess how the Joshua Duty should interact with Awaab's Law, the HHSRS and the Building Safety Act;
8. consider whether the duty should apply across all tenures and residential building heights; and
9. publish an implementation timetable.

The Principle

A structure whose purpose is to prevent a fatal fall should not be presumed safe merely because it remains standing or has been painted, maintained or visually inspected. Its continuing ability to protect life should be capable of being demonstrated.

That is the purpose of The Joshua Test.

Impact Assessment Summary

The Joshua Test

A Proposal for the Inspection, Maintenance and Ongoing Safety Assurance of Residential Fall-Protection Structures

Executive Summary

The Joshua Test proposes a new statutory framework to ensure that life-critical fall-protection structures within residential buildings remain safe throughout their operational life.

Current legislation—including Part K of the Building Regulations, Approved Document K and technical benchmarks such as BS 6180:2011—provides an established framework for the design and performance of barriers and balustrades. It does not, however, create a complete in-service inspection regime requiring responsible persons to demonstrate periodically that those structures remain structurally safe as buildings age.

The proposal introduces a proportionate, risk-based system of inspection, maintenance, record keeping and regulatory oversight intended to prevent avoidable deaths and serious injuries resulting from structural failure.

Policy Objective

To reduce deaths and serious injuries arising from the failure of residential fall-protection structures through the introduction of statutory lifecycle inspection and maintenance duties.

Problem Statement

The current regulatory framework is strongest at the point of design and construction. Approved Document K provides building-regulation guidance, while BS 6180 operates as a recognised design and performance benchmark for barriers in and about buildings. Neither should be characterised as a statutory regime that already mandates periodic in-service testing of every residential fall-protection structure.

Consequently, there is currently no single statutory duty requiring responsible persons to:

- identify all safety-critical barriers and balustrades;
- maintain a comprehensive barrier asset register identifying every relevant fall-protection structure;
- inspect structures at risk-based intervals;
- investigate concealed deterioration;
- retain lifetime inspection records;
- verify structural repairs;
- respond consistently to resident safety concerns; or
- undertake portfolio-wide reviews following serious structural failures.

This creates variability in practice and increases the risk that deterioration remains undetected until significant failure occurs.

Preferred Policy Option

Introduce primary legislation establishing The Joshua Duty, supported by secondary regulations, statutory guidance and revisions to existing technical guidance where appropriate.

The framework would include:

- a comprehensive barrier asset register;
- risk-based inspection programmes supported by clear escalation triggers;
- defined competence requirements for observation, inspection, technical assessment, engineering assessment and verification;
- photographic evidence and prescribed inspection records retained within the asset-management system;
- board-level reporting and assurance on inspection completion, defects, overdue actions and portfolio-wide risks;
- proportionate enforcement powers;
- national learning arrangements; and
- coordination with existing regulatory bodies.

Strategic Objectives

The proposal seeks to:

- improve public safety;
- strengthen accountability;
- support proactive asset management;
- improve organisational governance;
- reduce preventable structural failures;
- promote consistency across the housing sector;
- enhance resident confidence; and
- support continuous national learning.

Expected Benefits

Implementation of The Joshua Test is expected to deliver:

Safety Benefits

- Reduced likelihood of catastrophic structural failure.
- Earlier identification of deterioration.
- Improved maintenance planning.
- Better protection for residents.

Regulatory Benefits

- Greater consistency in inspection practice.
- Clearer allocation of legal responsibilities.
- Improved cooperation between regulators.
- Enhanced national safety intelligence.

Organisational Benefits

- Improved governance.
- Stronger board assurance.
- Better quality asset data.
- Reduced litigation exposure.
- Improved procurement oversight.
- Greater transparency.

Societal Benefits

- Reduced trauma.
- Increased public confidence.
- Stronger trust in social housing.
- Improved resilience of residential buildings.
- Enhanced learning from serious incidents.

Expected Costs

Implementation costs should be presented as planning estimates rather than formal quotations. Cost appraisal should distinguish the assurance programme itself from access and temporary protection, and should identify remediation as a separate cost category unless it is expressly included.

- initial asset identification and creation of the barrier asset register;
- baseline inspection and risk categorisation;
- access arrangements, temporary protection and resident communication where required;
- competence, training and quality assurance;
- digital record management, photographic evidence and reporting systems;
- remediation, strengthening, replacement or temporary works where defects are identified; and
- regulatory implementation, monitoring and board-level assurance.

Some activities align with existing landlord responsibilities and asset-management systems; the relevant regulatory impact is the additional cost attributable to the proposed assurance requirements. Specialist access, structural investigation and remediation may create material additional expenditure and should be tested through market evidence.

Cost Effectiveness

The proposal is based upon the principle that:

- planned assurance may avoid or reduce some emergency-response and reactive-investment costs;
- early identification can improve the timing and targeting of maintenance and capital decisions;
- early intervention reduces future remediation costs; and
- avoiding serious failure can prevent substantial human harm and may also avoid costs across emergency response, healthcare, housing, investigation, regulation and litigation.

Regulatory Impact

The Joshua Test is intended to complement—not replace—the existing legal framework.

It would operate alongside:

- Building Regulations;
- Approved Document K;
- BS 6180;
- the Building Safety Act 2022;
- Awaab's Law;
- the Housing Health and Safety Rating System;
- the Regulator of Social Housing;
- the Housing Ombudsman; and
- existing landlord repairing obligations.

The proposal fills a gap relating to ongoing lifecycle assurance, rather than initial design compliance. In this context, BS 6180 should be treated as an important design and performance benchmark, and Approved Document K as building-regulation guidance, not as substitutes for a complete statutory in-service inspection regime.

Equality Impact

The proposal is expected to provide positive benefits for:

- older people;
- disabled residents;
- children;
- vulnerable adults;
- social housing tenants;
- leaseholders;
- private renters; and
- visitors to residential buildings.

The legislation is intended to provide equivalent protection irrespective of housing tenure.

Risks

Potential implementation risks include:

- inconsistent inspection competence;

- variable organisational readiness;
- transitional resource pressures;
- incomplete historical records;
- funding constraints for legacy buildings; and
- differing levels of digital maturity.

These risks can be mitigated through phased implementation, statutory guidance, competency standards and proportionate regulatory oversight.

Preferred Implementation Approach

Phased national implementation programme

A phased national implementation programme is recommended comprising:

Phase 1

Preparation

- Publication of statutory guidance.
- Development of competency standards.
- Creation of model inspection templates, photographic-evidence requirements and asset-register fields.
- establishment of digital reporting, board-assurance and portfolio-risk arrangements.

Phase 2

Baseline **assurance**

- Asset identification.
- Initial inspections.
- Risk categorisation, including immediate portfolio-wide escalation where a dangerous or failed barrier is identified.
- Creation of asset registers.

Phase 3

Full statutory operation

- Routine inspections.
- Regulatory reporting.
- National learning arrangements.
- Enforcement powers.

Monitoring and Evaluation

Government should review implementation through:

- annual Building Safety Regulator reports;
- inspection compliance rates;
- structural incident reporting;

- enforcement activity;
- resident satisfaction;
- regulatory performance;
- independent evaluation; and
- periodic legislative review.

Overall Assessment

Assessment area	Conclusion
Strategic need	Strong
Public safety benefit	Very high
Economic justification	Strong
Regulatory burden	Proportionate
Implementation complexity	Moderate
Deliverability	High
Long-term value	Very high

Overall Conclusion

The Joshua Test represents a proportionate and evidence-based response to an identifiable gap within the current residential building safety framework.

Rather than creating an entirely new system, it strengthens existing legislation by introducing clear lifecycle duties for the inspection, maintenance and ongoing assurance of life-critical fall-protection structures.

The proposal is expected to improve public safety, support better asset management, strengthen accountability and reduce the risk of preventable deaths and serious injuries, while making efficient use of existing regulatory structures and professional expertise.

Implementation theme	Policy response
Legal clarity	Define a clear statutory duty and responsible person.
Inspection consistency	Introduce risk-based inspection levels and nationally recognised records.
Competence	Align inspection tasks with appropriate professional capability.
Resident confidence	Provide accessible safety information and reporting routes.
Regulatory learning	Capture incident data, inspection outcomes and lessons learned.

How to Read This White Paper

Purpose of this Document

This White Paper has been prepared to support consideration of The Joshua Test: a proposed statutory framework for the inspection, maintenance and ongoing safety assurance of residential fall-protection structures in England.

It brings together engineering principles, housing policy, public safety, building regulation and legislative proposals into a single document. Its purpose is to assist policymakers, regulators, housing providers, engineers, parliamentarians and residents in evaluating whether existing arrangements provide sufficient assurance that residential fall-protection structures remain safe throughout their operational life.

The White Paper is intended to contribute constructively to public policy discussions. It does not seek to determine legal liability in relation to any individual incident or prejudice the outcome of any ongoing investigation, inquest or legal proceedings.

Why This White Paper Has Been Written

The proposal known as The Joshua Test arose from the recognition that, while the United Kingdom has well-established legislation governing the design and construction of buildings, there is currently no single statutory framework requiring responsible persons to demonstrate that residential fall-protection structures remain structurally safe throughout the lifetime of a building.

The White Paper therefore asks a simple but important question:

How can we ensure that structures designed to prevent a fall continue to do so throughout their service life?

It proposes a proportionate, risk-based framework that builds upon existing legislation rather than replacing it.

Who This White Paper Is For

This document has been prepared for:

- Ministers and Government departments.
- Members of Parliament and Peers.
- The Building Safety Regulator.
- The Regulator of Social Housing.
- Local authorities.
- Housing associations and registered providers.
- Managing agents and building owners.
- Chartered Structural Engineers.
- Building surveyors and asset managers.
- Fire and rescue services.
- Coroners and legal professionals.
- Residents, leaseholders and tenants.
- Professional institutions.

- Standards organisations.
- Researchers and academics.

Structure of the White Paper

The document is organised into seven parts.

Part I – The Human Context

Joshua's story, chronology and the boundary between the ongoing legal processes and this public-policy proposal.

Part II – The Case for Reform

Existing law, current inspection practice, international approaches and the policy question.

Part III – Engineering and Risk

Deterioration, hidden risk, inspection methodology and professional competence.

Part IV – Building a Safer System

Governance, national learning, economics, implementation, resident voice and enforcement.

Part V – The Legislative Proposal

The proposed statutory framework and illustrative Draft Bill.

Part VI – Recommendations and Conclusion

The decisions invited of Government and Parliament, followed by the conclusion and glossary.

Part VII – Supporting Material

Figures, references and source material supporting the policy analysis.

How to Use This Document

Different readers will approach this White Paper from different perspectives.

Ministers and Parliamentarians

May wish to focus on:

- Executive Summary;
- Impact Assessment;
- Final Recommendations;
- Draft Bill.

Housing Providers

May wish to focus on:

- inspection methodology;
- competency framework;

- implementation roadmap;
- economic assessment.

Engineers and Surveyors

May wish to focus on:

- engineering principles;
- inspection methodology;
- deterioration mechanisms;
- technical appendices.

Regulators

May wish to focus on:

- enforcement;
- regulatory architecture;
- national reporting;
- learning systems.

Residents

May wish to focus on:

- Foreword;
- Executive Summary;
- The Joshua Test: At a Glance;
- Final Recommendations.

A Note on Evidence

This White Paper distinguishes between:

- Established evidence drawn from legislation, standards, published guidance, academic literature and publicly available reports.
- Policy analysis undertaken by the author.
- Recommendations for future legislative and regulatory reform.

Where reference is made to the death of Joshua Robbins, it is solely to explain the public interest context in which The Joshua Test has been developed. Nothing in this document should be interpreted as attributing civil or criminal liability to any individual or organisation.

A Living Proposal

The Joshua Test is intended to begin a national conversation rather than conclude one.

The proposals contained within this White Paper are offered to encourage discussion, scrutiny and collaboration across Government, regulators, housing providers, professional institutions, engineers, resident groups and policymakers.

The strongest legislation is developed through consultation, evidence and partnership. It is hoped that this document will contribute constructively to that process.

Before You Begin

The Joshua Test is founded upon a simple principle: every person responsible for a residential fall-protection structure should be under a continuing duty to demonstrate that the structure remains capable of preventing the fall it was installed to prevent.

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PART I

THE HUMAN CONTEXT

Why this White Paper was written.

Chapter 1

Joshua's Story

The Inspiration Behind The Joshua Test

"Every piece of legislation intended to save lives begins with a life that could not be saved."

This White Paper is inspired by the life of Joshua Conor Robbins, a much-loved son, brother, stepson, grandson, nephew and friend, whose death on 29 January 2026 has prompted the proposal for The Joshua Test.

Joshua was twenty-three years old and had lived with his father, William Robbins, at Flat 15, Thurstan Dwellings, Newton Street, Holborn, London, for approximately ten years. He loved living in London and embraced everything the city had to offer. Like many young people of his generation, he enjoyed gaming and spent countless hours talking to friends from around the world, forming connections that crossed countries and cultures.

Those who knew Joshua remember him not for extraordinary achievements, but for the extraordinary kindness he showed in everyday life. He believed in good manners, treated people with respect and instinctively looked out for others. He had a quiet empathy that often led him to stop and speak with people experiencing homelessness, offering conversation, encouragement, food or money—not because anyone expected him to, but because he believed every person deserved dignity and acknowledgement.

Joshua loved animals and found peace in nature. He enjoyed photographing London's sunsets and sunrises, capturing moments of beauty that many others would simply pass by. He had a gentle sense of humour and an easy warmth that left a lasting impression on those he met.

He was also a devoted big brother to his step-brother, Matt, and his step-sister, Orlagh. His death has left an immeasurable void in the lives of his family, who continue to grieve the loss of someone whose future held so much promise.

On the evening of Thursday, 29 January 2026, Joshua and his father were at home awaiting the delivery of a takeaway meal. As they waited, Joshua stepped onto the communal access walkway outside the flat to look for the delivery driver and help direct them to the correct entrance.

While standing on the walkway, Joshua leaned on the guardrail. The barrier gave way and he fell approximately five storeys to the ground below.

His father witnessed the incident.

Emergency services attended quickly and did everything they could to save him. Despite their efforts, Joshua sustained injuries that proved unsurvivable.

Joshua was not engaged in any unusual or reckless behaviour. He was simply waiting for a food delivery outside his home and using the communal walkway in the ordinary way it was intended to be used by residents.

The purpose of a safety barrier is to prevent a fall. On that evening, the barrier that Joshua relied upon did not perform that function.

The full circumstances surrounding Joshua's death are a matter for the appropriate legal and investigative processes. This White Paper does not seek to pre-empt those findings. Instead, it asks a broader policy question arising from this tragedy.

If a barrier exists to prevent a fatal fall, should there be a clear statutory duty requiring those responsible to demonstrate that it remains capable of performing that life-preserving function throughout its operational life?

That question lies at the heart of The Joshua Test.

Joshua cannot be brought back. No change in the law can undo the devastation experienced by those who loved him. However, Parliament has often responded to tragedy by strengthening protections for future generations. If this White Paper contributes to preventing even one family from experiencing a similar loss, then Joshua's legacy will extend far beyond the events of one January evening.

The Joshua Test is proposed in his memory, and in the hope that no family should ever again lose a loved one because a structure designed to prevent a fall failed to do so.

Chapter 2

Joshua Timeline

A Chronology of Events

The following timeline provides a factual chronology of the events that led to the development of The Joshua Test. It is intended to assist readers in understanding the sequence of events following the death of Joshua Conor Robbins and the subsequent development of this White Paper.

This timeline is not intended to determine liability or responsibility for any individual or organisation. It is included solely to provide factual context.

29 January 2026

Joshua Conor Robbins, aged 23, died following the failure of a communal guardrail located along the communal walkway adjacent to the lift on the fifth floor of Thurstan Dwellings, Newton Street, Holborn, London.

The incident immediately became the subject of a Metropolitan Police Service criminal investigation.

Specialist emergency services attended the scene, which was secured for forensic examination.

Late January – Early February 2026

The Metropolitan Police commenced a major investigation into the circumstances surrounding Joshua's death.

Investigative activity included:

- securing and examining the scene;
- recovering the failed guardrail as forensic evidence;
- deploying specialist forensic structural engineering expertise;
- flying a drone to create a comprehensive evidential survey of the building and surrounding structure;
- obtaining CCTV and other evidential material where available; and
- identifying potential witnesses.

Following completion of the initial forensic examination, the scene at Thurstan Dwellings was released back to Islington and Shoreditch Housing Association (ISHA) approximately one week after the incident.

February 2026

Fiona Garrett established the No More Falls Campaign following Joshua's death.

The campaign was founded to advocate for stronger residential fall-protection legislation and to campaign for preventative reforms that would reduce the risk of similar tragedies occurring in the future.

The campaign would later develop into the legislative proposal known as The Joshua Test.

January – March 2026

Joshua's body remained in the care of the authorities while the necessary forensic, pathological and legal examinations were undertaken.

During this period, Joshua's parents were required to make a number of profoundly difficult decisions relating to the post-mortem process before his body could finally be released to the family.

20 March 2026

Following completion of the necessary examinations, Joshua's body was released to his family.

Joshua was cremated.

In accordance with the wishes of his family, his ashes were divided equally between his parents.

One half remains with his father, who continues to reside at Thurstan Dwellings in London.

The other half was returned to Northern Ireland with his mother.

Spring 2026

The Metropolitan Police investigation continued to expand.

Enquiries included:

- specialist structural engineering analysis;
- examination of historical architectural and engineering documentation;
- review of maintenance, inspection and repair records;
- witness enquiries;
- collection and analysis of documentary evidence;
- liaison with specialist experts; and
- consultation with the Crown Prosecution Service through the Early Investigative Advice process.

July 2026

The Coroner formally opened the inquest.

At the opening hearing, the Coroner confirmed that proceedings would be limited to case management because of the ongoing Metropolitan Police criminal investigation.

Detective Inspector Mark Paterson, Senior Investigating Officer, updated the court on the progress of enquiries, confirming that the investigation remained active and that a substantial volume of historical material relating to the building continued to be examined.

The court also heard that Devonshires Solicitors, acting on behalf of Islington and Shoreditch Housing Association, were complying with Metropolitan Police requests by providing relevant documentation to assist the investigation.

July 2026

Development of The Joshua Test White Paper commenced.

Drawing upon legal research, engineering evidence, regulatory analysis and lived experience, the White Paper proposes the introduction of a statutory duty requiring those responsible for residential fall-protection structures to demonstrate that those structures remain capable of performing the life-saving function for which they were installed.

Current Position

At the time of publication:

- The Metropolitan Police criminal investigation remains ongoing;
- further investigative enquiries continue under the direction of the Senior Investigating Officer, Detective Inspector Mark Paterson;
- the Coroner has adjourned substantive consideration of the inquest pending progress of the criminal investigation;
- the next review date should be confirmed and updated before publication;
- No findings have been made regarding criminal or civil liability; and
- This White Paper has been prepared independently of those legal proceedings.

The purpose of this document is not to influence the outcome of any investigation or legal process. Rather, it seeks to identify opportunities for legislative reform that could improve residential building safety and help prevent similar tragedies in the future.

Figure 2.1 – Joshua Timeline

FIGURE 2.1

JOSHUA TIMELINE

Key events leading to the development of The Joshua Test

**PUBLIC-POLICY CONTEXT**

This chronology is provided for context only. It does not determine civil or criminal liability and does not seek to prejudice any investigation, inquest or legal proceedings.

Chronology of key events following Joshua Robbins’ death and the development of The Joshua Test.

Chapter 3

Metropolitan Police Investigation and Public Policy Context

This chapter summarises the known investigative context insofar as it explains the origin of the wider policy questions examined in this White Paper. It does not determine liability, attribute responsibility or seek to influence any ongoing criminal investigation, inquest or legal proceedings.

3.1 Investigation

Following Joshua Robbins' death on 29 January 2026, the Metropolitan Police Service commenced a criminal investigation. The scene was secured for forensic examination and the failed guard rail was recovered as evidence. Specialist forensic structural engineering expertise was deployed and a drone survey was undertaken to create an evidential record of the building and surrounding structure.

3.2 Continuing enquiries

The chronology prepared for this White Paper records continuing enquiries including examination of historical architectural and engineering documentation, maintenance and inspection records, witness enquiries, documentary evidence, specialist expert input and consultation with the Crown Prosecution Service through the Early Investigative Advice process.

At the July 2026 inquest opening, the Coroner limited proceedings to case management because of the ongoing criminal investigation. Detective Inspector Mark Paterson confirmed that the investigation remained active and that historical material relating to the building continued to be examined. The chronology also records that Devonshires Solicitors, acting for Islington and Shoreditch Housing Association, were complying with Metropolitan Police requests for relevant documentation.

3.3 Investigation and reform

The criminal investigation and the policy proposal perform different functions. The investigation concerns the circumstances of an individual death and any legal consequences arising from the evidence. This White Paper asks whether the wider system governing residential fall-protection structures can be strengthened to reduce future risk. The policy analysis is therefore capable of being considered independently of the outcome of the investigation.

3.4 Boundary of this publication

- It does not express a view on criminal liability.
- It does not attribute fault to any individual or organisation.
- It does not speculate on evidence that remains under investigation.
- It does not seek to anticipate the findings of the Coroner.

The remainder of the White Paper moves from this factual context to the legal, engineering and regulatory issues that can properly be examined as matters of public policy.

PART II

THE CASE FOR REFORM

Existing law, current practice and the policy question.

Chapter 4

Why Further Reform Should Be Considered

"The law requires structures to be safe. It does not universally require those responsible to demonstrate that they remain safe."

Introduction

The United Kingdom has developed one of the most comprehensive systems of building regulation in the world. The legislative framework governing residential buildings has expanded significantly following the Grenfell Tower fire, placing greater emphasis on accountability, risk management and resident safety.

Nevertheless, the law governing residential fall-protection structures remains dispersed across numerous statutes, regulations, technical standards and common law duties.

While these collectively impose important obligations upon those responsible for residential buildings, they do not establish a single, consistent statutory requirement to demonstrate, through recurring inspection and appropriate structural verification, that balconies, balustrades, communal railings and comparable structures remain capable of performing their intended safety function throughout their service life.

The Joshua Test seeks to address this specific regulatory gap.

4.1 A Safety-Critical Structure

Gas installations exist to deliver fuel.

Electrical systems exist to supply power.

Fire doors exist to contain fire.

Smoke alarms exist to warn occupants.

Balustrades, communal railings and balcony barriers exist for one purpose above all others:

To prevent people from falling from height.

They are life-safety systems.

Their failure may result in catastrophic injury or death.

Despite this, there is no universal statutory regime requiring responsible persons to periodically demonstrate that such structures remain structurally capable of fulfilling their life-preserving purpose.

4.2 Design Compliance Is Not Lifetime Assurance

Building Regulations establish minimum standards at the point of construction.

They help ensure that a building is safe when completed.

However, buildings are not static.

Throughout their operational lives they are exposed to:

- weathering;
- corrosion;
- moisture ingress;
- ultraviolet degradation;
- freeze-thaw cycles;
- vibration;
- repeated loading;
- accidental impact;
- inadequate repairs;
- material fatigue;
- ageing.

Consequently, compliance with construction standards at completion cannot be assumed to guarantee structural integrity decades later.

This distinction is fundamental.

The Joshua Test is not concerned with whether a structure was originally compliant.

It is concerned with whether it remains capable of preventing a fatal fall.

4.3 Inspection Does Not Always Mean Verification

Across the residential sector, inspections commonly include visual examinations undertaken during routine estate management or planned maintenance.

Visual inspection is an important component of building safety.

However, visual inspection alone may not identify every defect.

Depending upon the construction of the barrier, deterioration may occur within:

- concealed fixings;
- embedded anchors;
- welded joints;
- concrete reinforcement;
- hidden corrosion zones.

These defects may not become apparent until significant deterioration has already occurred.

This White Paper does not suggest that every structure requires identical inspection methods.

Rather, it proposes that legislation should require an evidence-based approach to demonstrating continuing structural safety, with inspection and verification methods proportionate to the level of risk.

4.4 Fragmented Responsibilities

Residential buildings frequently involve multiple duty holders.

Responsibilities may be shared between:

- freeholders;
- leaseholders;
- managing agents;
- local authorities;

- housing associations;
- maintenance contractors;
- specialist consultants.

While contractual arrangements may allocate responsibilities between these parties, residents often have little visibility of who is responsible for the safety of communal fall-protection structures.

This fragmentation can lead to:

- uncertainty regarding inspection responsibilities;
- inconsistent maintenance standards;
- incomplete records;
- delayed remedial works;
- disputes concerning ownership of defects.

The Joshua Test proposes a clear statutory duty upon the person responsible for maintaining the structure, reducing ambiguity and improving accountability.

4.5 The Evidential Gap

Following a structural failure, investigators commonly seek evidence including:

- inspection records;
- maintenance logs;
- repair histories;
- photographs;
- contractor reports;
- resident complaints;
- engineering assessments.

Where comprehensive records exist, investigators are better able to understand:

- the condition of the structure;
- what was known;
- when it became known;
- what actions were taken.

Where records are absent, these questions become significantly more difficult to answer.

The Joshua Test proposes that the absence of appropriate inspection and verification records should itself prompt regulatory scrutiny, although any legal consequences would need to be defined by Parliament.

4.6 Residents Cannot Verify Safety Themselves

Unlike portable electrical appliances or domestic fixtures, communal fall-protection structures are beyond the control of individual residents.

Residents cannot reasonably be expected to:

- dismantle fixings;
- assess corrosion;
- inspect concealed anchors;

- calculate structural capacity;
- determine engineering adequacy.

They must therefore rely upon those responsible for maintaining the building.

This dependency creates a strong public interest in ensuring that appropriate systems exist to demonstrate continuing structural safety.

4.7 A Comparison with Other Safety Regimes

UK law already requires recurring inspection or certification in a range of safety-critical contexts.

Examples include:

Safety system	Typical requirement
Gas installations	Periodic statutory safety checks in relevant rented accommodation.
Passenger lifts	Periodic thorough examination under applicable health and safety legislation where relevant.
Fire detection systems	Routine inspection and maintenance under applicable fire safety standards and duties.
Pressure systems	Periodic examination under specific regulations.
Work equipment	Inspection regimes where required under workplace legislation.

These regimes differ in their legal basis and scope, but they illustrate a common principle:

Where failure of a safety-critical system may cause serious harm, legislation often requires evidence of ongoing inspection or examination.

The Joshua Test asks whether a comparable principle should apply to residential fall-protection structures, with requirements tailored to the nature of those structures and the risks they present.

4.8 International Perspectives

Many jurisdictions recognise the importance of periodic inspection of buildings and safety-critical elements, although the legal mechanisms vary.

For example:

Singapore

Singapore has a statutory Periodic Façade Inspection regime for certain buildings, recognising that ageing building elements require ongoing assessment rather than reliance on original construction standards alone.

United States

Several cities and states require periodic inspection of specific building components, particularly following structural failures. Requirements vary by jurisdiction and may include façades, balconies or other structural elements.

Australia

Australian states have increasingly strengthened building safety regulation following high-profile defects in multi-storey residential buildings. Approaches differ between states but emphasise accountability, competent assessment and maintenance.

Canada

Several provinces require periodic inspections of building envelopes or structural components in particular circumstances, supported by professional engineering oversight.

These examples demonstrate an international trend towards recognising that the safety of ageing buildings depends not only upon original design but also upon continuing assessment throughout their operational life.

They do not establish a single international model for residential balustrade inspection. Rather, they illustrate the broader principle that critical structural elements may require ongoing professional oversight.

4.9 The Joshua Duty

The White Paper proposes that Parliament establish a new statutory duty.

The Joshua Duty

Every person responsible for a residential fall-protection structure shall be under a continuing duty to demonstrate that the structure remains capable of preventing the fall it was installed to prevent.

This duty would not prescribe a single engineering method.

Instead, it would require responsible persons to maintain evidence demonstrating continuing safety through measures proportional to the age, design, condition and risk profile of the structure.

4.10 Closing the Gap

The purpose of The Joshua Test is not to replace existing building safety legislation.

Nor is it intended to duplicate the Building Safety Act 2022.

Instead, it provides the missing operational link between:

- design;
- construction;
- occupation;
- maintenance;
- accountability.

It asks a simple question that every landlord, housing association, managing agent and freeholder should be able to answer.

The Joshua Test

If this barrier failed tomorrow, could those responsible demonstrate, with documented

evidence, that they had taken reasonable, competent and proportionate steps to ensure that it remained structurally capable of preventing a fatal fall?

If the answer is yes, the Joshua Test has been met.

If the answer is no, the White Paper proposes that the law should require prompt investigation, appropriate remedial action and, where necessary, regulatory intervention.

Chapter 5

The Existing Legal and Regulatory Framework

Introduction

The United Kingdom has an extensive framework of legislation, regulations and technical guidance intended to ensure the safety of residential buildings. These provisions govern the design, construction, occupation and maintenance of residential premises and establish duties on landlords, freeholders, managing agents and other responsible persons.

Despite this comprehensive framework, there is no single statutory regime requiring the periodic structural verification and certification of residential balconies, balustrades, communal railings and other fall-protection structures throughout their operational life.

This chapter examines the principal legislative and regulatory provisions currently applicable to residential fall protection and identifies the extent to which they address—or do not address—the continuing structural integrity of these safety-critical elements.

5.1 Building Regulations 2010

The Building Regulations 2010 establish minimum functional requirements for the design and construction of buildings in England. Equivalent regulations exist in Wales, Scotland and Northern Ireland.

The objective of the Regulations is to ensure that buildings are designed and constructed to provide reasonable standards of safety, health, accessibility and energy efficiency.

For the purposes of residential fall protection, the most relevant provisions are contained within Schedule 1, Part K – Protection from Falling, Collision and Impact.

Requirement K2 requires that stairs, balconies, landings and raised edges are provided with suitable guarding to reduce the risk of falls.

Approved Document K provides practical guidance on achieving compliance, including recommendations concerning:

- minimum guarding heights;
- resistance to imposed loads;
- limitations on openings;
- prevention of climbing where appropriate;
- guarding of communal access balconies and stairways.

Approved Documents are statutory guidance rather than legislation. Compliance with them is one recognised method of satisfying the Building Regulations, but alternative approaches may also demonstrate compliance.

Limitations

The Building Regulations principally regulate construction and material alteration. They are not a continuing maintenance regime.

Once a building has been completed and occupied, the Regulations do not create a universal statutory obligation requiring periodic structural verification of fall-protection systems throughout their service life.

Accordingly, compliance at the point of construction does not in itself demonstrate continuing structural integrity many years later.

5.2 Building Safety Act 2022

The Building Safety Act 2022 represents the most significant reform of building safety legislation in a generation.

Enacted following the Grenfell Tower fire and subsequent public inquiry, the Act establishes a new regulatory framework for higher-risk buildings and creates enhanced duties for those responsible for managing them.

The Act introduces, among other measures:

- the Building Safety Regulator;
- the concept of the Principal Accountable Person and Accountable Persons;
- safety case reporting;
- the "golden thread" of building information;
- enhanced resident engagement requirements;
- strengthened enforcement powers.

The Act is intended to ensure that building safety risks are identified, assessed and managed throughout the life of higher-risk buildings.

Relevance to fall-protection structures

Balconies, communal walkways and structural guarding may form part of the building safety risks considered under the Act where their condition could contribute to structural or life safety risks.

However, the Act does not prescribe a universal requirement for recurring structural verification or certification of all residential fall-protection structures.

Instead, it establishes a framework within which responsible persons must identify and manage relevant risks using a proportionate approach.

The remaining gap

The Act significantly strengthens governance and accountability but leaves the methodology for demonstrating the continuing structural integrity of individual fall-protection structures largely to the judgment of those responsible, informed by applicable law, guidance and competent professional advice.

5.3 Housing Act 2004 and the Housing Health and Safety Rating System

The Housing Act 2004 introduced the Housing Health and Safety Rating System (HHSRS), a risk-based method used by local authorities to assess housing conditions.

The HHSRS recognises Falls Associated with Stairs and Steps and Falls Between Levels as prescribed hazards.

Where a local authority identifies a Category 1 Hazard, it has a duty to take appropriate enforcement action. For Category 2 Hazards, it has discretionary enforcement powers.

Factors considered include:

- height of potential fall;
- condition of guarding;
- adequacy of barriers;
- vulnerability of occupants;
- likelihood of injury.

Strengths

The HHSRS provides an established enforcement mechanism where dangerous conditions are identified.

It enables local authorities to require remedial action where the condition of a property presents an unacceptable risk to occupants.

Limitations

The HHSRS is primarily reactive.

Inspection generally occurs following:

- complaints;
- routine local authority inspections;
- licensing activity;
- identified concerns.

The legislation does not establish a national programme requiring the periodic structural verification or certification of fall-protection systems before deterioration becomes apparent.

5.4 Occupiers' Liability Acts 1957 and 1984

The Occupiers' Liability Act 1957 imposes a duty upon occupiers to take such care as is reasonable in all the circumstances to ensure that lawful visitors are reasonably safe when using the premises for their intended purposes.

The Occupiers' Liability Act 1984 extends more limited duties to certain non-visitors.

In residential settings, these duties commonly arise in relation to communal areas under the control of landlords, freeholders or managing agents.

The standard is one of reasonable care, assessed according to the circumstances of each case.

Evidence that may be relevant includes:

- inspection regimes;
- maintenance records;
- previous complaints;
- known defects;
- industry standards;
- foreseeability of harm.

Limitations

The legislation does not prescribe the frequency, methodology or scope of inspections. Nor does it require recurring structural verification or certification of fall-protection structures.

Instead, these matters are assessed after an incident when determining whether reasonable care was exercised.

5.5 Defective Premises Act 1972

The Defective Premises Act 1972 imposes duties in relation to the construction and maintenance of dwellings.

Following amendments introduced by the Building Safety Act 2022, limitation periods for certain claims have been significantly extended.

The Act may provide a civil remedy where defective work renders a dwelling unfit for habitation or otherwise gives rise to actionable defects.

Relevance

Where a fall-protection structure was defectively designed or constructed, liability may arise under the Act.

However, the Act does not establish a continuing inspection or certification regime following occupation.

5.6 Landlord and Tenant Act 1985

Section 11 of the Landlord and Tenant Act 1985 imposes repairing obligations on landlords in relation to specified elements of residential premises.

Depending upon the terms of occupation and the nature of the building, additional contractual and statutory obligations may apply in relation to common parts.

These provisions support ongoing maintenance responsibilities but do not prescribe recurring structural verification of safety barriers.

5.7 Health and Safety at Work etc. Act 1974

The Health and Safety at Work etc. Act 1974 primarily regulates workplace health and safety. Its application to residential buildings depends upon the circumstances.

Where work activities are undertaken by landlords, managing agents or contractors, duties may arise under the Act to ensure, so far as is reasonably practicable, that persons not in their employment are not exposed to risks arising from those work activities.

The Act is therefore relevant to the management of maintenance work and common areas in certain contexts but is not a general statutory code governing the safety of residential premises occupied as private homes.

5.8 British Standards and Professional Guidance

A range of British Standards and technical guidance informs the design, assessment and maintenance of guarding and balustrades.

These include, among others:

- BS 6180 – Barriers in and about buildings.
- Relevant Eurocodes for structural loading.
- Institution of Structural Engineers guidance.
- Industry guidance issued by professional bodies and housing organisations.

These documents provide recognised technical benchmarks and are frequently relied upon by engineers and expert witnesses.

However, British Standards are not legislation. Their legal significance depends on the context in which they are applied.

5.9 Summary of the Existing Framework

The current legal framework establishes important duties relating to:

- safe design;
- construction standards;
- maintenance;
- risk management;
- reasonable care;
- enforcement against hazardous housing conditions.

These duties are substantial and should not be understated.

However, the framework is fragmented. Responsibilities arise from multiple statutes, common law duties and technical guidance rather than from a single coherent system focused specifically on residential fall-protection structures.

Most importantly, there is no universal statutory requirement requiring responsible persons to demonstrate, at prescribed intervals and through a documented process, that balconies, balustrades, communal railings and comparable fall-protection structures remain structurally capable of performing the life-preserving function for which they were installed.

It is this specific gap that The Joshua Test seeks to address.

Summary of legal coverage and remaining gap

Legal instrument	What it requires	What it does not require
Building Regulations 2010	Safe design and construction.	Periodic structural verification after occupation.
Building Safety Act 2022	Ongoing management of building safety risks in higher-risk buildings.	Universal recurring verification of all residential fall-protection structures.
Housing Act 2004 (HHSRS)	Enforcement against hazardous housing conditions.	A national recurring inspection and certification regime.
Occupiers' Liability Acts	Reasonable care for lawful visitors and certain non-visitors.	Prescribed inspection intervals or verification methods.
Defective Premises Act 1972	Civil remedies for defective work in applicable circumstances.	An ongoing statutory inspection duty.

Legal instrument	What it requires	What it does not require
British Standards	Technical guidance and recognised engineering practice.	A legal obligation to comply in every circumstance unless incorporated by law or contract.

Building Regulations 2010

Chapter 6

Inspection of Residential Fall-Protection Structures: Current Practice and Limitations

Introduction

Social landlords operate within a substantial framework of statutory duties, regulatory standards, asset-management practices and specialist compliance regimes.

Most registered providers undertake a combination of:

- stock-condition surveys;
- communal-area inspections;
- responsive repairs;
- planned and cyclical maintenance;
- specialist safety inspections;
- housing hazard assessments;
- building safety assessments; and
- investigations prompted by complaints, visible deterioration or reported defects.

These practices provide important protections. However, they do not necessarily amount to a consistent system of structural assurance for residential guardrails, balustrades and other fall-protection structures.

The principal concern is not whether inspections take place. It is whether the inspection undertaken is sufficiently targeted, technically competent and evidenced to demonstrate that a life-safety structure remains capable of performing its intended function.

1. Stock-Condition Surveys

Stock-condition surveys are a central component of social-housing asset management.

The Regulator of Social Housing's Safety and Quality Standard requires registered providers in England to maintain an accurate, current and evidenced understanding of the condition of their homes. This must be based on a physical assessment of every home and maintained at individual-property level. Providers must use this information to inform compliance, repairs, maintenance and planned improvement programmes.

In practice, stock-condition information may be collected through:

- comprehensive periodic surveys;
- sample surveys supported by data modelling;
- void inspections;
- responsive repair records;
- specialist compliance assessments;
- estate inspections;
- contractor reports; and
- information supplied by tenants.

Stock-condition surveys commonly record the apparent condition, age and anticipated remaining life of building components. They help providers forecast expenditure and determine when major works or replacement programmes may be required.

However, a general stock-condition survey is not automatically a structural investigation.

Its scope may be primarily directed towards:

- component condition;
- repair priorities;
- Decent Homes compliance;
- investment planning;
- energy efficiency;
- damp and mould;
- visible disrepair; and
- expected replacement dates.

A survey may record a railing as painted, present, apparently secure or in satisfactory visual condition without determining:

- the extent of concealed corrosion;
- the condition of embedded steel;
- the residual thickness of metal components;
- the integrity of welds;
- the adequacy of historic fixings;
- the strength of connections to the building;
- the effects of water penetration; or
- whether the barrier remains capable of resisting the required loads.

The value of a stock-condition survey therefore depends upon its scope, methodology, accessibility, surveyor competence and the extent to which specialist investigation is commissioned where risk indicators are identified.

2. Communal-Area and Estate Inspections

Housing providers commonly carry out inspections of communal areas and estates.

These may include visual checks of:

- walkways and access routes;
- stairwells;
- balconies;
- landings;
- lighting;
- doors;
- trip hazards;
- refuse areas;
- vandalism;
- grounds and external areas; and
- obvious repair or safety concerns.

Such inspections are valuable because they allow visible deterioration and emerging hazards to be identified between formal stock-condition surveys.

However, their frequency and scope can vary between providers and estates. The person conducting the inspection may be a housing officer, caretaker, neighbourhood officer, facilities operative, surveyor or contractor.

A routine estate inspection is not necessarily undertaken by someone qualified to assess structural integrity.

It may identify:

- loose components;
- visible rust;
- missing fixings;
- impact damage;
- flaking paint;
- obvious movement; or
- resident interference.

It may not identify deterioration that is:

- internal;
- embedded within concrete;
- obscured by coatings;
- concealed behind finishes;
- located at inaccessible connection points; or
- only apparent through measurement, intrusive investigation or engineering analysis.

A structure may therefore pass repeated visual inspections while its load-bearing capacity continues to deteriorate.

3. Responsive Repairs

Responsive repair systems provide an essential route through which residents and staff can report defects.

Reports concerning a railing or balustrade might include:

- movement or instability;
- corrosion;
- loose fixings;
- missing components;
- damage;
- cracking around connections;
- gaps in guarding;
- sharp edges; or
- concern that the structure feels unsafe.

A responsive repair may result in:

- attendance by a general repairs operative;
- temporary restriction of access;

- minor repair;
- referral to a specialist contractor;
- replacement of components; or
- escalation for surveying or engineering advice.

This process depends heavily upon the defect being:

1. visible or detectable;
2. reported;
3. accurately described;
4. appropriately categorised;
5. assigned to someone with the necessary competence; and
6. escalated where the condition may indicate structural deterioration.

Responsive repairs are therefore strongest where the defect has already become apparent. They are less effective as a means of identifying concealed or progressive deterioration before any visible warning is recognised.

The Joshua Test would not replace responsive repairs. It would supplement them by creating a preventative duty that does not depend exclusively upon a resident or employee first recognising that something may be wrong.

4. Planned and Cyclical Maintenance

Social landlords routinely undertake planned maintenance programmes, including:

- external decoration;
- corrosion treatment;
- concrete repairs;
- roof works;
- window replacement;
- communal-area refurbishment;
- balcony repairs; and
- renewal of building components.

Cyclical painting can provide an important protective function by reducing exposure to moisture and slowing corrosion.

However, painting and surface treatment must never be treated as proof of structural soundness, nor used to conceal or postpone investigation of suspect connections, fixings, corrosion, cracking or movement.

Where corrosion is concealed within hollow sections, behind baseplates, inside joints or within concrete, surface preparation and repainting may improve appearance without identifying the full extent of deterioration.

Maintenance activity should therefore be distinguished from structural verification.

A responsible maintenance record must therefore distinguish clearly between cosmetic treatment, protective maintenance, structural repair and technical verification. A record showing that a guardrail has been:

- painted;
- cleaned;

- patched;
- visually examined; or
- included within an external works programme

does not, by itself, establish that it retains sufficient strength.

Where signs of corrosion, water penetration, cracking, historic alteration or connection failure are present, the appropriate response may require specialist investigation rather than routine decoration.

5. Specialist Compliance Inspections

Social landlords operate several mature specialist compliance regimes.

These commonly include:

- gas safety checks;
- electrical inspections;
- lift examinations;
- fire-risk assessments;
- asbestos management;
- water-hygiene controls;
- smoke and carbon-monoxide alarm duties; and
- checks of other mechanical or life-safety systems.

These regimes often contain clearly defined requirements concerning:

- inspection frequency;
- competent persons;
- testing methodology;
- certification;
- record retention;
- remedial actions; and
- regulatory oversight.

The contrast is significant.

A lift is not assumed safe because it appears operational. Its safety is supported by specialist examination and documented evidence.

A gas installation is not treated as safe solely because no tenant has reported a smell or malfunction.

Fire doors are increasingly understood as engineered safety components whose condition, installation and performance require specific attention.

Residential fall-protection structures also serve a life-critical function. However, there is no equivalent universal statutory inspection and certification regime requiring every such structure to be periodically verified throughout its operational life.

6. Housing Health and Safety Rating System Inspections

The Housing Health and Safety Rating System is used by local authorities to identify and assess risks to the health and safety of occupiers and visitors.

Its hazard profiles include falls between levels and structural collapse. The system assesses the risk arising from a residential condition rather than merely determining whether a building component complies with the standards that applied when it was constructed.

The HHSRS is an important safeguard. Where a Category 1 hazard is identified, the local authority must take enforcement action. It has powers to act in relation to less serious Category 2 hazards.

However, HHSRS inspections are not routine structural certification surveys of every social-housing building.

They may arise following:

- a tenant complaint;
- a local-authority housing inspection;
- intelligence about property conditions;
- a licensing process;
- a serious incident; or
- concern identified by another agency.

The system is therefore capable of addressing an unsafe guardrail, but it does not itself require every guardrail to undergo scheduled engineering verification.

7. Building Safety Act Assessments

For occupied higher-risk residential buildings, the Building Safety Act 2022 introduced enhanced duties requiring Accountable Persons to assess and manage defined building safety risks.

These requirements have strengthened:

- building safety governance;
- accountability;
- safety-case preparation;
- information management;
- resident engagement; and
- reporting of safety occurrences.

However, the enhanced occupation regime primarily applies to buildings meeting the statutory height or storey threshold and focuses upon risks arising from fire spread and structural failure.

It does not create a stand-alone inspection cycle for every railing or balustrade in all residential buildings.

A provider may reasonably consider guardrails as part of wider structural-risk management. The depth and frequency of that assessment will nevertheless depend upon:

- the building's classification;
- the provider's safety-management system;
- available asset data;
- professional judgement;
- known defects; and

- the interpretation of structural risk.

8. Regulatory Inspections of Social Landlords

The Regulator of Social Housing carries out programmed inspections of large registered providers, with an aim of inspecting each at least once every four years. These inspections assess how effectively the landlord is delivering the outcomes required by the regulatory standards.

The regulator also reviews information supplied by landlords between programmed inspections.

A regulatory inspection is not a physical engineering inspection of every property or building component.

It examines the provider's systems, governance, evidence, assurance and delivery. It may consider:

- whether the provider understands stock condition;
- whether safety duties are being met;
- whether repair actions are completed;
- whether data is reliable;
- whether risks are escalated; and
- whether the board receives sufficient assurance.

The regulator may identify weaknesses in the landlord's systems, but it does not itself test every guardrail or certify its structural integrity.

9. Variability Across the Sector

There is no suggestion that social landlords universally neglect fall-protection safety.

Many providers undertake responsible inspection, maintenance and risk-management work. Some may already commission structural surveys, intrusive corrosion investigations or load testing where the condition, construction or history of a building justifies it.

The difficulty is consistency.

Current practice can vary according to:

- the provider's internal policies;
- the quality of its asset data;
- the age and composition of its stock;
- financial capacity;
- previous incidents;
- surveyor judgement;
- contractor competence;
- the frequency of inspections;
- the accessibility of the structure; and
- whether a defect has already been reported.

Two visually similar residential buildings may therefore receive different levels of inspection and assurance.

Residents may have no practical means of knowing:

- when a barrier was last examined;
- what type of inspection was undertaken;
- whether its fixings were inspected;
- whether corrosion was measured;
- whether any structural calculation was completed;
- whether remedial work was recommended; or
- whether the structure has ever been verified against an appropriate loading requirement.

10. The Distinction Between Inspection and Assurance

The following activities should not be treated as interchangeable:

Observation

Someone has looked at the structure.

Inspection

The structure has been examined according to a defined scope.

Maintenance

Work has been undertaken to preserve or repair it.

Structural assessment

A competent person has considered its construction, condition and capacity.

Testing

Its materials, fixings or performance have been examined using an appropriate technical method.

Assurance

Current, documented evidence supports the conclusion that the structure remains capable of performing its intended safety function.

The Joshua Test is principally concerned with the final category.

It does not propose that every railing must be subjected to identical testing at fixed intervals. It proposes that the responsible person should adopt a proportionate process capable of producing meaningful assurance.

Conclusion

Current inspection practice within social housing includes many important safeguards. However, the existing system can rely heavily upon general surveys, visual observations, responsive repairs and provider-specific approaches.

The resulting records may demonstrate that a building has been visited or maintained without conclusively demonstrating that a particular fall-protection structure remains structurally capable of preventing a fatal fall.

The policy objective of The Joshua Test is therefore not to replace existing landlord practice.

It is to establish a consistent legal expectation that those practices must, where proportionate to the risk, produce current and competent evidence of continuing structural integrity.

Chapter 7

International Approaches to Lifecycle Structural Safety

7.1 International Best Practice

No jurisdiction has yet introduced legislation identical to that proposed in The Joshua Test. Nevertheless, international experience demonstrates an increasing recognition that ageing buildings require continuing professional oversight.

Singapore

Singapore's Periodic Façade Inspection regime requires competent professionals to inspect specified older buildings at regular intervals.

Although directed primarily at façade safety, the legislation reflects an important policy principle: compliance at the point of construction should not be regarded as permanent evidence of structural safety.

California, United States

Following a number of fatal structural failures, California introduced legislation requiring the periodic inspection of exterior elevated elements—including balconies, decks, stairways and elevated walkways—in certain residential buildings.

Inspections must be undertaken by suitably qualified professionals, with defects requiring remedial action within prescribed timescales.

The Californian approach provides one of the closest international examples of legislation specifically directed towards ageing fall-protection structures.

Australia

Australian building reforms have increasingly emphasised competency, accountability, record keeping and proactive management of structural defects in residential buildings.

Canada

Several Canadian jurisdictions require periodic professional assessment of ageing building elements where public safety may be affected.

Although implementation differs between provinces and municipalities, the emphasis on lifecycle management is consistent with wider international trends.

7.2 Lessons from International Experience

Despite differences in legal systems and regulatory structures, several common principles emerge.

First, buildings should be managed throughout their operational life rather than regarded as permanently compliant following construction.

Secondly, inspection should be undertaken by competent persons applying recognised engineering principles.

Thirdly, safety should be capable of being demonstrated through documented evidence rather than assumption.

Finally, preventative maintenance and timely intervention are preferable to responding only after serious incidents have occurred.

These principles are fully consistent with the objectives of The Joshua Test.

PART III

ENGINEERING AND RISK

Why lifecycle assurance is an engineering as well as a policy question.

Chapter 8

Engineering Principles of Residential Fall-Protection Structures

8.1 Introduction

Every building begins to age from the day it is completed.

Environmental exposure, weather, temperature fluctuations, moisture ingress, corrosion, accidental damage, repeated loading and routine wear all contribute to gradual deterioration over time. This process is neither unusual nor unexpected; it is a fundamental principle of engineering and asset management.

For most building components, deterioration may result in inconvenience, increased maintenance costs or reduced efficiency.

For fall-protection structures, however, deterioration may have far more serious consequences.

Balconies, balustrades, communal guardrails and elevated walkways exist primarily to prevent occupants and visitors from falling from height. Their purpose is protective. They are relied upon instinctively by residents who may lean against them, steady themselves or depend upon them to arrest a loss of balance.

Unlike many other structural elements, the failure of a fall-protection structure is unlikely to present a gradual decline in serviceability. Instead, failure may occur suddenly, with potentially catastrophic consequences.

For this reason, the continuing integrity of these structures should be regarded as a matter of public safety rather than routine property maintenance alone.

8.2 Engineering Principles of Structural Deterioration

No engineering material remains unchanged indefinitely.

The performance of structural systems is influenced by time, environmental conditions, workmanship, maintenance history and patterns of use.

Common deterioration mechanisms include:

Corrosion

Steel balustrades, anchors, bolts and fixings are vulnerable to corrosion where protective coatings deteriorate or moisture penetrates joints and interfaces.

Corrosion may significantly reduce structural capacity before external signs become readily apparent.

Fatigue

Repeated loading over many years can initiate microscopic cracks that gradually propagate under normal service conditions.

Although fatigue is more commonly associated with major infrastructure, it may also affect structural connections exposed to repeated movement or vibration.

Concrete Degradation

Concrete balconies and supporting structures may deteriorate through:

- carbonation;
- chloride ingress;
- reinforcement corrosion;
- freeze-thaw damage;
- cracking associated with thermal movement.

These mechanisms may compromise embedded reinforcement while leaving only limited visible evidence during the early stages of deterioration.

Timber Decay

Where timber forms part of a guarding system, prolonged exposure to moisture may result in fungal decay or loss of structural integrity.

Environmental Exposure

Structures located in coastal environments, areas subject to airborne pollutants or locations exposed to severe weather conditions may experience accelerated deterioration.

Age alone is not an indicator of structural safety. Rather, it is one factor that should inform professional judgement when determining inspection and maintenance requirements.

8.3 Inspection, Verification and Structural Assurance

Routine inspection forms an essential part of responsible building management.

However, inspection alone should not automatically be regarded as evidence that a structure remains structurally capable of performing its intended safety function.

It is important to distinguish between three related concepts.

Inspection involves observing the condition of a structure and identifying visible defects or signs of deterioration.

Structural verification involves assessing whether sufficient evidence exists to demonstrate that the structure continues to perform safely.

Structural assurance is the documented confidence, based upon inspection, engineering assessment and maintenance records, that the structure remains fit for purpose.

The Joshua Test is founded upon this distinction.

Its objective is not to prescribe a single engineering methodology but to ensure that responsible persons can demonstrate, through proportionate evidence, that residential fall-protection structures remain capable of preventing the fall they were installed to prevent.

8.4 Hidden Defects and the Limitations of Visual Inspection

Visual inspection is an indispensable element of any maintenance regime.

Nevertheless, some defects develop in locations that cannot readily be assessed through routine observation alone.

Examples include:

- concealed corrosion of embedded anchors;
- deterioration within welded connections;
- corrosion of reinforcement concealed within concrete;
- degradation of resin anchor systems;
- hidden cracking within structural members;
- moisture-related deterioration concealed behind finishes.

The existence of hidden defects does not diminish the importance of visual inspection.

Rather, it demonstrates that professional judgement is required to determine when further investigation is justified.

This White Paper does not advocate intrusive investigation in every case.

Instead, it proposes that inspection methods should be selected according to risk, engineering judgement and the available evidence.

8.5 Risk-Based Lifecycle Management

Across engineering disciplines, the management of safety-critical assets increasingly follows a lifecycle approach.

Rather than assuming that compliance at the point of construction guarantees indefinite performance, responsible organisations adopt systems based upon:

- periodic inspection;
- condition monitoring;
- risk assessment;
- planned maintenance;
- documented decision-making;
- timely intervention before failure occurs.

This philosophy is reflected in internationally recognised asset management standards and engineering practice.

The Joshua Test applies the same principle to residential fall-protection structures.

The objective is not to eliminate all risk—a practical impossibility—but to ensure that foreseeable deterioration is identified and managed before catastrophic failure occurs.

8.6 Competence

Any statutory inspection regime is only as effective as the competence of those undertaking the work.

The White Paper therefore proposes that structural verification should be undertaken only by appropriately qualified and experienced persons acting within the limits of their professional competence.

Government should work with:

- the Building Safety Regulator;
- the Institution of Structural Engineers;
- the Institution of Civil Engineers;
- the Chartered Institution of Building;
- the Health and Safety Executive; and
- other relevant professional bodies,

to develop nationally recognised competency standards for those responsible for inspecting and assessing residential fall-protection structures.

Such standards should remain sufficiently flexible to accommodate future developments in engineering practice and technology.

Chapter 9

Understanding Deterioration, Hidden Risk and Structural Failure

This chapter explains why deterioration may develop progressively and why visible appearance alone cannot always establish structural condition. It provides the engineering rationale for proportionate escalation where evidence or uncertainty warrants further assessment.

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Figure 9.1 – Visual Evidence: Deterioration, Hidden Risk and Structural Failure

FIGURE 9.1

DETERIORATION, HIDDEN RISK AND STRUCTURAL FAILURE

Why appearance alone may not establish continuing structural capacity



Technical illustration of deterioration pathways and visible / hidden indicators.

Chapter 10

Inspection Methodology and Lifecycle Assurance

Introduction

The Joshua Test should establish a nationally consistent framework for the inspection, assessment and ongoing assurance of residential fall-protection structures.

Current legislation and technical guidance largely concentrate on the design and construction of barriers. They provide comparatively limited direction on how such structures should be inspected throughout decades of occupation, particularly where deterioration may be concealed or progressive.

A structure that complied with the standards applicable when it was installed may nevertheless become unsafe because of:

- corrosion;
- fatigue;
- carbonation;
- chloride ingress;
- water penetration;
- freeze-thaw action;
- movement;
- repeated loading;
- poor maintenance;
- incompatible repairs;
- concealed deterioration; or
- ageing materials.

The purpose of inspection should therefore be not simply to identify visible defects but to establish whether the structure continues to perform its intended protective function.

The central inspection principle should be:

Every safety-critical barrier should be capable of demonstrating continuing structural integrity throughout its service life, rather than relying solely upon historic compliance at the point of construction.

Figure 10.1 – Inspection Escalation Pathway

FIGURE 10.1

INSPECTION ESCALATION PATHWAY

Inspection intensity increases only when risk, condition or uncertainty justifies it.



Resident Safety Concern Escalation Flow Chart		
1. Record the concern	→	2. Determine whether immediate danger may exist
3. Send it promptly to the responsible person	→	4. Notify the correct enforcement body
5. Retain the evidence supplied	→	6. Provide the resident with a reference
7. Explain which body has taken ownership	→	8. Continue escalation if no adequate response is made

1. Inspection Philosophy

Inspection should be based upon four fundamental questions:

1. What was the structure intended to do?
2. What condition is it currently in?
3. Can it still safely perform that function?
4. What evidence supports that conclusion?

An inspection should never consist solely of confirming that a railing remains physically present.

2. A Risk-Based Inspection Framework

Inspection frequency should reflect risk rather than arbitrary time periods alone.

Relevant factors should include:

- age of the structure;
- material type;
- exposure to weather;
- coastal or corrosive environments;
- previous repairs;
- structural complexity;
- construction method;
- history of defects;
- occupancy level;
- vulnerability of residents;
- consequence of failure;
- maintenance history; and
- evidence of deterioration.

The highest-risk structures should receive the most frequent inspection.

3. Five Levels of Inspection

The Joshua Test should establish nationally recognised inspection levels.

Level 1 – Routine Visual Observation

Undertaken during:

- estate inspections;
- caretaking;
- cleaning;
- housing officer visits;
- contractor attendance.

Purpose:

To identify obvious changes requiring escalation.

No structural conclusions should be drawn.

Level 2 – Competent Visual Inspection

Undertaken by a suitably trained building inspector or surveyor.

Assessment includes:

- movement;
- corrosion;
- coatings;
- cracks;
- fixings;
- alignment;
- distortion;
- water ingress;
- previous repairs.

Photographs recorded.

The asset register should be updated, with photographic evidence and any inspection limitations recorded.

Level 3 – Detailed Technical Inspection

Required where:

- significant deterioration exists;
- previous repairs are extensive;
- uncertainty remains;
- repeated complaints occur.

May include:

- intrusive examination;
- opening-up;
- removal of finishes;
- measurement;
- corrosion assessment.

Level 4 – Specialist Engineering Assessment

Undertaken by an appropriately qualified structural engineer.

May include:

- structural calculations;
- residual capacity assessment;
- finite element analysis where appropriate;
- engineering judgement;
- repair strategy.

Level 5 – Verification Inspection

Completed after repair or replacement.

To verify that:

- works were completed;
- specification achieved;
- protective function restored;
- records updated.

No work order should be closed until verification is complete and the asset register, photographic record and resident-safety information have been updated.

4. Inspection Competence

Not every inspection requires a Chartered Structural Engineer.

However, competence should always be proportionate to risk.

The legislation should define minimum competence for:

- housing officers;
- surveyors;
- inspectors;
- contractors;
- engineers;
- specialist testers.

5. Inspection Planning

Every responsible person should prepare an inspection programme centred on a live barrier asset register and including:

- unique asset identification for each barrier, balustrade, guardrail or comparable fall-protection structure;
- inspection frequency;
- priorities;
- responsible inspector;
- access arrangements;
- resident communication;
- photographic evidence, inspection limitations and supporting records;
- review dates and board reporting.

6. What Should Be Inspected

Every inspection should consider:

Visible elements

- rails;
- balusters;
- panels;
- welds;
- fixings;
- coatings.

Concealed elements

Where appropriate:

- embedded steel;
- anchorages;
- reinforcement;
- concrete condition;
- hidden fixings.

The inspection should recognise that catastrophic failure frequently begins where deterioration cannot readily be seen.

7. Inspection Limitations

Every report should clearly state:

- what was inspected;
- what could not be inspected;
- assumptions made;
- access limitations;
- recommendations for further investigation.

Silence should never imply that concealed elements were satisfactory.

8. Resident Evidence

Resident observations should be treated as technical evidence requiring assessment.

Examples include:

- movement;
- vibration;
- unusual sounds;
- recurring rust staining;
- water ingress;
- repeated repairs;
- perceived instability.

Residents should not be expected to diagnose engineering failures.

9. Non-Destructive Testing

The Joshua Test should encourage proportionate use of:

- cover meters;
- corrosion assessment;
- ultrasonic testing;
- rebound hammer testing;
- moisture assessment;
- borescopes;
- thermal imaging where relevant.

Testing should always answer a defined engineering question.

10. Intrusive Investigation

Opening-up should be considered where:

- concealed deterioration is suspected;
- inspection limitations remain;
- structural uncertainty persists;
- previous repairs obscure original construction;
- corrosion cannot otherwise be assessed.

11. Residual Structural Capacity

Inspectors should determine:

Not simply:

"Is this damaged?"

But:

"Can this barrier still safely resist foreseeable loading?"

12. Repair Decisions

Following inspection:

The responsible person should determine whether:

- monitoring;
- maintenance;
- repair;
- strengthening;
- replacement;
- temporary protection; or
- closure

is required.

13. Verification

Completed repairs should be independently verified where appropriate.

Verification should include:

- inspection;
- photographs;
- testing where required;
- updated asset records;
- resident notification.

14. Service Life

Responsible persons should understand that every barrier has a finite service life.

Inspection programmes should anticipate ageing rather than merely reacting to failure.

15. Learning from Failure

Every dangerous barrier, serious structural defect or structural failure should trigger immediate local action and a portfolio-wide escalation process so that comparable barriers are identified, prioritised and examined without delay.

- engineering review;
- asset review;
- portfolio-wide comparison of similar barriers, connection details, construction age and exposure conditions;
- contractor review;
- maintenance review;
- regulatory reporting.

16. Proposed Statutory Duty

The legislation could provide:

Every responsible person shall establish and maintain a documented inspection programme, supported by a barrier asset register, competent inspection arrangements, photographic evidence, escalation procedures and board-level reporting, designed to provide continuing assurance that every relevant fall-protection structure remains capable of safely performing its intended protective function throughout its service life.

Conclusion

The Joshua Test should move inspection away from a reactive model—where action follows visible deterioration or catastrophic failure—and towards a preventative lifecycle assurance model.

Rather than asking whether a barrier was once compliant, the legislation should require responsible persons to demonstrate, through proportionate inspection and evidence-based assessment, that it remains safe today.

Chapter 11

Competence, Training and Professional Standards

Introduction

The effectiveness of any statutory inspection regime depends not solely upon the existence of legal duties, but upon the competence of those responsible for discharging them.

The Joshua Test does not propose that every residential fall-protection structure should be inspected by a Chartered Structural Engineer. Such an approach would be disproportionate, financially burdensome and unnecessary in many cases.

Instead, the legislation should establish a risk-based competency framework, ensuring that inspections are undertaken by individuals whose qualifications, knowledge, experience and professional judgement are proportionate to the complexity of the structure, the level of risk and the purpose of the inspection.

Competence should not be determined by job title alone. It should be demonstrated through a combination of education, practical experience, continuing professional development and, where appropriate, professional registration.

The guiding principle should be:

The level of competence required should always be proportionate to the level of risk.

1. A National Competency Framework

Government should establish a nationally recognised competency framework for the inspection of residential fall-protection structures.

The framework should:

- define minimum competency requirements;
- establish recognised inspection levels;
- identify when specialist expertise is required;
- support consistent practice across England;
- provide assurance to residents and regulators; and
- align with existing professional standards wherever possible.

The competency framework should be developed in partnership with:

- the Building Safety Regulator;
- the Institution of Structural Engineers;
- the Institution of Civil Engineers;
- the Royal Institution of Chartered Surveyors;
- the Chartered Institute of Housing;
- the Building Safety Competence Foundation (or successor bodies); and
- representatives of housing providers and resident groups.

2. Principles of Competence

Competence should be understood as the combination of:

- technical knowledge;
- practical skills;
- relevant experience;
- professional judgement;
- ethical conduct;
- communication skills; and
- an understanding of legal responsibilities.

Possessing a qualification alone should not automatically demonstrate competence.

Similarly, extensive experience without current technical knowledge or ongoing professional development should not be regarded as sufficient for undertaking higher-risk inspections.

3. Competency Levels

The Joshua Test should establish five competency levels aligned with the proposed inspection framework.

Level 1 – Routine Visual Observation

Suitable for:

- caretakers;
- estate officers;
- neighbourhood officers;
- concierge staff;
- maintenance operatives.

Training should include:

- recognising obvious defects;
- identifying signs of movement;
- understanding reporting procedures;
- safeguarding the scene where immediate danger exists;
- resident communication.

Level 1 personnel should never certify structural safety.

Level 2 – Competent Visual Inspection

Suitable for:

- building surveyors;
- housing asset inspectors;
- property compliance officers;
- suitably trained maintenance surveyors.

Competencies should include:

- recognising deterioration;
- understanding common failure mechanisms;

- identifying corrosion;
- recognising structural movement;
- assessing maintenance history;
- determining when escalation is required.

Level 3 – Detailed Technical Inspection

Suitable for:

- senior surveyors;
- building pathology specialists;
- experienced structural inspectors;
- specialist façade or concrete inspectors.

Competencies should include:

- intrusive investigations;
- interpretation of technical drawings;
- assessment of deterioration mechanisms;
- structural reporting;
- risk categorisation;
- repair recommendations.

Level 4 – Specialist Engineering Assessment

Undertaken by an appropriately qualified Chartered Structural Engineer.

Typically where:

- structural capacity is uncertain;
- significant deterioration exists;
- partial failure has occurred;
- structural calculations are required;
- replacement strategies are being developed;
- enforcement action is anticipated.

Level 5 – Verification Inspection

Certain high-risk repairs should be verified by an independent competent professional who was not responsible for the original repair.

Verification provides assurance that the protective function has been restored.

4. When Must a Chartered Structural Engineer Be Involved?

A Chartered Structural Engineer should normally be instructed where:

- significant structural movement is identified;
- reinforcement corrosion has affected structural capacity;
- concrete spalling exposes reinforcement;
- anchors or fixings show evidence of failure;
- the structure has partially collapsed;
- calculations are required;

- load capacity cannot be established visually;
- intrusive investigation identifies uncertainty;
- enforcement notices require engineering evidence;
- litigation or coronial proceedings are anticipated.

Routine inspections should not automatically require chartered engineering input.

5. Training Requirements

Government should support nationally recognised training programmes, proportionate to each inspection level, covering:

- structural behaviour of barriers;
- deterioration mechanisms;
- reinforced concrete pathology;
- corrosion processes;
- inspection techniques;
- photographic recording;
- risk assessment;
- evidence gathering;
- resident engagement;
- legal responsibilities;
- reporting standards, including photographic evidence, inspection limitations, escalation requirements and asset-register updates.

Training should be tailored to competency level and should make clear that observation, inspection, technical assessment, engineering assessment and independent verification are distinct functions requiring different knowledge, authority and professional accountability.

6. Continuing Professional Development (CPD)

Continuing Professional Development should be a mandatory part of the competency framework. Inspectors and professionals involved in fall-protection assurance should keep their knowledge current through regular training, technical updates and review of emerging evidence, standards and best practice.

CPD should also include learning from inspection findings, serious incidents, regulatory updates and relevant engineering developments. This would help ensure that professional judgement remains evidence-based and that inspectors continue to recognise deterioration mechanisms, hidden-risk indicators and appropriate escalation triggers.

A structured CPD requirement would also support consistency across the sector by reducing reliance on informal experience alone. It would provide residents, landlords and regulators with greater confidence that inspections are being carried out by people whose knowledge is current, relevant and proportionate to the risks being assessed.

CPD requirements should apply to all persons whose decisions influence inspection quality, escalation, verification, record keeping or board assurance. The requirements should be proportionate to role, risk and level of technical responsibility.

Minimum CPD expectations should include periodic refresher training, updates on emerging failure mechanisms, lessons from serious incidents and near misses, changes to statutory guidance, and developments in inspection technology and digital asset records.

Professionals responsible for inspection, assessment, verification, supervision or governance should complete regular CPD reflecting:

- changes in legislation;
- updates to British Standards;
- emerging evidence from failures, near misses and enforcement cases;
- developments in inspection technology, non-destructive testing and digital asset records;
- changes to statutory guidance, competence schemes and professional standards; and
- revisions to Approved Document K;
- developments in inspection technology;
- learning from structural failures;
- Prevention of Future Deaths Reports;
- emerging research into deterioration mechanisms.

Professional bodies should recognise this as part of existing CPD requirements.

7. Accreditation

Government should consider establishing a voluntary national accreditation scheme during the early implementation of The Joshua Test, with the potential for mandatory accreditation for higher-risk inspection categories following review.

Accreditation should assess:

- qualifications;
- experience;
- competence;
- professional conduct;
- CPD;
- understanding of statutory duties.

It should complement, rather than duplicate, existing professional registration schemes.

8. Organisational Competence

Competence should not be viewed solely as an individual responsibility.

Responsible organisations should demonstrate that they have:

- appropriate governance;
- competent staff;
- adequate supervision;
- quality assurance arrangements;
- access to specialist expertise;
- systems for escalating concerns;
- sufficient resources to discharge statutory duties.

Boards and senior leadership teams should receive assurance that inspection programmes are supported by appropriately competent personnel.

9. Quality Assurance

Inspection reports should be subject to proportionate quality assurance procedures.

These may include:

- peer review;
- supervisory review;
- random audit;
- independent technical sampling;
- regulator inspection;
- post-incident review.

Quality assurance supports consistency and public confidence.

10. Professional Ethics

Inspectors should be expected to act with integrity, independence and objectivity.

Where conflicts of interest arise, they should be declared and managed appropriately.

Commercial pressures should never compromise professional judgement where resident safety may be affected.

11. Workforce Development

Implementation of The Joshua Test provides an opportunity to strengthen professional capability across the housing sector.

Government should work with educational institutions, professional bodies and employers to encourage:

- new specialist training programmes;
- apprenticeships;
- postgraduate modules;
- research into structural inspection;
- multidisciplinary learning between engineers, surveyors and housing professionals.

Building safety should be recognised as a specialist discipline requiring lifelong learning.

12. Proposed Statutory Duty

The legislation could provide:

A Responsible Person shall ensure that any inspection, assessment, testing or verification required under this Act is undertaken only by a person whose competence is appropriate to the nature, complexity and level of risk presented by the relevant fall-protection structure.

13. Conclusion

The success of The Joshua Test will depend not only upon legislation, but upon the competence of those entrusted to implement it.

By establishing a nationally recognised competency framework, proportionate training requirements and clear expectations for professional development, the legislation can support consistent, evidence-based inspection practice across the housing sector.

Competence should be viewed as a continuous obligation rather than a one-time qualification. As engineering knowledge, building technologies and regulatory expectations evolve, so too must the skills of those responsible for protecting residents from preventable harm.

Ultimately, inspection is only as reliable as the person carrying it out. Ensuring the right people undertake the right inspections at the right time is therefore fundamental to achieving the objectives of The Joshua Test.

PART IV

BUILDING A SAFER SYSTEM

Governance, learning, implementation, resident voice and enforcement.

Chapter 12

Regulatory Architecture and Governance

Introduction

The Joshua Test should create a coherent regulatory system for the continuing safety of residential railings, balustrades, barriers, parapets and associated fall-protection structures.

The current legal and technical framework contains important protections.

Requirement K2 of the Building Regulations 2010 requires barriers to be provided where necessary to protect people in or around a building from falling. Approved Document K explains that suitable guarding should be used and identifies minimum siting, height and loading principles. It also refers users to BS 6180 for further guidance on the design of barriers and infill panels.

However, those provisions do not amount to a complete occupied-building inspection and maintenance regime.

The framework remains fragmented between:

- building control;
- housing enforcement;
- social housing regulation;
- the Building Safety Regulator;
- the Housing Ombudsman;
- landlord repair duties;
- Awaab's Law;
- professional standards;
- civil liability;
- health and safety law; and
- local authority powers.

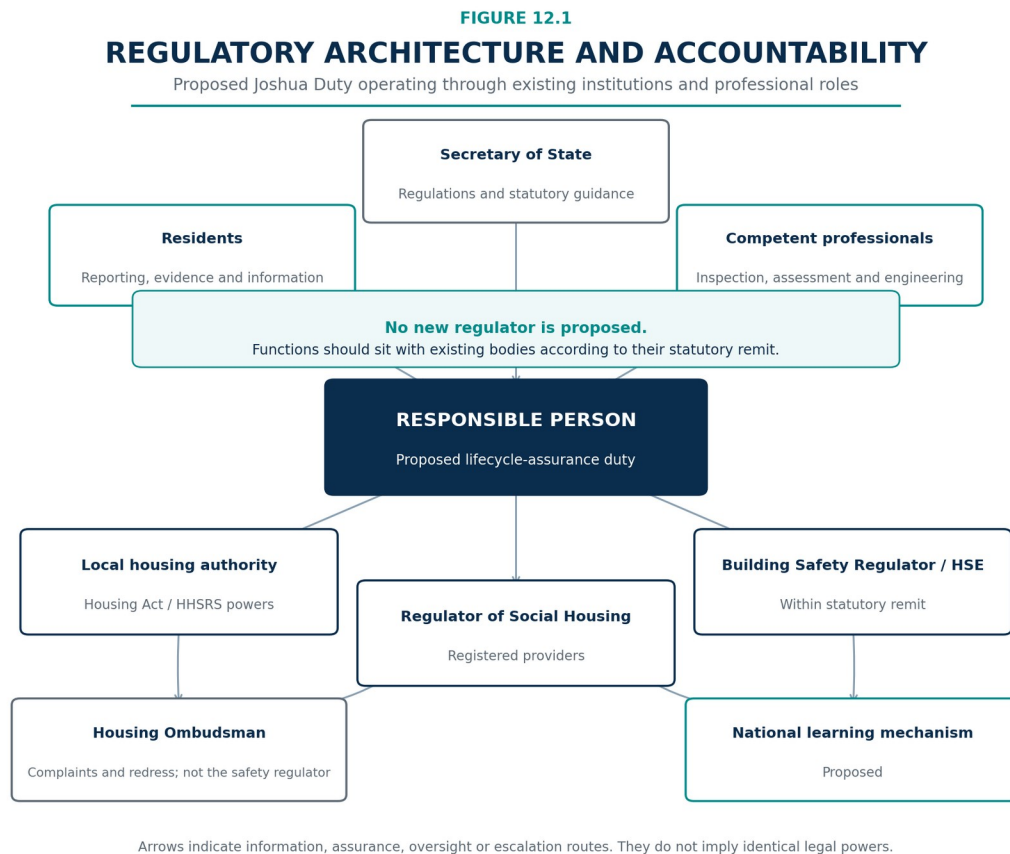
The Joshua Test should not replace those systems.

It should connect them through a clearly defined statutory duty, identifiable regulatory leadership, prescribed inspection powers and enforceable escalation thresholds.

The central regulatory principle should be:

Technical guidance should explain how safety may be achieved, but the law must identify who is required to inspect, who may intervene and what happens when a life-critical structure is not shown to be safe.

Figure 12.1 – Regulatory Architecture and Accountability Flow



1. Current Legal and Technical Baseline

1.1 Building Regulations Requirement K2

The legal requirement is contained in Part K of Schedule 1 to the Building Regulations 2010.

Requirement K2 provides, in substance, that:

- stairs;
- ramps;
- floors;
- balconies;
- accessible roofs;
- light wells;
- basement areas; and
- similar sunken areas

must be provided with barriers where necessary to protect people in or about the building from falling.

This is the legal performance requirement.

It is broader than a rule concerning one particular railing material or design.

1.2 Approved Document K

Approved Document K is statutory guidance explaining ways in which the Building Regulations may be satisfied.

It states expressly that:

- following an Approved Document normally creates a presumption of compliance;
- compliance is not guaranteed in every unusual case;
- alternative methods of compliance are permitted; and
- standards may address matters beyond the Building Regulations or recommend higher standards.

Approved Document K therefore should not be described as legislation.

It supports the legislation.

1.3 BS 6180

BS 6180:2011 is titled:

Barriers in and about buildings — Code of practice.

BSI presently identifies the 2011 edition as current and under review. It addresses the design, construction, height, strength and materials of temporary and permanent barriers.

Approved Document K refers to BS 6180 for further guidance on the design of barriers and infill panels.

The reference is important, but its legal effect should not be overstated.

BS 6180 is:

- a recognised technical code of practice;
- capable of informing accepted professional practice;
- relevant to design and assessment;
- capable of being incorporated contractually;
- capable of being considered in civil, regulatory or expert evidence; but
- not itself primary or secondary legislation.

1.4 Load Standards

Approved Document K separately directs that pedestrian guarding should resist, as a minimum, the loads specified in:

- BS EN 1991-1-1;
- its UK National Annex; and
- PD 6688-1-1.

The Joshua Test should therefore avoid presenting BS 6180 as the only relevant standard.

A proper assessment may need to consider:

- Part K;
- Approved Document K;
- BS 6180;

- structural loading standards;
- material-specific standards;
- glazing standards;
- workmanship;
- historic design standards;
- alterations;
- present condition; and
- professional engineering judgement.

2. The Principal Regulatory Gap

The existing framework is strongest at the stage of:

- design;
- approval;
- construction;
- material alteration; and
- completion of building work.

Approved Document K describes itself as guidance for compliance with Building Regulations in relation to building work. It explains that Building Regulations apply to activities such as erection, extension and material alteration.

The Joshua Test should address what happens after occupation.

A barrier may have complied when installed but subsequently become unsafe because of:

- corrosion;
- water penetration;
- deterioration of embedded steel;
- concrete spalling;
- failed fixings;
- fractured welds;
- material fatigue;
- timber decay;
- glass damage;
- accidental impact;
- unauthorised attachments;
- inappropriate repairs;
- coating failure;
- altered loading;
- missing maintenance; or
- the passage of time.

Neither historic approval nor original compliance proves present structural capacity.

The regulatory gap is therefore not simply an absence of design rules.

It is an absence of a consistent statutory system requiring owners and landlords to demonstrate that a life-critical barrier remains safe throughout its service life.

3. What BS 6180 Provides

BS 6180 should remain an important technical reference for The Joshua Test.

It can contribute principles concerning:

- barrier design;
- structural loading;
- barrier height;
- materials;
- infill panels;
- glazing;
- connections;
- different building uses;
- temporary and permanent barriers; and
- protection of people around buildings.

It may also assist competent professionals when considering whether an existing barrier remains consistent with the principles expected of a safe guarding system.

However, The Joshua Test should not simply state:

“All barriers must comply with BS 6180:2011.”

That formulation would be too simplistic.

It could create uncertainty because:

- some existing structures predate the 2011 edition;
- earlier standards may have applied when they were built;
- BS 6180 may be revised;
- compliance with a design standard does not prove freedom from deterioration;
- some defects concern supporting concrete or embedded connections rather than visible barrier geometry;
- the standard is not freely accessible to every resident;
- a code of practice does not establish a complete enforcement process;
- unusual structures may require additional analysis;
- the most relevant issue may be present residual capacity rather than original design compliance; and
- British Standards can recommend performance beyond the minimum demanded by Building Regulations.

The better legal formulation is that responsible persons must demonstrate that relevant structures are safe and fit for continuing service, having regard to prescribed technical standards, including the current edition of BS 6180 where applicable.

4. Where More Is Required

The Joshua Test should go beyond BS 6180 and Approved Document K by creating express duties concerning:

Asset Identification

Every relevant structure should be identified and entered into an asset register.

Periodic Inspection

Structures should be inspected at prescribed risk-based intervals.

Competence

The inspection should be undertaken by a person whose competence matches the complexity and risk.

Concealed Connections

Inspection should address fixings, anchorages, embedded steel and supporting construction where these are critical to performance.

Deterioration

Assessment should include corrosion, material loss, cracking, water penetration, spalling and previous repairs.

Resident Reports

Reports of movement, looseness, deterioration or fear should trigger statutory triage.

Escalation

Uncertainty should lead to further investigation rather than a presumption of safety.

Remediation

Emergency and significant risks should be controlled within prescribed timescales.

Verification

Repairs should not be closed without evidence that the protective function has been restored.

Records

Inspection, testing, repairs, photographs and decisions should form part of a retrievable safety record.

Portfolio Review

A serious failure should trigger examination of comparable structures.

These duties are not presently supplied merely by referring to BS 6180.

5. Proposed Lead Regulatory Structure

No single existing regulator presently covers every relevant building and tenure.

The Joshua Test should therefore establish a coordinated architecture rather than relying upon one body to undertake every function.

5.1 National Technical Lead

The Building Safety Regulator should act as the national technical and standards lead for England.

This role would be appropriate because the regulator already has responsibility for keeping the safety and standards of buildings under review and advising government about updates to Approved Documents. (GOV.UK)

Its Joshua Test functions should include:

- advising ministers;
- maintaining national technical guidance;
- coordinating review of Approved Document K;
- engaging with BSI;
- approving or recognising inspection methodologies;
- issuing safety alerts;
- analysing national occurrence data;
- coordinating systemic investigations;
- overseeing higher-risk buildings;
- establishing competence expectations; and
- publishing national learning.

This should not mean that the Building Safety Regulator personally inspects every residential railing.

5.2 Local Enforcement Lead

Local authorities should remain the primary local enforcement body for many premises outside the higher-risk-building regime.

Their functions should include:

- responding to complaints;
- inspecting premises;
- assessing housing hazards;
- serving improvement or prohibition notices;
- arranging emergency work where authorised;
- coordinating environmental health and building control;
- recovering costs;
- referring systemic matters nationally; and
- supporting residents whose landlord has failed to act.

5.3 Social Housing Systemic Regulation

The Regulator of Social Housing should oversee organisational and systemic compliance by registered providers.

Its focus should include:

- completeness of asset registers;
- statutory inspection programmes;
- governance;
- board assurance;
- funding;
- overdue remediation;
- resident reporting;
- data integrity;
- recurring failures;
- organisational culture; and
- compliance with consumer standards.

5.4 Resident Redress

The Housing Ombudsman should examine maladministration and resident-level service failure, including:

- reports not recorded;
- failure to act;
- missed deadlines;
- poor communication;
- complaint obstruction;
- inadequate record keeping;
- failure to consider vulnerability;
- repeated ineffective repairs; and
- inadequate redress.

The Ombudsman should not be expected to determine urgent structural safety in place of a competent inspector or enforcement authority.

6. A Single-Front-Door Principle

The resident should not need to identify the correct regulator before reporting a potentially fatal defect.

Every prescribed organisation receiving a report should be required to:

1. record the concern;
2. determine whether immediate danger may exist;
3. send it promptly to the responsible person;
4. notify the correct enforcement body;
5. retain the evidence supplied;
6. provide the resident with a reference;
7. explain which body has taken ownership; and
8. continue escalation if no adequate response is made.

A resident should not be passed repeatedly between:

- landlord repairs;

- managing agent;
- freeholder;
- local authority;
- building control;
- environmental health;
- Housing Ombudsman;
- Regulator of Social Housing; and
- Building Safety Regulator.

A coordination failure should itself be recorded as a regulatory failure.

7. Relationship With Awaab's Law

From 30 November 2026, Phase 2 of Awaab's Law will extend significant-hazard requirements in English social housing to hazards including falls between levels and structural collapse and falling elements.

The Joshua Test should not duplicate or weaken those rights.

Where a social tenant reports a potentially unsafe balcony or railing:

- Awaab's Law should govern the prescribed resident-facing investigation and repair deadlines;
- The Joshua Test should govern the technical asset, competence, inspection and record requirements;
- one coordinated investigation should satisfy both regimes;
- the stricter applicable deadline should be followed;
- the findings should update the Joshua asset record; and
- systemic concerns should trigger portfolio review.

Awaab's Law is largely triggered by awareness of a potential hazard.

The Joshua Test should add a proactive duty to identify and inspect relevant structures even where no resident has yet reported a defect.

8. Inspection Powers

Authorised regulators should have power to enter and inspect relevant premises subject to appropriate legal safeguards.

Powers should include the ability to:

- examine the structure;
- measure movement;
- inspect fixings;
- photograph deterioration;
- examine supporting concrete or masonry;
- require safe access;
- inspect temporary barriers;
- obtain maintenance records;
- review historic reports;

- request drawings;
- identify contractors;
- inspect previous repairs;
- require testing;
- take samples where justified;
- preserve failed components; and
- interview relevant personnel.

Entry into an individual home should remain subject to:

- consent;
- reasonable notice;
- statutory warrant procedures;
- emergency powers;
- privacy;
- safeguarding; and
- reasonable adjustments.

An owner or managing organisation should not be able to block inspection of communal structures through contractual or ownership disputes.

9. Information-Requirement Powers

Regulators should be able to require the responsible person to provide:

- the asset register;
- inspection dates;
- risk classifications;
- technical reports;
- photographs;
- testing data;
- structural drawings;
- repair orders;
- contractor details;
- invoices;
- completion records;
- temporary-control logs;
- complaints;
- resident reports;
- safety alerts;
- board papers;
- funding decisions;
- previous incidents;
- near misses;
- insurance notifications; and
- relevant digital audit trails.

Failure to provide complete information should permit:

- further investigation;

- an adverse regulatory inference;
- a formal notice;
- civil penalty; or
- prosecution where deliberate obstruction or falsification is involved.

10. Inspection Thresholds

The law should distinguish several regulatory thresholds.

Level 1: Routine Compliance

The structure is within its inspection period and no material concern is known.

Regulatory action should focus on audit and assurance.

Level 2: Potential Concern

Information suggests possible deterioration or inadequate records.

The responsible person should arrange competent triage or inspection within a prescribed period.

Level 3: Significant Hazard

There is a significant risk of death or serious injury requiring urgent investigation, safety work and preventative work.

The Awaab's Law timeframe should apply where the premises and resident fall within that regime. (GOV.UK)

Level 4: Emergency Hazard

There is an imminent and significant risk requiring immediate restriction, stabilisation, guarding, evacuation or other emergency protection.

The 24-hour Awaab's Law emergency framework should be treated as the maximum limit in covered social housing, not permission to delay where action can and should occur sooner. (GOV.UK)

Level 5: Systemic or Portfolio Risk

The defect may affect comparable structures across a building, estate or portfolio.

The regulator should be able to require wider inspection and reporting.

11. Improvement Notices

An improvement notice should be available where the responsible person has failed, or is likely to fail, to comply with the Joshua Duty.

A notice may require:

- completion of the asset register;
- inspection by a named competence category;
- opening-up;
- testing;

- correction of records;
- temporary controls;
- repair;
- replacement;
- independent verification;
- resident communication;
- contractor review;
- portfolio sampling;
- full portfolio inspection;
- board oversight;
- funding allocation; or
- periodic compliance reporting.

The notice should identify:

- the breach;
- evidence;
- required outcome;
- deadline;
- interim measures;
- reporting requirements;
- appeal route; and
- consequences of non-compliance.

12. Prohibition and Restriction Notices

Where continued use creates serious danger, the regulator or local authority should be able to prohibit or restrict:

- balcony use;
- access to a landing;
- use of an external walkway;
- occupation of an affected room;
- access to a roof terrace;
- use of a staircase;
- removal of temporary guarding;
- work that would conceal deterioration; or
- access beneath an unstable structure.

A prohibition notice should also require consideration of:

- alternative access;
- emergency escape;
- disability;
- security;
- resident communication;
- alternative accommodation;
- fire safety; and
- permanent remediation.

An appeal should not automatically suspend an emergency restriction.

13. Emergency Action

Where the responsible person does not act, an authorised body should be able to arrange emergency measures.

These may include:

- installing barriers;
- securing access;
- stabilising the structure;
- removing loose elements;
- appointing an engineer;
- conducting immediate testing;
- preserving evidence;
- providing alternative accommodation; and
- notifying affected residents.

The authority should be able to recover reasonable costs from the responsible person.

A financial dispute should not prevent intervention.

14. Civil Penalties

Civil penalties should be available for breaches such as:

- failure to inspect;
- failure to keep an asset register;
- failure to meet statutory timescales;
- failure to control immediate danger;
- failure to provide records;
- failure to maintain temporary measures;
- failure to complete remediation;
- failure to verify work;
- inaccurate compliance reporting;
- failure to cooperate;
- repeated non-compliance; and
- obstruction of an authorised inspector.

The amount should reflect:

- seriousness;
- duration;
- risk of death or injury;
- number of people affected;
- culpability;
- financial benefit;
- previous breaches;
- cooperation;
- attempts to conceal the issue; and

- effectiveness of subsequent remediation.

Penalties should not be passed to tenants or leaseholders through service charges.

15. Criminal Thresholds

Criminal sanctions should be reserved for serious conduct.

Possible offences should include knowingly or recklessly:

- falsifying inspection reports;
- destroying evidence;
- concealing a critical defect;
- claiming an inspection occurred when it did not;
- removing a prohibition barrier;
- failing to comply with an emergency notice;
- obstructing an inspector;
- submitting materially false information;
- using unqualified persons for prescribed critical work;
- covering severe deterioration without assessment; or
- interfering with witnesses.

The law should distinguish deliberate or reckless conduct from:

- honest professional disagreement;
- reasonable error;
- unavoidable delay; and
- lower-level administrative failure.

16. Escalation for Repeated Failure

A single administrative error may justify corrective action.

A repeated pattern may justify systemic intervention.

Escalation indicators should include:

- multiple missed inspection dates;
- recurring resident complaints;
- repeated reports of movement;
- prolonged temporary barriers;
- incomplete records;
- repeated patch repairs;
- contractor self-certification without verification;
- inconsistent risk classifications;
- unexplained closure of work orders;
- failure to examine similar structures;
- board ignorance of serious risk;
- underfunding;
- adverse Ombudsman findings; and
- previous regulatory notices.

Possible escalation should include:

1. informal correction; 2. formal improvement notice; 3. enhanced reporting; 4. independent audit; 5. civil penalty; 6. portfolio-wide direction; 7. special measures; 8. external management or oversight; 9. prohibition; 10. criminal referral where appropriate.

17. Portfolio-Wide Directions

Where a serious defect is identified, the regulator should be able to require examination of all reasonably comparable structures.

A portfolio direction may identify:

- design type;
- building age;
- material;
- contractor;
- repair method;
- fixing type;
- exposure;
- estate;
- geographic area; or
- period of installation.

The responsible person should then provide:

- population size;
- sampling methodology;
- immediate priorities;
- inspection timetable;
- findings;
- interim controls;
- remediation programme; and
- resident communications.

One structural failure should not be treated as an isolated anomaly without examining whether the same conditions exist elsewhere.

18. National Safety Alerts

The Building Safety Regulator should operate a national alert process for concerns involving:

- particular railing systems;
- defective fixings;
- material incompatibility;
- corrosion mechanisms;
- failed repair methods;
- unsafe temporary barriers;
- product defects;
- repeated contractor failures;
- concealed deterioration;
- specific building types; or
- inadequacies discovered in existing guidance.

An alert should identify:

- structures potentially affected;
- action required;
- inspection competence;
- urgency;
- records to review;
- testing;
- reporting requirements; and
- regulatory contact.

Responsible persons should be required to document whether the alert applies to their stock.

19. Review of BS 6180

No More Falls should support formal engagement with BSI concerning the present review of BS 6180:2011.

The campaign should seek consideration of whether the revised standard requires stronger provisions concerning existing buildings.

Potential representations should include:

Inspection in Service

Clear guidance on periodic inspection after occupation.

Risk-Based Frequency

Factors determining inspection intervals.

Concealed Fixings

Assessment of embedded posts, anchors and supporting substrates.

Corrosion

Guidance on corrosion, section loss and water entrapment.

Existing Structures

Methods for assessing barriers without complete design records.

Residual Capacity

Assessment where the original design may be compliant but deterioration is present.

Testing

When controlled testing, opening-up or non-destructive testing should be considered.

Repairs

Requirements for repair design, workmanship and verification.

Decorative Work

Obligations to record and escalate deterioration found during painting.

Temporary Protection

Standards for temporary guarding in occupied housing.

Records

Minimum inspection, testing and repair documentation.

Resident Reports

Recognition that reports of movement or looseness are relevant safety evidence.

Competence

Clear competence expectations for differing inspection levels.

Systemic Review

Action following failure of one component within a repeated system.

These matters could be incorporated into BS 6180 or addressed through an associated code of practice specifically for inspection and maintenance.

20. Review of Approved Document K

Representations should also be made to the Ministry of Housing, Communities and Local Government and the Building Safety Regulator regarding Approved Document K.

The current document remains the 2013 edition and refers to BS 6180:2011. The Building Safety Regulator now has a statutory role in keeping building safety and Approved Documents under review. (GOV.UK)

The review should consider whether Approved Document K should:

- explain more clearly the relationship between design compliance and continuing safety;
- recognise degradation over the building lifecycle;
- cross-refer expressly to inspection and maintenance duties;
- require accessible records for safety-critical barriers;
- address alterations and repairs to existing guarding;
- distinguish cosmetic treatment from structural remediation;
- cover concealed connections;
- strengthen handover requirements;
- clarify responsibilities where repair work constitutes building work;
- reference the latest edition of BS 6180;
- cross-refer to Awaab's Law;
- cross-refer to higher-risk-building safety management; and
- identify the need for competent assessment following movement, corrosion or partial failure.

Approved Document K alone cannot impose every occupied-building duty proposed by The Joshua Test.

Some reforms will require primary or secondary legislation.

21. Why Amendment of Guidance Alone Is Insufficient

Updating BS 6180 or Approved Document K would be valuable.

It would not fully achieve the campaign's aims.

Guidance alone would not necessarily create:

- a mandatory inspection cycle;
- an asset register;
- enforceable resident deadlines;
- an obligation to disclose reports;
- a duty to inspect historic stock;
- portfolio-wide review;
- a national incident database;
- alternative accommodation;
- penalties for failing to inspect;
- resident court remedies;
- protection across all tenures; or
- a clear lead dutyholder.

The Joshua Test therefore requires a combination of:

1. primary legislation establishing the Joshua Duty; 2. secondary regulations setting inspection and response requirements; 3. Approved Document amendments clarifying construction and alteration standards; 4. BSI revision strengthening technical practice; 5. statutory guidance supporting implementation; 6. regulatory standards applying organisational oversight; and 7. resident remedies making the duty enforceable.

22. Proposed Legal Status of Technical Standards

The legislation should not hard-code only “BS 6180:2011,” because the standard is currently under review and may be replaced.

Instead, regulations should refer to:

BS 6180, or any superseding standard designated by the Secretary of State, together with such other prescribed structural, material and testing standards as are relevant to the structure.

The legislation should also provide that:

- compliance with a designated standard is evidence of good practice;
- it does not prove safety where deterioration or unusual conditions are present;
- alternative methods may be accepted where they provide equivalent or greater safety;
- departures must be justified and recorded;
- the current condition of the structure must always be considered; and
- statutory duties cannot be avoided solely because the structure complied when

constructed.

23. Proposed Compliance Test

A responsible person should have to demonstrate all of the following:

1. the structure was identified; 2. its intended protective function was understood; 3. the applicable design information was reviewed where available; 4. the current condition was competently assessed; 5. fixings and support were considered; 6. relevant standards were applied; 7. deterioration and environmental exposure were considered; 8. foreseeable use was assessed; 9. uncertainty was identified; 10. additional investigation was arranged where necessary; 11. required work was completed; 12. completion was verified; and 13. the next inspection date was set.

A certificate stating only “complies with BS 6180” should not be sufficient unless it explains:

- what was inspected;
- which edition was applied;
- what evidence was reviewed;
- whether concealed elements were assessed;
- what limitations remained; and
- why continuing safety was established.

24. Regulatory Decision-Making Principles

Regulators should apply the following principles:

Risk Before Process

Immediate physical protection takes priority over administrative allocation.

Consequence Before Building Category

A potentially fatal fall risk should not receive lower priority because the building is below a particular height.

Evidence Before Assurance

A work order, invoice or certificate is not proof of safety without supporting evidence.

Uncertainty Requires Action

Missing records or concealed deterioration should not be treated as evidence of satisfactory condition.

Independence Where Necessary

High-risk or disputed work should receive independent verification.

Wider Learning

A failure in one repeated system should trigger consideration of similar structures.

Resident Evidence Matters

Reports of movement, looseness or prior repair should form part of the technical assessment.

Temporary Means Temporary

Interim barriers should have review dates and permanent remediation plans.

25. Proposed Statutory Regulatory Duty

The legislation could provide in substance:

The designated regulator must oversee and promote compliance with the Joshua Duty, coordinate with other relevant authorities, maintain national technical guidance and take proportionate enforcement action where a relevant fall-protection structure presents or may present a material risk.

26. Proposed Inspection Power

Draft wording could provide:

An authorised officer may, upon reasonable notice or without notice in an emergency, enter relevant premises, inspect a relevant fall-protection structure, require reasonable assistance, examine records, undertake or commission testing and take such other proportionate steps as are necessary to determine compliance with the Joshua Duty.

Entry into a dwelling should remain subject to judicial safeguards except where lawful emergency powers apply.

27. Proposed Improvement-Notice Power

Draft wording could provide:

Where an authorised authority reasonably believes that a responsible person has failed, is failing or is likely to fail to comply with the Joshua Duty, it may serve a notice specifying the required safety outcome, action, evidence and period for compliance.

28. Proposed Emergency-Prohibition Power

Draft wording could provide:

Where an authorised authority reasonably believes that use of an area or structure presents an imminent and significant risk of death or serious injury, it may prohibit or restrict that use and require immediate protective measures.

29. Proposed Standards-Review Duty

The Secretary of State and Building Safety Regulator should be required periodically to review:

- Approved Document K;
- designated British Standards;
- inspection methodologies;
- incident evidence;

- corrosion and deterioration research;
- enforcement outcomes;
- professional competence;
- Awaab's Law experience; and
- recommendations arising from serious incidents or coronial proceedings.

A report should be published at prescribed intervals.

30. Recommended No More Falls Representations

No More Falls should make two connected representations.

Representation to BSI

Request formal participation or evidence submission in the review of BS 6180:2011, specifically concerning:

- occupied-building inspection;
- deterioration;
- concealed anchorage;
- corrosion;
- maintenance;
- resident reports;
- repair verification; and
- systemic review following failure.

Representation to Government and the Building Safety Regulator

Request:

- formal review of Approved Document K;
- explicit recognition that Part K does not provide a complete lifecycle inspection regime;
- statutory inspection and record duties;
- integration with Awaab's Law;
- tenure-neutral protection;
- national incident learning;
- enforceable remediation requirements; and
- consideration of The Joshua Test in primary legislation.

These representations should be made in parallel.

Changing the British Standard alone would improve technical practice but would not make the full Joshua Duty law.

Conclusion

BS 6180 and Approved Document K provide an important foundation for The Joshua Test.

BS 6180 sets out recognised technical principles for barriers in and around buildings.

Approved Document K refers to it for further guidance and identifies minimum guarding,

height and loading expectations. Requirement K2 of the Building Regulations provides the underlying legal requirement to protect people from falling.

However, the present framework does not by itself require every residential dutyholder to:

- identify all relevant barriers;
- inspect them periodically;
- investigate deterioration;
- examine concealed connections;
- respond to residents within consistent deadlines;
- retain lifecycle records;
- verify repairs;
- review comparable structures; and
- demonstrate continuing safety throughout occupation.

The Joshua Test should therefore not seek to replace BS 6180.

It should place that technical standard within a broader statutory system.

Its regulatory architecture should:

- make the Building Safety Regulator the national technical lead;
- retain local authority inspection and intervention;
- involve the Regulator of Social Housing in systemic provider failures;
- preserve Housing Ombudsman redress;
- coordinate with Awaab's Law;
- create inspection and information powers;
- establish improvement and prohibition notices;
- authorise emergency action;
- permit civil and criminal enforcement;
- require national safety alerts;
- support revision of BS 6180 and Approved Document K; and
- ensure that compliance is judged by present safety, not historic paperwork alone.

BS 6180 should help define what a safe barrier looks like. The Joshua Test should make someone legally responsible for proving that it remains safe. The central principle should be:

Chapter 13

National Learning, Serious Incident Investigation and Continuous Improvement

Introduction

The purpose of The Joshua Test is not solely to improve inspection or strengthen enforcement.

Its principal objective is to prevent avoidable deaths and serious injuries by ensuring that knowledge gained from one incident is systematically translated into improvements across the residential built environment.

Every structural failure represents an opportunity to identify weaknesses in:

- design;
- inspection;
- maintenance;
- organisational governance;
- procurement;
- contractor competence;
- regulatory oversight; or
- legislation.

Where these lessons are not identified, shared and acted upon, similar failures may recur elsewhere.

A mature safety system should not rely on tragedy to reveal systemic weaknesses repeatedly.

Instead, it should be capable of identifying patterns, disseminating learning and requiring preventative action before further harm occurs.

The central principle should be:

Every serious structural failure should improve the safety of every comparable structure, not just the building in which it occurred.

1. A National Learning Culture

The United Kingdom has developed mature learning systems in sectors such as aviation, rail and healthcare.

These systems recognise that:

- incidents are rarely isolated;
- organisational failures often develop over time;
- learning should extend beyond the immediate parties involved;
- and recommendations should lead to measurable improvements.

The Joshua Test should embed the same philosophy within residential building safety.

The emphasis should be on continuous improvement rather than reactive compliance.

2. Mandatory Reporting of Serious Incidents

Certain events should trigger mandatory notification to the designated regulator.

These should include:

- complete barrier failure;
- partial structural collapse;
- detachment of guarding;
- failure of supporting construction;
- emergency removal of a barrier due to structural instability;
- serious injury resulting from barrier failure;
- fatal incidents;
- near misses where death or serious injury was narrowly avoided;
- discovery of systemic defects affecting multiple structures; and
- other prescribed high-risk occurrences.

Reporting should occur within prescribed statutory timescales.

3. National Incident Database

The Building Safety Regulator should maintain a secure national database recording:

- location (appropriately anonymised where necessary);
- building type;
- age of construction;
- ownership model;
- tenure;
- structural system;
- materials;
- defect mechanism;
- inspection history;
- maintenance history;
- repair history;
- contractor involvement;
- engineering findings;
- regulatory action;
- lessons identified; and
- preventative measures implemented.

The purpose of the database would not be to allocate blame.

Its purpose would be to identify emerging national trends.

4. Near Miss Reporting

One of the greatest opportunities for prevention lies in learning from incidents that did not result in injury.

Examples include:

- a loose railing identified before collapse;
- significant corrosion discovered during inspection;

- structural movement requiring emergency closure;
- temporary barriers installed following unexpected deterioration;
- or defects discovered during refurbishment.

Near misses should be regarded as valuable safety intelligence rather than fortunate accidents.

5. Prevention of Future Deaths Reports

Reports issued by coroners under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 should play a central role in the Joshua Test.

Where a Prevention of Future Deaths (PFD) Report concerns:

- fall protection;
- structural deterioration;
- inspection failures;
- maintenance deficiencies;
- regulatory weaknesses; or
- organisational learning,

the designated regulator should be required to:

- review the report;
- assess whether national action is required;
- consider changes to guidance;
- evaluate inspection methodologies;
- identify comparable risks;
- and publish a response outlining any action taken.

PFD Reports should become catalysts for national improvement rather than isolated case documents.

6. Serious Incident Reviews

Every fatality or serious structural failure should trigger a structured review.

The review should examine:

- engineering causes;
- organisational decision-making;
- inspection history;
- maintenance strategy;
- governance;
- contractor performance;
- resident reporting;
- communication;
- regulatory oversight;
- and whether warning signs were missed.

The review should distinguish clearly between:

- immediate causes;

- contributing factors;
- organisational factors;
- systemic issues; and
- opportunities for prevention.

7. Root Cause Analysis

Investigations should extend beyond identifying the immediate technical failure.

They should examine:

- why deterioration occurred;
- why it was not identified;
- why previous opportunities were missed;
- whether records were adequate;
- whether responsibilities were understood;
- whether funding decisions contributed;
- whether governance arrangements were effective;
- and whether organisational culture discouraged reporting or escalation.

As discussed earlier in this White Paper, methodologies such as James C. Patterson's Beyond the Five Whys provide a valuable framework for examining complex systems rather than stopping at superficial explanations.

8. Portfolio Learning

Where one barrier fails, the responsible person should ask:

"Where else do we have the same design, construction method, contractor or maintenance history?"

The law should require organisations to investigate comparable assets across their portfolio.

Learning should extend beyond the individual building.

9. National Safety Alerts

Where a systemic issue is identified, the Building Safety Regulator should be able to issue National Safety Alerts.

These alerts should specify:

- affected structure types;
- inspection priorities;
- recommended interim measures;
- reporting requirements;
- and expectations for remedial action.

Responsible persons should confirm whether the alert applies to their stock and record the outcome.

10. Research and Continuous Improvement

Government should establish a programme of ongoing research into:

- structural deterioration;
- corrosion mechanisms;
- inspection technologies;
- digital asset management;
- material performance;
- human factors;
- organisational learning;
- resident engagement;
- and emerging construction methods.

Research findings should inform future revisions of:

- Approved Document K;
- BS 6180;
- statutory guidance;
- inspection standards;
- and The Joshua Test regulations.

11. Annual National Report

The Building Safety Regulator should publish an annual report containing:

- incident statistics;
- emerging themes;
- enforcement trends;
- lessons learned;
- examples of good practice;
- regulatory recommendations;
- proposed legislative changes;
- and progress against previous recommendations.

The report should be laid before Parliament.

12. Public Transparency

Residents should have confidence that lessons are being learned.

Accordingly, the regulator should publish anonymised summaries of:

- serious incidents;
- national safety alerts;
- completed investigations;
- thematic reviews;
- and recommendations.

Transparency supports trust, accountability and informed decision-making.

13. International Learning

The regulator should monitor significant international developments concerning:

- balcony failures;
- balustrade standards;

- corrosion research;
- regulatory reform;
- inspection technologies;
- and building safety investigations.

Where relevant, overseas lessons should inform UK guidance and legislation.

14. Knowledge Sharing Across Regulators

Effective learning requires cooperation between:

- the Building Safety Regulator;
- the Regulator of Social Housing;
- local authorities;
- the Housing Ombudsman;
- the Health and Safety Executive;
- coroners;
- professional institutions;
- standards organisations;
- and government departments.

Information-sharing protocols should support timely dissemination of significant findings while respecting legal and privacy obligations.

15. Education and Professional Development

Lessons identified through investigations should be incorporated into:

- professional training;
- continuing professional development;
- engineering education;
- surveying qualifications;
- housing management programmes;
- contractor accreditation;
- and regulator training.

The objective should be to embed learning throughout the profession rather than limiting it to published reports.

16. Resident Involvement

Residents often identify emerging safety concerns before professionals.

The Joshua Test should ensure that:

- resident reports inform investigations;
- lived experience is considered alongside technical evidence;
- feedback is provided on outcomes;
- and residents are informed of lessons learned where appropriate.

A strong reporting culture depends upon residents believing that their concerns matter.

17. Proposed Statutory Duty

The legislation could provide:

The designated regulator shall establish and maintain arrangements for the collection, analysis, dissemination and implementation of lessons arising from serious incidents, near misses, Prevention of Future Deaths Reports and other prescribed events relating to relevant fall-protection structures.

18. Conclusion

The Joshua Test should establish a learning system in which every serious incident strengthens the safety of the wider housing stock.

The aim is not merely to respond effectively when failures occur, but to reduce the likelihood of recurrence through structured investigation, national learning and continuous improvement.

A safety regime that records incidents without learning from them is incomplete.

The Joshua Test should ensure that knowledge gained from tragedy is translated into practical improvements, technical guidance, regulatory reform and safer homes for future generations.

Chapter 14

Economic Impact Assessment and Cost–Benefit Analysis

Introduction

The economic case for The Joshua Test should be assessed through proportionality, additionality and evidence. This chapter does not assign a monetary value to Joshua’s life, or to any other life. Its purpose is to identify the cost categories Government would need to test and the benefits that should be considered alongside them.

A credible impact assessment must distinguish costs that landlords already incur through ordinary asset management from additional costs created by a new statutory assurance duty. It must also avoid presenting early planning assumptions as if they were market quotations.

1. The Appropriate Economic Question

The relevant question is not whether inspection, investigation or remediation costs money. They do. The question is whether a proportionate lifecycle-assurance framework produces sufficient safety, governance and information benefits to justify its additional cost when compared with credible alternatives, including maintaining the current position.

Government should therefore compare at least: the current framework; enhanced non-statutory guidance; a targeted statutory lifecycle-assurance duty; and a more prescriptive inspection or testing regime.

2. Cost Categories

For appraisal purposes, costs should be separated into four categories:

- assurance programme costs — asset identification, risk screening, inspection, targeted investigation, record keeping and quality assurance;
- access and delivery costs — scaffolding, mobile access equipment, temporary edge protection, mobilisation and resident communication where required;
- remediation costs — repair, strengthening, replacement and temporary works arising from identified defects; and
- public-sector implementation costs — regulations, guidance, oversight, enforcement, evaluation and any national learning arrangements.

This separation matters because a relatively modest inspection programme can identify remedial liabilities that are materially larger. Remediation should not be hidden inside a headline inspection figure, nor should it be treated as a cost caused solely by the inspection if the underlying defect already existed.

3. Independent Sector Review: Financial Planning

Wayne Hughes of HQN reviewed an earlier costed proposal from an asset-management, regulatory and practical perspective. He considered the indicative baseline and recurring programme assumptions to be in the right order of magnitude for planning purposes, but

cautioned that some elements appeared low when compared with the likely cost of competent specialist structural work and access.

His financial observations materially changed the way this White Paper presents cost. In particular, he advised that costs should be calculated by block, barrier system and risk rather than simply by dwelling; that specialist inspection, non-destructive testing, opening-up, access equipment and temporary protection can increase unit costs substantially; and that remediation should be clearly separated because it may exceed the inspection programme by a significant margin.

He also considered phasing a baseline programme over approximately two years to be a sensible planning approach, subject to immediate action where a serious risk is already known. His review recommended contingency and clearer caveats rather than false precision.

This contribution is an asset-management and financial-planning perspective. It is not a quotation, a structural-engineering opinion or an endorsement of the final legislative proposal.

Figure 14.1 – Cost Planning for Lifecycle Assurance

FIGURE 14.1

COST PLANNING FOR LIFECYCLE ASSURANCE

Separate assurance, access and remediation costs before judging affordability.



4. Illustrative Provider-Level Planning Assumptions

An earlier provider-level model considered a baseline programme range of approximately £325,000–£650,000, with a working planning figure of £450,000, and an ongoing annual programme of approximately £80,000–£150,000, with a working figure of £110,000. These figures were developed for a specific portfolio context and are retained here only as an illustration of the order and structure of planning assumptions.

Wayne Hughes considered those figures broadly within the right order of magnitude for planning but potentially low in places once specialist structural input, difficult access and temporary protection are reflected. They should not be extrapolated nationally, treated as market rates or presented as formal quotations.

5. Principal Cost Drivers

The cost of implementation is likely to be driven more by the characteristics of buildings and barrier systems than by dwelling numbers alone. Important variables include:

- number and type of relevant barrier systems;
- building height, access constraints and need for temporary protection;
- age, materials, exposure and construction details;
- quality and completeness of existing records;
- frequency with which baseline inspection triggers specialist escalation;
- regional professional capacity and procurement conditions; and
- the extent of remediation identified.

6. Additionality

The impact assessment should identify which activities are genuinely additional. Where a provider already maintains an adequate barrier asset register, commissions competent structural assessments and preserves suitable records, the incremental burden may be limited. Where those systems are absent or incomplete, transitional costs may be higher.

Evidence gathered under another suitable regime should be capable of satisfying the proposed duty where it is sufficiently recent, relevant, competent and documented. The objective is assurance, not duplicate commissioning.

7. Remediation and Contingency

Inspection and remediation are financially distinct. A baseline assurance programme may expose existing defects requiring urgent or planned capital work. Those liabilities should be identified transparently and budgeted separately.

Government and providers should model sensitivity scenarios in which escalation and remediation rates are higher than expected. This is preferable to using an artificially low inspection figure that does not reflect the consequences of what inspection may reveal.

8. Phasing and Market Testing

Phased implementation can reduce demand shocks and improve procurement. A pilot and early market testing should establish realistic rates for different inspection levels, access methods and building archetypes before national cost assumptions are finalised.

Phasing must not delay immediate protective action where a credible serious risk is already identified.

9. Benefits and Avoided Costs

Potential benefits include earlier identification of deterioration, more targeted maintenance, improved asset data, stronger board assurance, reduced emergency intervention, improved resident confidence and better evidence for regulators and investigators.

Some benefits are not readily monetised. Prevention of death and serious injury, avoidance of bereavement and trauma, and confidence that safety-critical structures are being managed responsibly remain central public-interest considerations.

10. Distributional Effects

The financial impact may differ between large providers, small landlords, leasehold arrangements and other ownership structures. Government should assess provider size, access to professional expertise, lawful cost-recovery mechanisms and the risk of disproportionate transfer of costs to residents.

This White Paper does not propose a new resident charging mechanism. Any question of recoverability through rents or service charges requires separate legal and economic analysis.

11. Formal Government Impact Assessment

Before legislation is introduced, Government should undertake a full regulatory impact assessment using current market evidence and sensitivity analysis. It should test implementation pace, inspection escalation rates, access costs, remediation assumptions, workforce capacity and the distribution of costs across sectors.

The analysis should be updated after pilot implementation so that final regulations are based on observed delivery evidence rather than theoretical unit rates.

Conclusion

The economic case for The Joshua Test should not rest on a claim that prevention is always cheaper in every individual case. It rests on a more defensible proposition: proportionate assurance can identify risk earlier, improve the quality of asset-management decisions and reduce the likelihood that serious deterioration remains unmanaged until failure.

The cost framework should therefore be transparent, market-tested and explicit about uncertainty. Inspection, access and remediation should be costed separately; existing activity should be distinguished from additional burden; and the final policy should be scaled according to evidence and risk.

Chapter 15

Implementation Roadmap and Transitional Arrangements

Introduction

The introduction of The Joshua Test should be undertaken through a phased and proportionate implementation programme that enables government, regulators, landlords, managing agents, housing providers and residents to prepare for the new statutory duties.

The objective is to improve public safety without creating unnecessary disruption to housing providers or compromising the continued delivery of housing services.

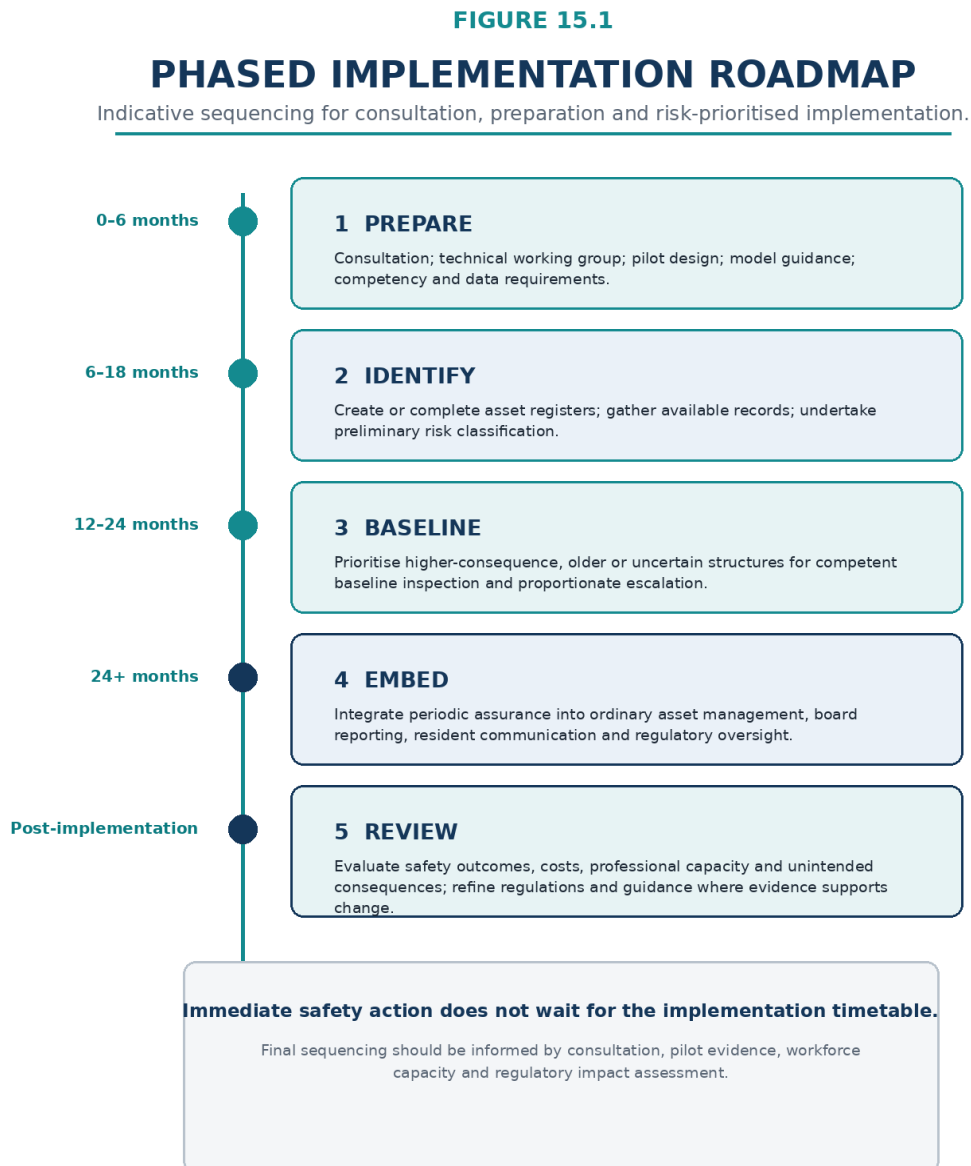
Implementation should therefore recognise that organisations begin from different levels of maturity in relation to asset management, inspection programmes and digital record keeping.

The legislation should establish clear legal duties from commencement while allowing sufficient transitional arrangements to ensure effective compliance.

The central implementation principle should be:

Every responsible person should have a clear pathway to compliance, but no resident should wait unnecessarily for protection from an identified life-critical risk.

Figure 15.1 – Phased Implementation Roadmap



1. Guiding Principles

Implementation should be:

- proportionate;
- evidence-based;
- risk-led;
- nationally consistent;

- transparent;
- achievable;
- enforceable; and
- centred upon resident safety.

The programme should prioritise the reduction of foreseeable risk over administrative completion.

2. Legislative Commencement

The Joshua Test should receive Royal Assent before being brought into force through staged commencement regulations.

This approach would allow:

- publication of statutory guidance;
- development of competency frameworks;
- regulator preparation;
- training programmes;
- digital system development;
- and stakeholder engagement.

Not every provision need commence on the same day.

3. Phase One – National Preparation (0–6 Months)

Following Royal Assent, Government should establish a National Implementation Programme led by the Building Safety Regulator in partnership with:

- the Ministry of Housing, Communities and Local Government;
- the Regulator of Social Housing;
- the Housing Ombudsman;
- the Health and Safety Executive;
- local authorities;
- the British Standards Institution;
- professional engineering bodies;
- housing representative organisations; and
- resident representatives.

The objectives of Phase One would be to:

- publish statutory guidance;
- issue draft regulations;
- prepare competency standards;
- develop inspection templates;
- establish national reporting mechanisms;
- publish model asset registers;
- create digital reporting standards; and
- begin public awareness activity.

4. Phase Two – Identification of Relevant Structures (6–18 Months)

During the second phase, every responsible person should identify all relevant fall-protection structures within their control.

This should include:

- balconies;
- balustrades;
- parapets;
- communal walkways;
- roof terraces;
- external access galleries;
- retaining barriers;
- accessible roofs;
- communal stair guarding; and
- other prescribed structures.

Each asset should receive a unique identifier and be entered into a digital asset register.

Where construction information is unavailable, reasonable efforts should be made to reconstruct the available history through existing maintenance records, drawings or surveys.

5. Phase Three – Baseline Inspection (12–24 Months)

Following identification, every relevant structure should undergo an initial baseline inspection.

The purpose is to establish:

- current condition;
- risk category;
- inspection frequency;
- maintenance requirements;
- and whether immediate intervention is required.

This baseline assessment should become the reference point for future inspections.

Where inspection identifies an emergency hazard, transitional arrangements should not delay immediate action.

6. Risk Prioritisation

Implementation should prioritise structures presenting the greatest foreseeable risk.

Factors should include:

- building age;
- exposure to severe weather;
- previous repairs;
- evidence of deterioration;
- vulnerable residents;
- incomplete maintenance records;
- known corrosion;

- structural complexity;
- previous complaints; and
- high occupancy.

This approach enables resources to be directed towards the highest-risk assets first.

7. Existing Inspection Programmes

Where landlords already operate inspection regimes that substantially achieve the objectives of The Joshua Test, duplication should be avoided.

Responsible persons should be permitted to demonstrate equivalence where existing arrangements:

- meet statutory outcomes;
- are evidence-based;
- maintain suitable records;
- and are subject to appropriate oversight.

The legislation should encourage continuous improvement rather than unnecessary administrative duplication.

8. Competency Transition

Government should recognise that additional inspection capacity may be required during implementation.

Accordingly, professional institutions should be supported to:

- develop accredited training;
- expand continuing professional development;
- publish competency guidance;
- and increase the availability of suitably qualified inspectors.

Existing professionals should be able to demonstrate competence through recognised qualifications, experience or transitional accreditation arrangements.

9. Digital Transformation

Responsible persons should be encouraged to integrate Joshua Test requirements into existing asset management systems wherever practicable.

Government should publish common data standards covering:

- asset identifiers;
- inspection records;
- photographs;
- maintenance history;
- risk categories;
- inspection outcomes;
- repair verification;
- and review dates.

Standardisation will facilitate consistent reporting and national analysis.

10. Funding and Financial Planning

Implementation should be incorporated into existing long-term asset management and capital investment programmes wherever possible.

Government should consider targeted support for:

- smaller registered providers;
- local authorities facing exceptional legacy challenges;
- specialist supported housing providers; and
- charitable housing organisations.

The White Paper does not propose the creation of a permanent central funding scheme but recognises that transitional assistance may be appropriate where implementation costs are disproportionate.

11. Resident Communication

Residents should receive clear information explaining:

- the purpose of The Joshua Test;
- what structures are covered;
- how inspections will be undertaken;
- expected timescales;
- how to report concerns;
- and how inspection findings may affect access during remedial works.

Clear communication will support confidence and reduce unnecessary anxiety.

12. Enforcement During Transition

The legislation should distinguish between:

Transitional non-compliance

Where organisations are making demonstrable progress towards compliance.
and

Wilful or reckless non-compliance

Where organisations fail to engage with implementation or knowingly ignore significant safety risks.

Regulators should retain powers to intervene immediately where serious risks are identified, regardless of transitional timescales.

13. Review After Implementation

Government should conduct a formal post-implementation review three years after full commencement.

The review should assess:

- inspection compliance rates;
- structural incident trends;

- resident confidence;
- enforcement activity;
- regulator performance;
- implementation costs;
- unintended consequences; and
- opportunities for legislative refinement.

The findings should be reported to Parliament.

14. Interaction with Existing Law

Implementation of The Joshua Test should complement, rather than replace, existing statutory obligations under:

- the Building Safety Act 2022;
- the Building Regulations 2010;
- Approved Document K;
- Awaab's Law;
- the Housing Health and Safety Rating System;
- landlord repairing obligations;
- health and safety legislation; and
- relevant equality legislation.

Compliance with one statutory regime should not remove responsibilities under another. Instead, organisations should seek integrated compliance wherever possible.

15. Measuring Success

The success of The Joshua Test should not be measured solely by the number of inspections completed.

Success indicators should include:

- reductions in serious structural failures;
- earlier identification of deterioration;
- improved resident confidence;
- improved quality of asset records;
- reduced emergency interventions;
- improved regulatory consistency;
- stronger organisational governance; and
- demonstrable learning from incidents.

Ultimately, success will be measured by tragedies that never occur because hazards were identified and addressed before failure.

16. Conclusion

The Joshua Test is intended to be a practical and deliverable reform rather than an aspirational statement of principle.

A phased implementation programme will allow organisations to build capability, establish robust inspection systems and embed a culture of proactive safety management without imposing unnecessary disruption.

At the same time, the legislation must make clear that transitional arrangements cannot justify delay where a life-critical risk has already been identified.

By combining clear statutory duties with realistic implementation timescales, The Joshua Test can be introduced in a manner that strengthens public safety, supports responsible asset management and promotes confidence in the safety of residential buildings across England.

Chapter 16

Resident Voice, Transparency and the Right to Safety Information

Introduction

Residents are the people who rely upon residential fall-protection structures every day.

They walk beside communal railings.

They use balconies, landings, stairways and access decks.

They allow children, relatives, carers and visitors to use those areas.

Yet residents may have little or no access to information about:

- when a structure was last inspected;
- who inspected it;
- what type of inspection was undertaken;
- whether corrosion or movement was identified;
- whether repairs were recommended;
- whether those repairs were completed; or
- whether the structure has ever been assessed by a suitably competent person.

The Joshua Test should correct this imbalance.

Residents should not be expected to prove that a railing, balustrade or barrier is structurally unsafe before the responsible person is required to investigate it.

Nor should residents be required to understand engineering terminology, identify the precise cause of a defect or obtain their own expert evidence before a credible concern is taken seriously.

The proposed framework should therefore establish clear rights to:

- receive meaningful safety information;
- report concerns through accessible channels;
- obtain a timely response;
- understand inspection findings;
- be informed about outstanding work;
- escalate unresolved safety concerns;
- participate in decisions affecting access and safety; and
- receive protection from retaliation or disadvantage.

Transparency should not mean publishing large quantities of technical material without explanation.

It should mean giving residents information that is accurate, relevant, understandable and capable of helping them protect themselves and their families.

1. The Principle of Resident-Centred Safety

The Joshua Test should be built upon the principle that residents are not passive occupants.

They are:

- users of the building;
- observers of its changing condition;
- potential sources of early warning;
- people directly affected by access restrictions and repairs;
- holders of important historical information; and
- people entitled to understand material risks within their homes and communal areas.

Resident engagement should not be treated as a communications exercise undertaken after technical decisions have already been made.

It should form part of the safety-management process.

Residents may identify:

- movement that occurs only during use;
- a defect that is not visible during a brief inspection;
- repeated unsuccessful repairs;
- water penetration following certain weather conditions;
- changes in condition over time;
- impact damage;
- missing or loose components;
- contractor activity; or
- differences between the documented condition and lived reality.

This information can assist competent professionals.

It cannot replace professional assessment, but it should not be dismissed because it is expressed in ordinary language.

2. The Right to Know Who Is Responsible

Every resident should be able to identify the person or body responsible for the inspection, maintenance and repair of communal fall-protection structures.

The responsible person's details should be communicated clearly through:

- tenancy information;
- leaseholder information;
- resident handbooks;
- building noticeboards;
- digital resident portals;
- repair-reporting systems; and
- safety communications.

The information should include:

- the name of the responsible organisation;

- the relevant department or contact;
- emergency reporting details;
- the ordinary reporting route;
- the complaints route;
- the relevant regulator or enforcement authority; and
- arrangements applying outside normal working hours.

Residents should not be expected to determine whether responsibility lies with:

- the freeholder;
- a housing association;
- a local authority;
- a managing agent;
- a resident management company;
- a contractor;
- an Accountable Person; or
- another party.

Where ownership or management arrangements are complex, the organisations involved should resolve responsibility between themselves.

The resident should receive one clear route through which a concern can be raised and acted upon.

3. The Right to Basic Safety Information

Residents should have access to a plain-language summary of the inspection and maintenance status of relevant fall-protection structures.

The information should include:

- the date of the most recent competent inspection;
- the general type of inspection undertaken;
- the name or professional role of the inspector;
- the overall condition classification;
- whether any part of the structure was inaccessible;
- whether further investigation was recommended;
- whether remedial work was required;
- the status of that work;
- any temporary safety measures; and
- the date or period of the next review.

The summary should distinguish between:

- a routine visual observation;
- a competent close inspection;
- a specialist structural assessment;
- intrusive investigation;
- testing; and
- completion of repair work.

A statement that a structure has been “checked” is insufficient where it does not explain what that check involved.

Similarly, a statement that the structure is “compliant” should not be used where the responsible person is relying only upon historic construction approval or a limited visual inspection.

4. Access to Detailed Inspection Information

Residents should be entitled to request more detailed information where they have a legitimate interest in the safety of the structure.

This could include:

- the relevant section of an inspection report;
- photographs;
- the condition classification;
- the inspector’s recommendations;
- the timetable for remedial work;
- confirmation that repairs have been verified;
- the reason for any delay; and
- the basis for deciding that a structure remains in use.

The responsible person should be able to withhold or redact information where necessary to protect:

- personal data;
- building security;
- legally privileged material;
- confidential commercial information; or
- an active criminal investigation.

However, these grounds should not be used to conceal material safety findings.

Even where a full technical report cannot be disclosed, residents should receive a meaningful summary of:

- the identified risk;
- action being taken;
- interim protections; and
- expected timescales.

5. The Right to Report a Concern

Residents should be able to report concerns through several accessible routes.

These should include, where practicable:

- telephone;
- email;
- online portal;
- mobile application;
- in-person reporting;

- emergency repairs service;
- housing officer;
- caretaker;
- concierge;
- managing agent; and
- an authorised representative.

Residents should be able to report concerns in their own words.

They should not be required to identify whether a problem involves:

- corrosion;
- structural failure;
- anchorage;
- weld failure;
- concrete spalling;
- material loss; or
- another technical mechanism.

Reports such as the following should trigger appropriate consideration:

- “The railing moves.”
- “It feels loose.”
- “There is rust underneath the paint.”
- “The concrete around it is cracking.”
- “A bolt appears to be missing.”
- “It made a noise when I leaned near it.”
- “This has been repaired before but is moving again.”
- “A contractor covered over damage.”
- “I do not feel safe allowing my child near it.”

The reporting system should capture the resident’s description accurately rather than reducing it to an unsuitable generic repair category.

6. Safety-Critical Triage

Housing and building-management systems should distinguish potential structural safety reports from routine decorative repairs.

Reports involving the following should receive enhanced triage:

- movement;
- instability;
- detachment;
- missing fixings;
- significant corrosion;
- cracking around connections;
- impact damage;
- deformation;
- failure of a previous repair;
- exposed embedded metal;

- sudden change in condition; or
- concern that a barrier may not withstand pressure.

Relevant words and phrases should prompt escalation to a trained person.

This should not depend entirely upon automated keyword recognition.

Staff receiving reports should receive training to identify when ordinary language may indicate a serious risk.

A report should not be downgraded merely because:

- no one has yet been injured;
- the structure remains upright;
- it has recently been painted;
- no previous complaint is recorded;
- the resident cannot provide photographs; or
- another member of staff previously considered it satisfactory.

7. Acknowledgement and Response Standards

Residents should receive prompt confirmation that a safety concern has been recorded.

The acknowledgement should include:

- a reference number;
- the issue as recorded;
- the response priority;
- what will happen next;
- any immediate precautions;
- the expected inspection timeframe; and
- contact details for further information.

Where a report indicates an immediate or potentially serious risk, the responsible person should consider:

- urgent attendance;
- temporary restriction of access;
- installation of temporary protection;
- warning notices;
- alternative routes;
- resident welfare needs; and
- emergency professional advice.

The resident should be informed when an inspection has taken place and should receive an appropriate summary of the outcome.

A concern should not be closed merely because an operative attended.

Closure should require evidence that:

- the condition was properly assessed;
- necessary action was identified;
- immediate risk was controlled;
- repair or investigation was completed where required; and

- the resident was informed.

8. The Right to Written Findings

Where a resident reports a material concern, they should receive written findings in accessible language.

The response should explain:

- what was inspected;
- when it was inspected;
- by whom;
- what was found;
- whether the structure is considered safe for continued use;
- whether further investigation is required;
- whether repairs are needed;
- any interim measures;
- expected completion timescales; and
- how the resident can challenge or escalate the outcome.

The written findings should distinguish clearly between:

- no defect identified;
- minor maintenance required;
- monitoring required;
- further investigation required;
- repair required; and
- unsafe condition.

Where no defect is found, the response should not suggest that the resident acted unreasonably in reporting the concern.

A safety-reporting culture depends upon residents feeling able to raise concerns without embarrassment or fear of dismissal.

9. The Burden of Proof

The Joshua Test should avoid placing an unreasonable evidential burden on residents.

A resident should not be required to:

- commission an engineer;
- obtain laboratory testing;
- prove loss of structural capacity;
- identify the original design standard;
- demonstrate the precise cause of deterioration; or
- establish that failure is imminent.

The resident's role is to report the observed or experienced concern.

The responsible person's role is to determine, through a competent and proportionate process, whether the concern indicates a safety risk.

This distinction is essential.

Hidden structural deterioration may not be capable of proof through photographs or casual observation.

The absence of resident-supplied technical evidence should not be treated as evidence that the structure is safe.

Where there is genuine uncertainty, the appropriate response may be further investigation rather than closure of the complaint.

10. Repeated and Linked Reports

Repeated reports should be linked and reviewed collectively.

A series of apparently minor reports may indicate a more serious pattern.

Examples include:

- separate residents reporting movement;
- repeated repainting of the same corroded area;
- recurring cracks around fixings;
- repeated repairs that fail;
- similar defects across several balconies;
- reports from different blocks sharing the same design; or
- concerns raised by contractors as well as residents.

The responsible person's information system should identify:

- repeated reports about the same structure;
- recurring issues at the same location;
- similar defects across an estate;
- increasing frequency of repair;
- repeated reports closed without specialist assessment; and
- patterns involving the same contractor or repair method.

A fresh report should not be treated in isolation where relevant historical information exists.

11. Residents With Additional Needs

Information and reporting systems must be accessible to residents with additional needs.

This may include residents who:

- are disabled;
- have a visual or hearing impairment;
- have a learning disability;
- are neurodivergent;
- have limited literacy;
- do not speak English as a first language;
- experience mental distress;
- require an advocate;
- are digitally excluded; or
- have mobility needs affecting access arrangements.

Reasonable provision should include:

- alternative formats;
- large print;
- easy-read information;
- translated material;
- text relay or accessible telephone services;
- in-person communication;
- support through an advocate;
- clear visual notices; and
- additional time or explanation where required.

Emergency restrictions must also account for residents who cannot easily use alternative routes.

A decision to close a balcony, walkway, stair or entrance may create serious practical consequences.

The responsible person should assess those consequences and provide suitable support.

12. Communication During Urgent Safety Action

Where a structure is assessed as unsafe or requires immediate restrictions, residents should receive clear and timely information.

The communication should explain:

- which area is affected;
- what residents must not do;
- the reason for the restriction;
- whether the risk is immediate;
- what temporary protection is being installed;
- alternative access arrangements;
- who to contact;
- the expected next step; and
- when a further update will be provided.

The communication should avoid:

- vague reassurance;
- unexplained technical language;
- speculative statements;
- premature attribution of blame; and
- claims that the matter is resolved before verification.

Where an active police, regulatory or legal investigation limits disclosure, residents should still receive sufficient practical information to remain safe.

13. Consultation on Planned Works

Residents should be informed about significant inspection and remediation programmes affecting their homes or communal areas.

Consultation should address:

- the reason for the work;
- the structures involved;
- the intended inspection method;
- access requirements;
- expected disruption;
- temporary closures;
- contractor arrangements;
- anticipated timescales;
- resident safety during works;
- how findings will be communicated; and
- who will verify completion.

Resident engagement should not provide a veto over necessary safety work.

However, residents may hold information capable of improving planning, including:

- access difficulties;
- caring responsibilities;
- disability requirements;
- previous defects;
- historic repairs;
- vulnerable household members; and
- times when particular areas are heavily used.

This information should inform delivery.

14. Leaseholder Information and Charges

Where inspection or repair costs may be recovered from leaseholders, transparency is particularly important.

Leaseholders should receive clear information about:

- the legal basis for the work;
- the identified safety concern;
- the inspection findings;
- the proposed remedy;
- procurement arrangements;
- estimated costs;
- professional fees;
- alternative options considered;
- consultation rights;
- available funding;
- payment arrangements; and
- routes for challenging unreasonable charges.

Safety should not be used as a justification for opaque procurement or excessive costs.

At the same time, disputes concerning ultimate liability should not delay urgent protective measures.

Where immediate action is required, safety work should proceed while questions of cost allocation are resolved through the appropriate process.

15. Resident Representation

In larger or higher-risk buildings, responsible persons should engage recognised resident groups where they exist.

These may include:

- tenant and resident associations;
- recognised tenants' panels;
- leaseholder groups;
- resident management companies;
- building safety groups; and
- other representative bodies.

Resident representatives could contribute to:

- identifying recurring concerns;
- reviewing communication materials;
- planning access;
- understanding disruption;
- monitoring outstanding actions;
- improving reporting routes; and
- evaluating the effectiveness of the inspection programme.

Resident participation should not transfer the responsible person's legal duty to the group.

Residents can inform and challenge safety management.

They should not become responsible for certifying structural safety or policing their neighbours.

16. Access to Independent Advice

Residents may require independent information where they dispute the responsible person's assessment.

Government should consider access to:

- local-authority housing advice;
- ombudsman services;
- building safety advice;
- legal advice;
- tenant advocacy;
- leasehold advisory services;
- approved dispute-resolution routes; and
- independent technical review in defined cases.

It would be disproportionate to provide a publicly funded independent engineering assessment for every disagreement.

However, a review mechanism may be justified where:

- repeated reports have been dismissed;
- the structure continues to move;
- different professionals have reached conflicting conclusions;
- the landlord refuses to disclose findings;
- remedial work remains seriously overdue;
- a credible whistleblower raises concern; or
- the consequences of potential failure are severe.

The review process should be capable of directing further investigation where the existing evidence is insufficient.

17. Complaints and Escalation

Every responsible person should operate a clear complaints and escalation route.

The resident should be told:

- how to challenge the initial response;
- the timeframe for review;
- who will conduct the review;
- whether the reviewer is independent of the original decision;
- how to contact the relevant ombudsman;
- which regulator may have jurisdiction; and
- what to do where the risk appears immediate.

A complaint involving potential structural danger should not be delayed solely because it is being processed through an ordinary complaints timetable.

Safety action and complaint handling should proceed in parallel where necessary.

The system should prevent disputes about communication, liability or service quality from delaying urgent inspection.

18. The Role of the Housing Ombudsman

For social housing, the Housing Ombudsman can examine complaints concerning landlord services, including repairs, communication, complaint handling and compliance with relevant obligations.

The Joshua Test should ensure that residents can use the ombudsman route where concerns include:

- failure to investigate;
- repeated missed appointments;
- unreasonable delay;
- inadequate communication;
- failure to follow professional recommendations;
- inaccurate records;
- failure to complete repairs;
- poor complaint handling; or
- failure to make reasonable adjustments.

The ombudsman should not replace the emergency powers of regulators or local authorities.

Where an immediate risk exists, the matter should be referred to an authority capable of taking urgent protective action.

Ombudsman findings should nevertheless inform regulatory learning where they reveal:

- recurring organisational failure;
- unreliable data;
- systemic delay;
- disregard of resident evidence; or
- ineffective contractor management.

19. Protection Against Retaliation

Residents must be able to raise safety concerns without fear of disadvantage.

The law and regulatory framework should protect residents from retaliatory conduct linked to genuine safety reporting.

Potential concerns include:

- threats affecting tenancy or services;
- harassment;
- intimidation;
- withdrawal of ordinary communication;
- unreasonable accusations of causing damage;
- discriminatory treatment;
- pressure to withdraw a complaint; or
- inappropriate use of legal threats.

This protection should not prevent responsible persons from investigating deliberate damage, abusive conduct or knowingly false reports.

The distinction should be between legitimate management action and retaliation intended to silence a resident.

A culture in which residents fear consequences for reporting movement or corrosion is incompatible with preventative safety.

20. Protection for Bereaved Families and Injured Residents

Where a serious or fatal incident occurs, communication with affected families must be trauma-informed and coordinated.

Families should receive:

- a named point of contact;
- clear explanations of organisational processes;
- preservation of relevant records;
- prompt notification of significant safety actions;
- cooperation with police, coroners and regulators;
- respectful communication;
- protection from speculative or defensive statements; and
- clear information about available support.

The responsible organisation should avoid placing the burden on a bereaved family to:

- identify all relevant records;
- reconstruct the maintenance history;
- locate contractors;
- determine regulatory responsibility;
- repeatedly provide the same information; or
- pursue multiple organisations for basic answers.

Where legally permissible, agencies should coordinate requests and communications.

The framework should recognise that procedural fragmentation can compound trauma.

21. Preservation of Evidence

Following a serious incident, near miss or discovery of major deterioration, relevant evidence should be preserved.

This may include:

- the structure itself;
- failed components;
- fixings;
- photographs;
- inspection records;
- repair reports;
- work orders;
- contractor communications;
- complaints;
- drawings;
- procurement records;
- testing results;
- electronic records; and
- relevant surveillance footage.

Residents and families should not be responsible for ensuring that organisations preserve evidence.

The duty should rest upon those who control the building, records and relevant systems.

Evidence preservation should not prevent immediate work required to make the area safe.

Where emergency alteration or removal is necessary, the original condition should be documented as fully as practicable.

22. Data Protection and Privacy

Resident transparency must operate consistently with data-protection law.

Safety information should be shared in a way that avoids unnecessary disclosure of:

- personal details;
- health information;
- individual complaint histories;

- private correspondence; or
- information identifying vulnerable residents.

Reports can often be summarised or redacted while preserving the material safety content.

The responsible person should not rely upon data protection as a blanket reason for withholding:

- the existence of a defect;
- the overall condition category;
- the status of remedial work;
- relevant access restrictions; or
- the date of the next inspection.

Safety transparency and privacy protection are compatible when information is managed carefully.

23. Public Reporting

Larger landlords and regulated providers should publish proportionate aggregate information about compliance.

This might include:

- the number of relevant structures recorded;
- percentage with current inspections;
- number requiring remedial work;
- number of overdue actions;
- urgent restrictions;
- average repair completion times;
- improvement activity; and
- lessons learned from serious defects.

Public reporting should not disclose:

- personal information;
- information prejudicing active investigations;
- sensitive security details; or
- commercially confidential material without justification.

The purpose should be to support accountability and learning rather than create league tables lacking context.

24. Resident Safety Notices

Buildings should display or provide access to a concise resident safety notice.

This could identify:

- the responsible person;
- how to report a concern;
- the date of the latest relevant inspection;
- the current overall status;
- the next planned review;

- emergency contact details; and
- where further information can be obtained.

The notice should not become a misleading certificate.

It should state the basis and limitations of the information.

Where different structures within the building have different conditions, the notice should not imply that one inspection result covers every barrier.

Digital access may supplement the notice but should not be the only route.

25. Resident Engagement Standards

The Joshua Test should establish minimum standards for resident engagement.

These should include:

Clarity

Information should be understandable without specialist knowledge.

Accuracy

Communications should distinguish established findings from matters still under investigation.

Timeliness

Residents should be informed promptly about restrictions, serious findings and delays.

Accessibility

Information should be available in appropriate formats.

Respect

Residents should not be dismissed, blamed or discouraged from reporting concerns.

Traceability

Reports, responses and decisions should be recorded.

Accountability

Residents should know who made the decision and how it can be challenged.

Continuity

Residents should not be required to restart the process whenever staff or contractors change.

26. Measuring Resident Experience

Compliance should not be measured solely through technical records.

Regulators and responsible persons should also examine whether residents experience the system as:

- accessible;

- responsive;
- transparent;
- respectful;
- safe;
- consistent; and
- capable of resolving concerns.

Relevant indicators could include:

- acknowledgement times;
- inspection response times;
- repeat reports;
- complaints about communication;
- unresolved safety concerns;
- reasonable-adjustment failures;
- resident understanding of reporting routes;
- satisfaction with safety information; and
- confidence that concerns will be taken seriously.

Positive satisfaction scores should not outweigh objective evidence of unresolved structural risk.

Resident feedback should complement, not replace, technical assurance.

27. Co-Design of Guidance

Detailed resident information and reporting processes should be co-designed with:

- tenants;
- leaseholders;
- disabled residents;
- residents with communication needs;
- resident associations;
- housing professionals;
- engineers;
- local authorities;
- ombudsman services;
- building safety specialists; and
- bereaved families.

Co-design can help ensure that guidance reflects:

- the language residents actually use;
- practical barriers to reporting;
- fear of not being believed;
- digital exclusion;
- complaint fatigue;
- distrust created by repeated failed repairs;
- the effects of trauma; and
- the need for clear escalation.

Lived experience should inform the system without replacing technical, legal or regulatory expertise.

28. A Proposed Resident Safety Information Standard

Government could establish a standard requiring responsible persons to provide the following minimum information.

Building-Level Information

- responsible organisation;
- reporting routes;
- emergency contact;
- latest inspection date;
- inspection category;
- next review date;
- outstanding high-priority work; and
- current restrictions.

Report-Specific Information

- acknowledgement;
- report reference;
- assigned priority;
- attendance date;
- findings;
- next action;
- completion target;
- interim controls; and
- escalation route.

Works Information

- reason for work;
- affected area;
- access implications;
- contractor details;
- expected duration;
- temporary protections;
- completion confirmation; and
- verification status.

Complaint Information

- review process;
- response timeframe;
- ombudsman or regulatory route;
- emergency escalation; and
- advocacy or accessibility support.

Standardisation would support consistency while allowing different providers to use their own communication systems.

29. Proposed Statutory Resident Rights

The legislation could provide residents with rights to:

1. report a concern without needing technical evidence; 2. receive prompt acknowledgement; 3. receive written findings following a material safety report; 4. obtain a plain-language summary of relevant inspection information; 5. be informed of urgent restrictions and remedial action; 6. request reasonable adjustments and accessible communication; 7. challenge an inadequate response; 8. contact an appropriate regulator or enforcement authority; 9. receive protection against retaliation for genuine reporting; and 10. obtain confirmation when required safety work has been completed and verified.

These rights should be supported by clear remedies.

A right without an accessible enforcement route may provide little practical protection.

30. The Relationship Between Transparency and Liability

Some organisations may fear that providing detailed safety information could increase legal or reputational exposure.

That concern should not justify withholding material information from residents.

Transparency can:

- support early reporting;
- improve resident cooperation;
- reduce speculation;
- demonstrate responsible management;
- encourage timely action;
- support regulatory assurance; and
- build trust.

The framework should encourage responsible persons to identify and address defects openly.

An organisation that finds deterioration, imposes controls and completes appropriate repairs should not be treated in the same way as one that ignores or conceals the same condition.

The system should reward disclosure and prompt action rather than creating an incentive to avoid inspection.

Conclusion

The Joshua Test should not place the responsibility for detecting structural danger upon residents.

Residents should be encouraged to report what they see, hear, feel or experience.

They should not be required to prove why it is happening or how close the structure may be to failure.

That responsibility belongs to the person legally responsible for the building, supported by competent professionals and effective regulators.

The resident-facing principles of the Joshua Test should therefore be:

- residents must know who is responsible;
- residents must be able to report concerns easily;
- reports must be triaged according to potential risk;
- residents must receive clear written findings;
- uncertainty must lead to investigation rather than dismissal;
- material safety information must be transparent;
- urgent restrictions must be communicated clearly;
- complaints and escalation routes must be accessible;
- residents must be protected from retaliation; and
- bereaved and injured families must not be left to reconstruct the safety history

alone.

The governing principle should be:

Residents may be the first people to notice that something is wrong, but they must never be made responsible for proving that a life-critical structure is unsafe.

Chapter 17

Enforcement, Compliance and Regulatory Response

Introduction

A statutory duty has limited value unless responsibility is clear, compliance can be verified and failures produce meaningful consequences.

The Joshua Test should therefore be supported by an enforcement framework that is:

- preventative rather than solely reactive;
- proportionate to risk;
- coordinated across existing regulators;
- transparent to residents;
- capable of identifying systemic failure;
- sufficiently resourced;
- technically informed; and
- strong enough to address deliberate or persistent non-compliance.

The purpose of enforcement should not be to punish every administrative mistake.

Its primary purpose should be to secure the continuing safety of residential fall-protection structures and ensure that defects are identified and addressed before catastrophic failure occurs.

However, the framework must also recognise that some failures may involve more than poor administration.

Serious cases may include:

- knowingly failing to inspect a high-risk structure;
- ignoring repeated resident reports;
- failing to act upon professional warnings;
- concealing significant deterioration;
- allowing overdue remedial work to remain unresolved;
- using unqualified persons for safety-critical decisions;
- falsifying inspection records;
- misrepresenting maintenance work as structural assurance; or
- permitting residents to continue using an area known to be unsafe.

The enforcement response should reflect the seriousness of the conduct, the level of risk created and the extent of actual or potential harm.

1. Clear Allocation of Responsibility

The law should identify a responsible person for every fall-protection structure within scope.

Residential buildings may involve several parties, including:

- freeholders;
- social landlords;
- local authorities;

- head lessors;
- managing agents;
- resident management companies;
- right-to-manage companies;
- commonhold associations;
- facilities-management contractors;
- Accountable Persons;
- Principal Accountable Persons; and
- specialist contractors.

Complex ownership arrangements must not create a gap in accountability.

The primary duty should attach to the person or body with legal responsibility and sufficient control over:

- access;
- inspection;
- maintenance;
- repair;
- replacement;
- funding decisions; and
- appointment of contractors.

Where more than one party has relevant control, the law should impose duties to:

- cooperate;
- share information;
- coordinate inspections;
- identify the lead dutyholder;
- notify each other of defects;
- avoid duplication; and
- ensure remedial work is completed.

A contractual arrangement should not automatically permit a building owner or landlord to transfer all legal responsibility to a managing agent or contractor.

The person commissioning the work should remain responsible for ensuring that:

- the scope is adequate;
- the contractor is competent;
- findings are reviewed;
- recommendations are acted upon;
- completion is verified; and
- records are retained.

2. The Role of Governing Bodies and Senior Leadership

Compliance with The Joshua Test should not be treated solely as an operational maintenance issue.

For larger organisations, including housing associations and local authorities, governing bodies should receive assurance concerning:

- the number of structures within scope;
- the proportion with completed baseline assessments;
- the number of overdue inspections;
- significant defects;
- urgent restrictions;
- outstanding remedial work;
- recurring failure patterns;
- data quality;
- contractor performance;
- financial exposure; and
- resident concerns.

Boards and senior officers should be expected to challenge whether the information provided is:

- current;
- complete;
- reliable;
- independently verified where necessary; and
- sufficient to support declarations of compliance.

A report stating that inspections are “in progress” should not be accepted indefinitely without:

- completion dates;
- risk prioritisation;
- evidence of interim controls; and
- explanation of outstanding barriers.

Responsibility for compliance should be assigned to an appropriately senior individual with authority to secure:

- access;
- funding;
- professional support;
- remedial action; and
- cross-departmental cooperation.

3. Regulatory Coordination

The Joshua Test is likely to intersect with several existing regulatory systems.

These may include:

- the Building Safety Regulator;
- the Regulator of Social Housing;
- local housing authorities;
- environmental health teams;
- local-authority building control;
- health and safety regulators where applicable;
- fire and rescue authorities;

- housing ombudsman services;
- professional regulators; and
- courts or tribunals.

Government should avoid creating a system in which residents are repeatedly passed between agencies because no regulator considers the issue wholly within its remit.

A memorandum or statutory framework for regulatory coordination should establish:

- which body leads in each building category;
- how referrals are made;
- when information must be shared;
- who may require inspection records;
- who can impose remedial action;
- how emergency risks are managed;
- how duplicate investigations are avoided; and
- how systemic concerns are escalated.

Where more than one regulator has jurisdiction, there should be a clearly identified lead authority.

4. The Building Safety Regulator

For occupied higher-risk buildings, the Building Safety Regulator could provide oversight through the existing building-safety framework.

Relevant functions could include:

- examining whether fall-protection risks are reflected in safety management;
- reviewing inspection and maintenance information;
- requiring evidence of competent assessment;
- examining recurring defects;
- assessing whether safety cases address relevant structural hazards;
- requiring remedial action;
- investigating serious failures or near misses; and
- coordinating with other authorities.

The Building Safety Regulator should not be expected to inspect every individual railing directly.

Its role should be to assess whether the Accountable Person's system is capable of identifying and controlling the risk.

However, it should retain the power to require specific investigation where:

- records are incomplete;
- the risk has been underestimated;
- defects remain unresolved;
- professional advice has been ignored; or
- wider structural concerns may exist.

5. The Regulator of Social Housing

The Regulator of Social Housing should oversee whether registered providers have effective systems for complying with The Joshua Test.

Regulatory assessment could consider:

- whether the provider has identified relevant structures;
- the accuracy of asset data;
- the quality of risk classification;
- inspection completion rates;
- the competence of appointed professionals;
- the number of overdue remedial actions;
- the quality of board assurance;
- resident communication;
- contractor monitoring; and
- whether serious defects are escalated promptly.

A failure affecting one structure may indicate an isolated operational error.

Repeated failures across multiple estates may indicate:

- weak governance;
- unreliable stock-condition data;
- inadequate procurement;
- insufficient technical oversight;
- systemic underinvestment;
- ineffective contractor management; or
- poor safety culture.

The regulator should be capable of distinguishing between these.

Regulatory responses might include:

- requests for information;
- improvement plans;
- additional monitoring;
- independent validation;
- regulatory notices;
- enforcement action;
- changes to regulatory judgement; and
- intervention in serious cases.

6. Local Housing Authorities

Local housing authorities would have an important role in lower-rise, privately rented and other residential buildings outside the higher-risk building regime.

Their functions could include:

- investigating reports of unsafe guarding;
- assessing fall and structural hazards;
- requiring access to records;

- commissioning or requiring specialist inspections;
- issuing improvement notices;
- taking emergency action;
- restricting access;
- recovering enforcement costs; and
- prosecuting serious offences where authorised.

Local authorities should not be required to rely solely upon visual housing inspections where the condition of a structure requires engineering expertise.

They should have access to:

- approved technical guidance;
- competent professional panels;
- specialist advice;
- standard inspection notices;
- risk-assessment tools; and
- adequate funding.

A new duty without enforcement resources would create only nominal protection.

7. Reporting and Regulatory Returns

Responsible persons should be required to maintain building-level records.

Government should also consider proportionate regulatory reporting.

Data returns might include:

- number of structures within scope;
- number assessed;
- number overdue;
- condition classifications;
- number requiring specialist investigation;
- number subject to urgent restrictions;
- outstanding repairs;
- average completion times;
- unresolved access issues;
- serious resident reports;
- near misses; and
- confirmed failures.

Reporting should be designed to support risk identification rather than generate unnecessary paperwork.

Smaller landlords should not be required to submit the same volume of information as large national providers unless the risk justifies it.

However, every responsible person should be capable of producing current records upon request.

8. Inspection Certificates and Declarations

The Joshua Test should avoid creating a superficial certificate that gives false reassurance.

A declaration should not simply state that a structure has “passed” without explaining:

- the scope of inspection;
- the method used;
- limitations;
- inaccessible areas;
- competence of the inspector;
- condition classification;
- recommended actions;
- next review date; and
- whether specialist investigation remains outstanding.

Where appropriate, responsible persons could be required to make a periodic compliance declaration confirming that:

- relevant structures have been identified;
- required inspections have been completed;
- findings have been reviewed;
- urgent actions have been taken;
- remedial work is being managed;
- records are current; and
- no known unsafe structure remains in unrestricted use.

False or reckless declarations should attract serious consequences.

9. Condition-Based Enforcement

Enforcement should reflect both the condition of the structure and the conduct of the responsible person.

Satisfactory Structure, Administrative Defect

Where the structure is safe but records are incomplete, the initial response may involve:

- advice;
- a compliance notice;
- a requirement to update records; or
- a short remedial period.

Inspection Overdue

Where a required inspection has not been completed, the regulator may require:

- inspection within a specified period;
- interim visual checks;
- temporary controls;
- explanation of the delay; and
- evidence that higher-risk structures have been prioritised.

Further Investigation Required

Where an inspector cannot determine safety, the structure should not automatically remain classified as satisfactory.

The responsible person may be required to:

- commission specialist investigation;
- shorten the completion timescale;
- impose temporary restrictions;
- provide resident information; and
- report the outcome.

Remedial Work Required

Where defects require repair, enforcement should focus on:

- an appropriate completion deadline;
- interim risk controls;
- competent repair specifications;
- quality assurance;
- confirmation of completion; and
- updated inspection records.

Unsafe Structure

Where a structure is unsafe or potentially unstable, action may include:

- immediate restriction of access;
- evacuation from the affected area;
- temporary edge protection;
- emergency stabilisation;
- alternative access arrangements;
- regulator notification;
- urgent repair or replacement; and
- formal investigation.

10. Compliance Notices

Regulators should have powers to issue compliance notices where a responsible person has failed to meet the duty.

A notice could require the recipient to:

- identify relevant structures;
- produce records;
- appoint a competent inspector;
- commission further investigation;
- complete specified repairs;
- restrict access;
- provide information to residents;
- verify completed work; or

- correct inaccurate regulatory information.

The notice should specify:

- the legal breach;
- the required action;
- the deadline;
- interim controls;
- evidence required for closure;
- rights of appeal; and
- consequences of non-compliance.

Deadlines should reflect risk.

A serious safety matter should not receive the same completion period as an administrative record-keeping failure.

11. Civil Financial Penalties

Civil financial penalties may provide a proportionate response where prosecution is unnecessary but formal deterrence is required.

They could apply to:

- failure to complete a required inspection;
- failure to retain records;
- failure to provide information;
- failure to comply with a notice;
- repeated overdue remedial work;
- obstruction of an authorised officer; or
- inaccurate compliance declarations.

Penalty levels should take account of:

- seriousness;
- duration;
- risk created;
- size and resources of the organisation;
- previous conduct;
- cooperation;
- steps taken to remedy the breach; and
- whether financial benefit was obtained through non-compliance.

Penalties should not be treated as an alternative to completing necessary safety work.

Payment of a fine should not extinguish the duty to inspect, repair or replace the structure.

12. Criminal Offences

Criminal offences should be reserved for serious conduct.

Potential offences could include:

- knowingly or recklessly providing false safety information;
- falsifying inspection records;

- concealing a known serious defect;
- intentionally obstructing an inspector;
- failing to comply with an emergency restriction;
- repeated failure to comply with a statutory notice; or
- allowing continued use of a structure known to present a serious risk.

The prosecution should be required to prove the applicable mental element where the offence is based upon deliberate or reckless conduct.

The framework should distinguish serious wrongdoing from:

- reasonable professional disagreement;
- minor administrative error;
- unforeseen deterioration; or
- a good-faith decision based upon competent advice.

13. Senior Management Accountability

Where an offence by an organisation occurs with the consent, connivance or attributable neglect of a senior officer, legislation could permit individual liability where appropriate.

This should not create automatic personal criminal liability whenever a defect occurs.

Individual accountability should focus upon conduct such as:

- knowingly suppressing safety findings;
- refusing necessary expenditure despite clear warnings;
- directing staff to alter records;
- repeatedly ignoring serious defects;
- providing false assurance to a board or regulator; or
- preventing appropriate escalation.

The purpose is to ensure that organisational structures cannot be used to avoid accountability for deliberate or reckless senior-level decisions.

14. Emergency Powers

Regulators and local authorities should have clear emergency powers where a fall-protection structure presents an immediate risk.

These may include powers to:

- prohibit access;
- close walkways, balconies or stair areas;
- require temporary barriers;
- arrange emergency works;
- enter premises where legally justified;
- require evacuation from affected areas;
- obtain urgent engineering advice; and
- recover reasonable costs from the responsible person.

Emergency action should be proportionate and should consider:

- accessibility;

- disability;
- fire escape routes;
- alternative access;
- safeguarding;
- displacement; and
- resident welfare.

Closing an access route may itself create additional risks. Emergency decisions should therefore be coordinated with relevant safety professionals.

15. Resident Complaints and Escalation

Residents should have a clear route to escalate concerns where the responsible person fails to act.

A resident should be able to report:

- movement;
- corrosion;
- looseness;
- missing fixings;
- cracking;
- failed repairs;
- repeated water penetration;
- restrictions not being enforced;
- overdue works; or
- concern that an inspection was inadequate.

The escalation route should identify:

1. the landlord or responsible person; 2. the internal complaints process; 3. the relevant regulator or local authority; 4. the appropriate ombudsman or redress scheme; and 5. legal remedies where necessary.

Residents should not be required to identify the correct engineering terminology before their concern is taken seriously.

Reports such as “the railing moves” or “the barrier feels loose” should be treated as potential safety information, not merely as minor maintenance complaints.

16. Whistleblowing and Professional Escalation

Employees and contractors may become aware of serious deterioration before residents or senior management.

The framework should support safe escalation by:

- housing officers;
- caretakers;
- repair operatives;
- painters;
- surveyors;
- engineers;

- contractors;
- building managers; and
- compliance staff.

Contracts and internal procedures should provide a route for reporting:

- unsafe instructions;
- concealed defects;
- poor-quality repairs;
- inaccurate records;
- pressure to downgrade findings;
- unqualified decision-making; or
- failure to impose necessary restrictions.

No worker should be penalised for raising a genuine safety concern through an appropriate channel.

Professional inspectors should also have a duty to escalate an immediate danger where the responsible person fails to act.

17. Contractor Oversight

The responsible person should monitor the competence and performance of contractors.

Oversight should include:

- verification of qualifications and experience;
- clear inspection specifications;
- defined reporting requirements;
- photographic records;
- quality checks;
- review of repeated defects;
- auditing of completed repairs;
- prohibition of unapproved subcontracting where safety-critical;
- disclosure of conflicts of interest; and
- processes for removing poor-performing contractors.

Lowest-price procurement should not determine safety-critical appointments without adequate consideration of:

- competence;
- capacity;
- methodology;
- independence;
- supervision; and
- quality assurance.

Where an inspection contractor also stands to receive the subsequent repair contract, the responsible person should consider whether additional independent verification is necessary.

18. Independent Audit

Regulators should have the power to require independent audit where:

- inspection records appear unreliable;
- large numbers of structures remain unassessed;
- repeated failures occur;
- repair completion cannot be verified;
- data conflicts with resident reports;
- internal assurance has proved inaccurate; or
- serious governance concerns exist.

An independent audit might examine:

- a sample of buildings;
- inspection methodology;
- risk classification;
- staff competence;
- contractor reports;
- repair verification;
- data quality;
- board reporting; and
- resident communication.

Sampling should be risk-based.

A favourable result from a limited sample should not be used to dismiss evidence of defects elsewhere without proper investigation.

19. Incident and Near-Miss Reporting

The regulatory system should learn from failures and near misses.

A reportable event might include:

- partial detachment;
- sudden movement;
- collapse of a component;
- failure during testing;
- discovery of severe concealed corrosion;
- emergency restriction of a communal route;
- repeated failure of a common design;
- a fall prevented only by another structure; or
- evidence that a barrier had materially lost capacity.

Reporting thresholds should be clearly defined to avoid both under-reporting and excessive low-value reporting.

The purpose should be to identify:

- recurring designs;
- vulnerable materials;
- ineffective repairs;

- regional corrosion patterns;
- contractor failures;
- inspection limitations; and
- emerging systemic risks.

Anonymised learning should be circulated across the housing and building-safety sectors.

20. National Safety Alerts

Where a serious defect may affect comparable buildings, the responsible regulator should be able to issue a national or sector-specific safety alert.

An alert could require organisations to:

- identify similar structures;
- complete preliminary checks;
- review historic records;
- commission specialist assessment;
- report findings;
- impose interim controls; or
- complete remedial work.

Safety alerts should contain:

- the nature of the concern;
- affected construction types;
- known warning signs;
- required actions;
- competence expectations;
- reporting deadlines; and
- contact details for technical clarification.

The system should allow lessons from one building to protect residents elsewhere.

21. Data Transparency

Government and regulators should publish proportionate aggregate data concerning implementation.

This could include:

- percentage of structures assessed;
- number of serious defects identified;
- overdue inspections;
- urgent restrictions;
- average repair times;
- enforcement notices;
- civil penalties;
- recurring defect types; and
- national safety alerts.

Published data should not disclose personal information or compromise active investigations.

Transparency would allow Parliament, residents and industry to assess whether the regime is producing meaningful safety improvements.

22. Appeals and Procedural Fairness

Responsible persons should have a right to challenge regulatory decisions.

Appeal mechanisms may be needed for:

- compliance notices;
- condition classifications imposed by regulators;
- financial penalties;
- cost-recovery decisions;
- emergency measures; and
- disputed scope or responsibility.

Appeal rights should not automatically suspend urgent measures where delay could expose residents to serious risk.

The framework should provide:

- clear reasons;
- access to evidence;
- reasonable response periods;
- independent review;
- tribunal or court oversight; and
- protection against arbitrary enforcement.

Procedural fairness strengthens rather than weakens effective regulation.

23. Enforcement Proportionality

Enforcement should take account of both risk and behaviour.

Relevant factors include:

- seriousness of the defect;
- potential consequences;
- duration of non-compliance;
- whether residents were exposed;
- whether reports were ignored;
- whether the organisation cooperated;
- whether interim controls were introduced;
- whether competent advice was obtained;
- whether records were falsified;
- previous compliance history; and
- speed of remedial action.

A responsible person who identifies a defect, restricts access, informs residents and completes repair promptly should not be treated in the same way as one who conceals or ignores the same risk.

Enforcement should reward openness and prompt action while retaining strong sanctions for serious failure.

24. Avoiding Regulatory Fragmentation

A central objective of The Joshua Test is to reduce fragmentation.

The regime should therefore include:

- common definitions;
- consistent condition categories;
- compatible data standards;
- shared guidance;
- clear referral routes;
- designated lead regulators;
- reciprocal information-sharing powers;
- coordinated enforcement;
- recognition of equivalent inspections; and
- a single resident-facing explanation of responsibilities.

A landlord should not be required to produce several differently formatted versions of the same evidence for several regulators.

Equally, information supplied to one regulator should not become inaccessible to another body with a legitimate safety function.

25. Proposed Enforcement Ladder

A proportionate enforcement ladder could include:

Stage 1: Advice and Informal Resolution

Used for minor or first-time administrative failures where no immediate safety risk exists.

Stage 2: Written Warning

Identifies the breach, required corrective action and completion date.

Stage 3: Compliance Notice

Creates a formal legal obligation to complete specified actions.

Stage 4: Enhanced Monitoring or Independent Audit

Used where systems appear unreliable or repeated failures occur.

Stage 5: Civil Financial Penalty

Used where formal deterrence is required.

Stage 6: Emergency Action

Used where a structure presents an immediate or serious risk.

Stage 7: Regulatory Intervention

May include governance action, appointment of advisers or stronger organisational measures.

Stage 8: Prosecution

Reserved for serious, deliberate, reckless or persistent non-compliance.

Progression should not always be sequential.

An immediate danger or deliberate falsification may justify direct escalation to emergency action or prosecution.

26. Proposed Statutory Duties of Cooperation

The legislation should require relevant parties to cooperate.

This may include duties to:

- provide access;
- share historic drawings;
- provide repair records;
- identify previous contractors;
- disclose known defects;
- coordinate inspections;
- notify linked building owners;
- transfer records when ownership changes; and
- assist emergency work.

Failure to cooperate can delay safety action even where the principal dutyholder is willing to act.

A person should not be permitted to withhold essential safety information because of:

- contractual disputes;
- ownership changes;
- commercial sensitivity;
- organisational restructuring; or
- disagreement over ultimate financial liability.

Questions of cost recovery can be resolved separately.

Immediate safety information should be shared without avoidable delay.

27. Funding Enforcement

Effective enforcement will require adequate resources.

Government should assess the cost of:

- technical staff;
- structural engineering advice;
- inspections;
- legal action;
- digital records;

- data analysis;
- resident communication;
- emergency response; and
- professional training.

Potential funding mechanisms may include:

- central government funding;
- local-authority grants;
- regulatory fees;
- recovery of enforcement costs;
- civil penalties;
- sector levies; and
- charges for complex applications or interventions.

Financial arrangements should not create an incentive for regulators to pursue high-value penalties rather than safety outcomes.

Enforcement bodies should have stable funding sufficient to undertake preventative work.

Conclusion

The Joshua Test requires more than an inspection standard.

It requires an accountability system capable of answering five questions:

1. Who is responsible? 2. What must they do? 3. What evidence must they retain? 4. Who verifies compliance? 5. What happens when they fail?

The proposed framework should prioritise prevention, cooperation and timely remediation.

Most responsible persons should be able to comply through proportionate inspections, competent advice, accurate records and prompt action.

Strong enforcement should be reserved for cases where risk is ignored, duties are repeatedly breached or safety information is concealed or falsified.

The governing principle should be:

A resident should never have to wait for a catastrophic failure before the system decides who was responsible for preventing it.

Clear responsibility, credible oversight and meaningful enforcement are essential if the Joshua Duty is to become an effective safety reform rather than an aspiration.

PART V

THE LEGISLATIVE PROPOSAL

From policy principle to illustrative statutory framework.

Chapter 18

The Joshua Test: Proposed Statutory Framework

Introduction

The Joshua Test proposes a continuing legal duty requiring the person responsible for a residential fall-protection structure to demonstrate that the structure remains capable of preventing the fall it was installed to prevent.

The proposal is founded on a simple principle:

A life-safety structure should not be presumed safe solely because it remains standing, appears visually intact or has previously complied with the standards applicable at the time of construction.

Buildings age.

Protective coatings deteriorate.

Water penetrates joints and interfaces.

Metal corrodes.

Fixings loosen or weaken.

Concrete cracks and deteriorates.

Alterations are made.

Maintenance records are lost.

The condition of a structure at the time it was installed cannot provide permanent assurance of its condition decades later.

The Joshua Test would therefore introduce a proportionate system of lifecycle assurance for residential guardrails, balustrades and comparable structures intended to prevent falls from height.

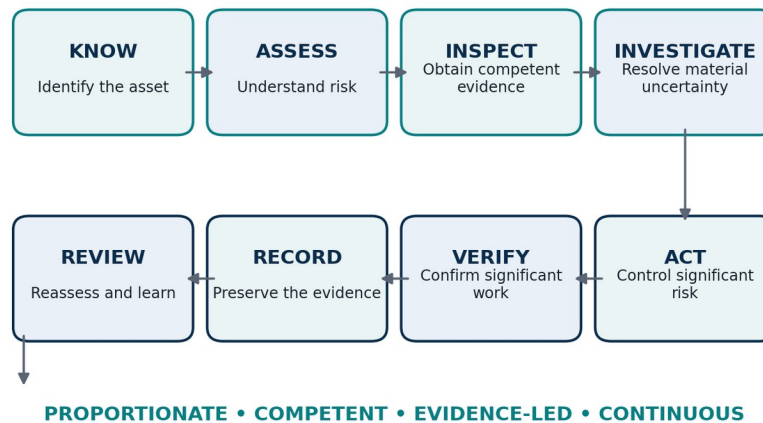
It would not prescribe one inspection technique for every structure. Instead, it would require the responsible person to adopt an evidence-led approach appropriate to the structure's risk profile.

Figure 18.1 – The Joshua Test: Lifecycle Assurance

FIGURE 18.1

THE JOSHUA TEST: LIFECYCLE ASSURANCE

Eight linked functions - not a single physical test.



The duty is to provide reasonable and proportionate assurance throughout service life, not an absolute guarantee against every possible failure.

1. The Proposed Joshua Duty

The central legislative provision should establish that:

Every person with responsibility for a residential fall-protection structure must take reasonable and proportionate steps to demonstrate, throughout its service life, that the structure remains capable of performing its intended fall-prevention function.

The duty should apply continuously rather than only:

- at construction;
- when the property changes ownership;
- after a complaint;
- following visible deterioration;
- when major works are planned; or
- after an incident has occurred.

The duty should require the responsible person to:

1. identify relevant fall-protection structures; 2. understand their design and construction; 3. assess their age, exposure and condition; 4. establish an appropriate inspection regime; 5. appoint competent persons where specialist assessment is required; 6. investigate evidence of deterioration; 7. complete remedial work within proportionate timescales; 8. retain relevant safety records; and 9. provide appropriate assurance to residents and regulators.

The legal test should focus upon whether the responsible person can demonstrate that reasonable and proportionate steps were taken, rather than whether one nationally prescribed engineering method was followed in every case.

2. Structures Within Scope

The proposed duty should apply to permanent structures whose principal or substantial purpose is to prevent a person from falling from one level to another.

These should include:

- guardrails;
- balustrades;
- balcony barriers;
- communal walkway railings;
- landing barriers;
- stair guarding;
- roof-edge protection provided for residents or visitors;
- parapets performing a fall-protection function;
- protective screens;
- barriers surrounding lightwells or voids;
- guarding around ramps and raised access areas; and
- comparable fixed systems intended to prevent falls from height.

The framework should be sufficiently broad to address differences in architectural terminology and construction type.

The legal definition should focus on the safety function of the structure rather than its name.

A structure should fall within scope where its failure, detachment, deformation or inadequacy could foreseeably result in a fall capable of causing death or serious injury.

3. Residential Buildings Within Scope

The Joshua Test should not be limited exclusively to high-rise or higher-risk buildings.

A fatal fall can occur from a building that does not meet the height or storey thresholds used elsewhere in building safety legislation.

The proposed duty should therefore be considered for:

- purpose-built blocks of flats;
- converted residential buildings;
- social housing;
- privately rented housing;
- leasehold developments;
- commonhold property;
- supported accommodation;
- student accommodation;
- mixed-use buildings containing homes;
- sheltered and retirement housing; and
- other multi-occupied residential premises containing communal fall-protection structures.

Government should also consider how the duty might apply to relevant structures serving an individual dwelling, particularly where the landlord or another person retains repair responsibility.

The application of the duty should be determined by the existence and risk profile of the fall-protection structure rather than solely by the height, tenure or ownership category of the building.

4. Identification of the Responsible Person

The success of the framework would depend upon clear legal responsibility.

In many residential buildings, ownership and management may be divided between:

- a freeholder;
- a head lessor;
- a housing association;
- a local authority;
- a resident management company;
- a right-to-manage company;
- a commonhold association;
- a managing agent;
- a facilities-management provider;
- an Accountable Person under the Building Safety Act; and
- contractors responsible for inspection or maintenance.

The primary duty should attach to the person or body with legal responsibility and practical control over the inspection, maintenance, repair or replacement of the structure.

Delegating work to a managing agent or contractor should not automatically transfer or extinguish the underlying legal duty.

The responsible person should remain required to ensure that:

- the work is properly specified;
- the appointed person is competent;
- reports are reviewed;
- defects are appropriately prioritised;
- remedial work is completed; and
- adequate records are retained.

Where responsibility is divided, the law should require cooperation and information sharing between relevant parties.

No fall-protection structure should be left without an identifiable dutyholder because of complex ownership or contractual arrangements.

5. A Risk-Based Approach

The Joshua Test should be proportionate.

It should not require every residential railing to undergo identical testing at identical intervals.

The level and frequency of inspection should reflect factors including:

- the height and potential consequence of a fall;
- the age of the structure;
- construction materials;
- design and connection details;
- environmental exposure;
- proximity to the coast or other corrosive environments;
- water penetration;
- evidence of cracking or concrete deterioration;
- the presence of hollow sections;
- the condition of protective coatings;
- previous repairs;
- alterations;
- impact damage;
- maintenance history;
- previous inspection findings;
- known defects in comparable structures;
- intensity of use;
- accessibility to residents and visitors; and
- the extent and reliability of available records.

A modern internal balustrade in a controlled environment may require a different inspection regime from an external steel guardrail that has been exposed to rain and pollutants for several decades.

The framework should allow professional judgement while requiring that the rationale for the inspection programme is recorded.

6. Proposed Inspection Hierarchy

The Joshua Test could establish a tiered inspection framework.

Level 1: Routine Observation

Routine observation could be undertaken by appropriately trained housing, estate or facilities staff during normal building inspections.

It should identify visible indicators such as:

- movement;
- looseness;
- missing components;
- impact damage;
- advanced rust;
- flaking or blistering coatings;
- cracking near fixings;
- gaps or distortion;
- damaged welds;
- water staining;

- exposed steel;
- deterioration of surrounding concrete; and
- reports from residents that a barrier moves or feels unsafe.

Routine observation would not amount to structural certification.

Its purpose would be to identify conditions requiring escalation.

Staff carrying out these checks should receive basic training on warning signs and reporting procedures.

Level 2: Competent Visual and Tactile Inspection

A competent inspection should be undertaken at a frequency determined by the structure's risk profile.

It may include:

- close visual examination;
- physical checks for movement;
- inspection of accessible fixings and connections;
- assessment of coatings;
- review of corrosion;
- examination of supporting substrates;
- consideration of water pathways;
- comparison with previous records;
- review of design and maintenance information; and
- identification of areas requiring specialist investigation.

The inspector should be capable of recognising when the limits of visual inspection have been reached.

Level 3: Detailed Specialist Investigation

A detailed investigation should be required where:

- deterioration is visible;
- the construction conceals critical components;
- records are absent or unreliable;
- movement has been reported;
- previous repairs are of uncertain quality;
- corrosion is suspected beneath coatings;
- connections are embedded within concrete;
- the structure is approaching or exceeding an expected service interval;
- similar structures have failed;
- visual inspection cannot establish condition; or
- the consequences of failure are particularly severe.

Specialist investigation may include:

- coating removal;
- opening-up works;
- ultrasonic thickness measurement;

- corrosion assessment;
- borescope inspection;
- examination of embedded fixings;
- concrete testing;
- weld inspection;
- dimensional surveys;
- material sampling;
- structural calculations; and
- other appropriate non-destructive or intrusive techniques.

Level 4: Structural Verification or Load Testing

Where the structure's residual capacity remains uncertain, structural verification may be required.

This may involve:

- engineering calculations;
- assessment against relevant loading criteria;
- proof testing;
- controlled load testing;
- assessment of connections and anchorage;
- modelling;
- testing of representative components; or
- replacement where testing would be unsafe or disproportionate.

Load testing should not be treated as universally necessary.

It should be used where justified by risk, uncertainty, design, condition and professional advice.

Testing must itself be properly planned so that it does not create an uncontrolled risk of failure.

7. Inspection Frequency

The legislation should establish the principle of periodic inspection while allowing technical guidance to determine appropriate intervals.

The interval should not be based upon time alone.

It should reflect:

- condition;
- age;
- exposure;
- material;
- construction;
- maintenance history;
- previous findings;
- consequence of failure; and
- level of uncertainty.

A possible model could include:

- an initial baseline assessment;
- routine observations during ordinary communal-area inspections;
- competent periodic inspection at risk-based intervals;
- shortened intervals where deterioration is identified;
- immediate reassessment after impact, alteration or significant building works; and
- specialist review following reports of movement, instability or damage.

Government should consult industry before establishing maximum intervals.

However, the framework should prevent a life-critical structure from remaining indefinitely without a recorded competent assessment.

8. Baseline Assessment

The introduction of the Joshua Test should require responsible persons to establish a baseline record of relevant structures.

The baseline assessment should identify:

- location;
- type;
- approximate age;
- material;
- design;
- dimensions;
- fixing arrangement;
- exposure;
- apparent condition;
- known alterations;
- available drawings;
- previous repairs;
- inspection history;
- identified hazards;
- risk classification; and
- proposed future inspection interval.

Where original design records are unavailable, the responsible person should record that uncertainty and consider whether further investigation is required.

The absence of historical documentation should not be treated as evidence that no risk exists.

In older buildings, missing information may itself justify a more cautious inspection strategy.

9. Competence Requirements

The inspection regime should clearly distinguish between different levels of competence.

A person carrying out routine observations need not possess the same qualifications as a structural engineer.

However, they must understand:

- the limits of their role;
- the warning signs requiring escalation;
- how to record defects;
- who should receive the report; and
- when immediate access restrictions may be necessary.

Specialist assessment should be undertaken by persons with demonstrable competence relevant to:

- structural engineering;
- façade engineering;
- corrosion;
- metallurgy;
- concrete repair;
- building pathology;
- testing;
- inspection of protective structures; or
- another relevant discipline.

Competence should include more than possession of a general professional title.

The responsible person should consider:

- qualifications;
- training;
- experience;
- professional registration;
- knowledge of the construction type;
- familiarity with deterioration mechanisms;
- ability to interpret test results; and
- independence from the original work where appropriate.

Government should consult professional institutions and industry bodies on an appropriate competency framework.

10. Condition Classification

Inspection findings should be recorded using clear and nationally consistent categories.

A possible classification system could include:

Category A: Satisfactory

No material defect identified.

The structure is suitable for continued use, subject to routine monitoring and the next scheduled inspection.

Category B: Satisfactory Subject to Monitoring

Deterioration or uncertainty is present but does not currently require repair.

The structure requires increased monitoring or a shortened inspection interval.

Category C: Remedial Work Required

Defects require repair within a specified period.

The inspector should state:

- the nature of the defect;
- the required action;
- the timescale;
- whether temporary controls are needed; and
- whether further investigation is necessary.

Category D: Further Investigation Required

The available inspection does not provide sufficient evidence to determine continuing structural safety.

Specialist investigation, testing or opening-up work is required.

The structure should not be recorded as satisfactory merely because its condition cannot be fully observed.

Category E: Unsafe

The structure presents an immediate or potentially imminent risk.

Required actions may include:

- restricting access;
- installing temporary protection;
- providing alternative routes;
- propping or stabilisation;
- notifying relevant authorities;
- urgent repair; or
- replacement.

The classification should reflect both current condition and the anticipated development of deterioration before the next planned inspection.

11. Remedial Action and Timescales

An inspection regime has limited value unless identified defects lead to action.

The responsible person should be required to:

- review inspection findings promptly;
- determine the appropriate response;
- prioritise work according to risk;
- implement temporary controls where necessary;
- commission further investigation;
- complete repairs within defined timescales;
- verify the quality of completed work; and
- update the building record.

Timescales should reflect the seriousness of the condition.

An unsafe structure may require immediate access restrictions and emergency intervention.

A developing but non-immediate defect may require planned repair before the next inspection cycle.

Minor maintenance may be incorporated within a scheduled works programme, provided the decision is properly justified and recorded.

Repeated deferral should not be permitted without a documented professional basis.

12. Quality Assurance of Repairs

Repairing a fall-protection structure should not be treated as complete merely because the contractor has attended or an invoice has been paid.

The responsible person should obtain evidence that:

- the defect was correctly diagnosed;
- the repair specification was appropriate;
- suitable materials were used;
- defective components were removed or treated;
- hidden deterioration was addressed;
- the work complied with the specification;
- connections were properly installed;
- protective coatings were correctly applied;
- any necessary testing was completed; and
- the structure was safe to return to service.

For higher-risk repairs, independent inspection or sign-off may be appropriate.

Photographic evidence, material records, test certificates and completion reports should form part of the building's continuing safety record.

13. The Fall-Protection Safety Record

Each relevant building should maintain a durable record for its fall-protection structures.

This record should contain:

- an asset register;
- location plans;
- photographs;
- available design drawings;
- materials and construction details;
- inspection dates;
- inspector identity and competence;
- inspection methodology;
- condition classifications;
- reports of resident concerns;
- maintenance records;
- repair specifications;
- contractor completion evidence;
- testing results;

- structural calculations;
- temporary safety measures;
- outstanding actions;
- next inspection dates; and
- reasons for any departure from the planned inspection programme.

The record should remain with the building when:

- ownership changes;
- management responsibility changes;
- a new contractor is appointed;
- a provider merges;
- a freehold is transferred; or
- the building becomes subject to a different management structure.

Records should be retained in an accessible and intelligible format.

Fragmented documents held across contractors, email accounts and legacy systems should not be accepted as adequate lifecycle assurance.

14. Resident Information and Transparency

Residents should not be expected to interpret technical engineering reports.

They should, however, have access to meaningful safety information.

This could include:

- the identity of the responsible person;
- the date of the most recent competent inspection;
- the type of inspection undertaken;
- the overall condition category;
- whether remedial action was required;
- whether that work has been completed;
- the date of the next review; and
- how to report movement, damage or other concerns.

Where a structure is subject to temporary restrictions or urgent works, residents should receive clear information about:

- the risk;
- affected areas;
- interim safety measures;
- expected next steps; and
- alternative access arrangements.

Transparency should not be treated as an optional communication exercise.

Residents are the people who rely upon these structures every day.

15. Resident Reporting

The framework should provide a clear route for residents to report concerns about fall-protection structures.

Reports should be capable of being made by:

- telephone;
- online form;
- email;
- emergency repair service;
- housing officer;
- caretaker; or
- another accessible route.

Reports involving movement, instability, missing sections, significant corrosion or impact damage should be assigned an appropriate safety priority.

Housing providers should avoid categorising all railing concerns as routine decorative or minor repair matters.

The system should identify safety-critical language and trigger escalation.

Residents should receive:

- confirmation that the report has been recorded;
- information about the response priority;
- an update following inspection;
- notice of temporary controls; and
- confirmation when the issue has been resolved.

Repeated reports about the same structure should be linked and reviewed collectively.

16. Contractor Responsibilities

Contractors carrying out painting, repairs, cleaning, refurbishment or other works may be among the people most likely to observe deterioration at close range.

Contracts should therefore require relevant contractors to report:

- severe corrosion;
- loose or missing fixings;
- movement;
- damaged welds;
- cracking;
- loss of section;
- deteriorated concrete;
- unsafe previous repairs; and
- any condition suggesting potential structural weakness.

A contractor instructed to paint a railing should not be expected to certify its structural integrity unless specifically competent and appointed to do so.

However, the contractor should be prohibited from concealing significant deterioration without reporting it.

Where preparation work exposes serious corrosion or damage, work should stop where necessary and the matter should be escalated.

The contractual reporting duty should be supported by:

- clear specifications;
- photographic records;
- escalation contacts;
- stop-work procedures;
- competent supervision; and
- protection for workers who raise safety concerns.

17. Interaction With Existing Law

The Joshua Test should complement, rather than replace, existing duties.

It should operate alongside:

- the Building Safety Act 2022;
- the Housing Act 2004;
- the Landlord and Tenant Act 1985;
- the Defective Premises Act 1972;
- social-housing consumer standards;
- Awaab's Law;
- building regulations;
- occupiers' liability legislation;
- health and safety legislation where applicable;
- leasehold and commonhold obligations; and
- contractual repair responsibilities.

The proposed duty would address a specific question not consistently answered by the current framework:

Can the responsible person produce current, proportionate and competent evidence that the fall-protection structure remains capable of performing its intended safety function?

A duty under one legal regime should not remove obligations arising under another.

Compliance with the Joshua Test should not provide an automatic defence where a person has otherwise acted negligently or breached an existing statutory duty.

18. Enforcement

The enforcement model should be proportionate and coordinated with existing regulatory structures.

Government should consider which bodies are best placed to enforce the duty, potentially including:

- local housing authorities;
- the Regulator of Social Housing;
- the Building Safety Regulator;
- local-authority building control;
- environmental health teams; and
- other relevant regulators.

Enforcement powers could include:

- requiring production of records;
- requiring an inspection;
- issuing improvement notices;
- setting remedial deadlines;
- restricting access to unsafe areas;
- commissioning emergency work;
- recovering costs;
- imposing civil financial penalties;
- regulatory downgrade or intervention; and
- prosecution in the most serious cases.

The enforcement framework should distinguish between:

- an administrative record-keeping failure;
- failure to complete a required inspection;
- failure to act on an identified defect;
- deliberate concealment;
- falsification of records; and
- conduct exposing residents to a serious risk of harm.

The objective should be to secure compliance and prevent harm, while retaining meaningful consequences for serious or persistent failure.

19. Proportionality for Smaller Landlords

The Joshua Test should apply consistently, but implementation must recognise differences in organisational scale.

Smaller landlords and resident-led management bodies may require:

- standardised templates;
- approved guidance;
- access to competent-person registers;
- model inspection specifications;
- shared procurement arrangements;
- transitional support;
- proportionate record-keeping systems; and
- clear thresholds for specialist escalation.

Proportionality should affect how the duty is fulfilled.

It should not determine whether residents are entitled to protection.

A person living in a building managed by a small organisation should not receive a materially lower standard of life-safety assurance.

20. Transitional Arrangements

Implementation should be phased.

A possible transitional programme could require responsible persons to:

1. identify all relevant structures; 2. create an initial asset register; 3. collect available historical records; 4. complete a preliminary risk classification; 5. prioritise structures presenting the greatest potential consequences; 6. commission baseline inspections; 7. develop inspection programmes; 8. complete urgent remedial actions; and 9. provide initial assurance information to residents.

Higher-priority structures could include those:

- at greater height;
- exposed to weather;
- of significant age;
- showing visible deterioration;
- with concealed fixings;
- with incomplete records;
- previously repaired;
- subject to resident reports; or
- forming part of a wider pattern of defects.

Government should allow a realistic implementation period while ensuring that known or suspected serious hazards are not deferred.

21. Technical Guidance and Standards

Primary legislation should establish the duty and core responsibilities.

Detailed technical expectations should be developed through statutory guidance, approved codes of practice or recognised standards.

This would allow the framework to respond to:

- new inspection technologies;
- improved understanding of corrosion;
- changing engineering standards;
- emerging failure patterns;
- new materials;
- digital building records; and
- professional practice.

Technical guidance should be developed in consultation with:

- structural engineers;
- façade engineers;
- corrosion specialists;
- housing providers;
- local authorities;
- the Regulator of Social Housing;
- the Building Safety Regulator;
- professional institutions;
- building surveyors;
- insurers;
- contractors;

- resident groups; and
- bereaved families with relevant lived experience.

The framework should not be designed solely by government or solely by industry.

Effective reform will require legal clarity, engineering expertise, operational experience and resident insight.

22. Proposed Statutory Principles

The legislation could be underpinned by the following principles:

Principle 1: Continuing Safety

Compliance at the time of construction does not remove the need to assess continuing safety.

Principle 2: Proportionality

Inspection and testing should reflect the structure's risk, age, condition and exposure.

Principle 3: Competence

Safety-critical decisions must be made by persons whose competence is appropriate to the task.

Principle 4: Evidence

The responsible person must retain reliable evidence of inspections, findings, repairs and outstanding actions.

Principle 5: Escalation

Visual uncertainty or evidence of deterioration must lead to appropriate specialist investigation.

Principle 6: Prevention

The system should identify and address deterioration before catastrophic failure occurs.

Principle 7: Accountability

Responsibility must remain clear despite complex ownership, management or contracting arrangements.

Principle 8: Transparency

Residents should receive meaningful information about the safety of the structures upon which they rely.

Principle 9: Continuity

Safety records should remain with the building throughout changes of ownership and management.

Principle 10: Learning

Failures, near misses and recurring defects should inform future inspection guidance and regulatory practice.

Conclusion

The Joshua Test would not require every railing to be subjected to the same test every year.

It would require something more fundamental:

A responsible person should be able to explain what has been inspected, by whom, using what method, what was found, what action was taken and why the evidence is sufficient to demonstrate continuing safety.

For well-managed structures in good condition, compliance may involve proportionate inspection and reliable records.

For older, exposed or deteriorating structures, it may require specialist investigation, engineering assessment or replacement.

The proposal is therefore neither a blanket testing regime nor a purely visual inspection requirement.

It is a framework of accountable, evidence-led and proportionate lifecycle assurance.

Its purpose is to ensure that the safety of a structure intended to prevent a fatal fall is actively demonstrated rather than passively assumed.

Chapter 19

Draft Residential Fall Protection (Inspection and Safety) Bill and Explanatory Notes

STATUS OF THIS DRAFT

This document is an illustrative draft Bill prepared by Fiona Jane Garrett MCIPR, Joshua's mum, on behalf of the No More Falls Campaign. It has been prepared to support policy discussion and consideration of legislative reform. It has not been introduced into Parliament and has not been drafted or approved by the Office of the Parliamentary Counsel.

EXPLANATORY NOTES

Explanatory Notes prepared by the No More Falls Campaign are included after the Schedules. They are intended to assist readers in understanding the purpose and intended effect of the illustrative draft provisions.

EUROPEAN CONVENTION ON HUMAN RIGHTS

No Ministerial statement has been made under section 19 of the Human Rights Act 1998 in relation to this illustrative draft. Human-rights considerations identified by the No More Falls Campaign are set out in the accompanying Explanatory Notes.

[ILLUSTRATIVE DRAFT]

A B I L L

TO

Establish duties relating to the inspection, maintenance and management of residential fall-protection structures; provide for the protection of residents from the risk of death or serious injury arising from structural failure; confer powers on the Secretary of State and designated regulators; and for connected purposes. BE IT ENACTED by the King's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

PART 1

PRELIMINARY

1 Short title

(1) This Act may be cited as the Residential Fall Protection (Inspection and Safety) Act (Date TBC). (2) This Act establishes the statutory framework to be known as The Joshua Test. 5

2 Purpose of the Act The purposes of this Act are— (a) to reduce the risk of death and serious injury arising from the failure of residential fall-protection structures; (b) to establish a statutory duty to inspect, maintain and manage such structures throughout their 10 operational life; (c) to promote consistency in inspection, maintenance and record keeping; (d) to improve accountability for the safety of residents; (e) to support national learning

arising from structural failures and near misses; and (f) to complement existing duties arising under building safety, housing and health and safety legislation.

3 Guiding principles Persons exercising functions under this Act shall have regard to the following principles— (a) prevention of harm is preferable to reactive intervention; (b) resident safety shall be the primary consideration; 20 (c) inspection shall be proportionate to foreseeable risk; (d) responsible persons shall demonstrate continuing structural safety; (e) regulatory action shall be evidence-based and proportionate; and (f) lessons arising from structural failures shall contribute to national improvement.

PART 2 25

INTERPRETATION

4 Definitions In this Act— “Relevant fall-protection structure” means any barrier, balustrade, parapet, guarding, handrail, balcony barrier, roof-edge protection, gallery barrier, retaining barrier, or other prescribed structure intended wholly or partly to prevent persons from falling from one level to another. “Relevant premises” means residential premises prescribed by regulations made under this Act. 30

2 Residential Fall Protection Bill Part 3—The Joshua Duty

“Responsible Person” means the person or organisation having responsibility for the inspection, maintenance or management of a relevant fall-protection structure and includes —

(a) a freeholder; (b) a landlord; (c) a registered provider of social housing; (d) a management company; 5 (e) an Accountable Person within the meaning of the Building Safety Act 2022; or (f) any other prescribed person. “Competent Person” means a person possessing the qualifications, knowledge, skills and experience appropriate to the inspection or work undertaken. “Emergency Hazard” means a condition presenting an imminent and significant risk of death or serious injury. “Significant Hazard” means a condition presenting a substantial foreseeable risk of serious injury if left unremedied.

PART 3

THE JOSHUA DUTY

5 General duty Every Responsible Person shall— (a) identify every relevant fall-protection structure under their control; 15 (b) ensure that each relevant structure remains capable of safely performing its intended protective function throughout its service life; (c) establish and maintain an inspection programme; (d) maintain prescribed records; (e) undertake appropriate maintenance; 20 (f) remedy identified defects within prescribed timescales; and (g) retain evidence demonstrating compliance with this Act.

6 Duty to inspect A Responsible Person shall ensure that every relevant fall-protection structure is inspected— (a) before first occupation where required by regulations; 25 (b) at intervals prescribed by regulations; (c) following significant repair or alteration; (d) following any serious incident affecting the structure; (e) where deterioration is suspected; or (f) following a resident report indicating a potential safety concern. 30 Inspection frequency shall be proportionate to the level of foreseeable risk.

7 Duty to maintain records Every Responsible Person shall maintain— (a) an asset register; (b) inspection records; 35 (c) engineering reports; (d) maintenance records; (e) repair histories; (f) photographic records; (g) risk assessments; and 40 (h) the date of the next required inspection. Records shall be retained for the period prescribed by regulations.

8 Resident reporting Responsible Persons shall establish arrangements enabling residents to report concerns relating to relevant fall-protection structures. Every report shall— 45 (a) be acknowledged; (b) be recorded; (c) be assessed within prescribed timescales; and (d) receive a written outcome.

PART 4 5

INSPECTION STANDARDS

9 Competence Inspection shall only be undertaken by persons possessing competence appropriate to the level of in- spection prescribed by regulations.

10 Regulations relating to inspection The Secretary of State may by regulations prescribe— 10 (a) inspection methodologies; (b) inspection frequencies; (c) competency requirements; (d) inspection classifications; (e) reporting standards; 15 (f) verification procedures; (g) digital record requirements; and (h) such other matters as are necessary for the effective operation of this Act.

11 Technical guidance In determining compliance with this Act, regard shall be had, where applicable, to— 20 (a) the Building Regulations 2010; (b) Approved Document K; (c) BS 6180 or any successor standard recognised by the Secretary of State; (d) relevant British Standards; (e) statutory guidance issued under this Act; and 25 (f) such other engineering guidance as may be prescribed.

PART 5

ENFORCEMENT

12 Improvement notices Where an authorised authority is satisfied that a Responsible Person has failed, or is likely to fail, to comply with this Act, it may serve an Improvement Notice specifying—

(a) the nature of the failure; (b) the action required; (c) the period within which compliance must be achieved; and (d) any interim protective measures required.

13 Emergency notices 35 Where an Emergency Hazard exists, an authorised authority may— (a) prohibit or restrict access; (b) require emergency works; (c) require temporary protective measures; (d) require evacuation where necessary; and 40 (e) take such other steps as are reasonably necessary to protect life.

4 Residential Fall Protection Bill Part 8—Regulations

14 Information notices An authorised authority may require the Responsible Person to provide— (a) inspection reports; (b) maintenance records; (c) engineering assessments; 5 (d) drawings; (e) photographs; (f) contracts; (g) asset registers; and (h) such other information as may reasonably be required. 10

PART 6

OFFENCES

15 Offences A Responsible Person commits an offence where, without reasonable excuse, they— (a) fail to comply with an Improvement Notice; 15 (b) knowingly or recklessly provide false information; (c) falsify inspection records; (d) obstruct an authorised inspector; (e) knowingly conceal a serious structural defect; or (f) fail to comply with an Emergency Notice. 20

16 Corporate liability Where an offence under this Act is committed by a body corporate, and is proved to have been committed with the consent, connivance or neglect of a director, manager, secretary or similar officer, that individual as well as the body corporate shall be guilty of the offence.

PART 7

NATIONAL LEARNING

17 National incident reporting 25 Serious incidents and prescribed near misses involving relevant fall-protection structures shall be reported to the designated regulator in accordance with regulations.

18 National incident database The designated regulator shall establish and maintain a national database of prescribed incidents for the purpose of identifying systemic risks and promoting public safety.

19 National safety alerts Where the designated regulator considers that a systemic risk exists, it may issue a National Safety Alert requiring specified classes of Responsible Person to undertake prescribed actions.

20 Prevention of Future Deaths Reports Where a coroner issues a Prevention of Future Deaths Report concerning a relevant fall-protection structure, the designated regulator shall review the report and determine whether changes to guidance, regulation or enforcement practice are required.

PART 8

REGULATIONS

21 Regulation-making powers The Secretary of State may make regulations concerning— (a) inspection frequencies; (b) competency standards; (c) prescribed structures; 5 (d) prescribed premises; (e) record keeping; (f) reporting requirements; (g) enforcement procedures; (h) exemptions; 10 (i) transitional arrangements; and (j) any other matter necessary for giving effect to this Act. Regulations under this section shall be made by statutory instrument.

PART 9

TRANSITIONAL ARRANGEMENTS 15

22 Existing buildings The Secretary of State shall make regulations providing for the phased implementation of this Act in relation to buildings completed before commencement.

23 Existing inspection systems A Responsible Person operating an inspection system that substantially achieves the objectives of this Act may rely upon that system where it complies with regulations made under this Act.

PART 10 20

COMMENCEMENT, EXTENT AND REVIEW

24 Commencement This Act shall come into force on such day or days as the Secretary of State may by regulations appoint. Different provisions may be brought into force on different dates.

25 Extent 25 This Act extends to England. The Secretary of State may make provision for corresponding or similar arrangements to be agreed with the devolved administrations, subject to legislative competence.

26 Review The Secretary of State shall— (a) undertake a review of the operation of this Act no later than three years after full commencement; 30 and (b) thereafter conduct reviews at intervals not exceeding five years. A report of each review shall be laid before Parliament.

6 Residential Fall Protection Bill Schedule 1—Relevant Fall-Protection Structures

SCHEDULE 1

RELEVANT FALL-PROTECTION STRUCTURES

The following structures are indicative of those to which this Act applies— (a) balcony guarding; (b) balustrades; 5 (c) parapets; (d) roof-edge protection; (e) external access gallery barriers; (f) communal walkway barriers; (g) stair guarding; 10 (h) ramp guarding; (i) raised podium guarding; (j) retaining barriers adjacent to level changes; (k) guarding to light wells and basement areas; and (l) such other prescribed structures as regulations may specify. 15

Residential Fall Protection Bill Schedule 2—Matters to be Prescribed by Regulations 7

SCHEDULE 2

MATTERS TO BE PRESCRIBED BY REGULATIONS

Regulations made under this Act may prescribe— (a) inspection methodologies; (b) inspection intervals; 5 (c) competency requirements; (d) inspection classifications; (e) digital asset records; (f) resident reporting procedures; (g) verification standards; 10 (h) enforcement procedures; (i) forms and notices; (j) record retention periods; (k) technical guidance; (l) prescribed standards; and 15 (m) transitional provisions.

Residential Fall Protection (Inspection and Safety) Bill

EXPLANATORY NOTES

ILLUSTRATIVE DRAFT

These Explanatory Notes relate to the draft Residential Fall Protection (Inspection and Safety) Bill, referred to throughout the White Paper as The Joshua Test. They have been prepared by the No More Falls Campaign to assist readers in understanding the purpose and intended effect of the illustrative draft provisions.

Prepared by Fiona Jane Garrett MCIPR (Joshua's Mum)

No More Falls Campaign

2 Residential Fall Protection Bill— Explanatory Notes

Introduction

(1) These Explanatory Notes relate to the draft Residential Fall Protection (Inspection and Safety) Bill, referred to throughout this White Paper as The Joshua Test. (2) They have been prepared to assist readers in understanding the purpose and intended effect of the draft Bill. (3) They do not form part of the Bill and are not intended to be a comprehensive description of every provision. (4) The draft Bill is intended to illustrate how the recommendations contained within this White Paper could be translated into primary legislation. Should Government decide to proceed with legislation, the Bill would require further refinement through consultation and drafting by the Office of the Parliamentary Counsel.

Commentary on Part 1 — Preliminary

Clause 1 — Short title This clause provides the formal title of the proposed Act and recognises “The Joshua Test” as the name of the statutory framework.

The policy has been given a formal legislative title while retaining the campaign identity, following the approach adopted with measures such as Awaab’s Law.

Clause 2 — Purpose This clause establishes the principal objectives of the legislation.

It makes clear that the Act is preventative in nature and is intended to improve inspection, maintenance, accountability and national learning rather than simply increasing regulation.

Clause 3 — Principles This clause sets out the guiding principles that should inform interpretation of the Act.

It recognises that resident safety should remain the overriding consideration and that prevention should take precedence over reactive intervention.

Commentary on Part 2 — Interpretation The definitions are intentionally broad.

Detailed technical definitions should be capable of amendment through regulations rather than requiring primary legislation whenever standards evolve.

The Bill therefore provides core statutory definitions while allowing Government flexibility to prescribe further detail.

Commentary on Part 3 — The Joshua Duty This Part creates the central statutory obligation.

Rather than requiring responsible persons to demonstrate that a structure complied with standards at the time it was constructed, the Bill requires them to demonstrate continuing structural safety throughout the operational life of the asset.

This represents the principal policy innovation contained within The Joshua Test.

Clause 5 — General duty The clause establishes a positive duty to—

(a) identify; (b) inspect; (c) maintain; (d) repair; and (e) evidence compliance. It is intentionally framed as a continuing duty rather than a one-off obligation.

Clause 6 — Inspection Inspection frequency is not prescribed within the Bill.

Instead, Parliament delegates this technical matter to secondary legislation.

This approach allows inspection intervals to evolve alongside engineering knowledge and future revisions of British Standards without requiring amendment of primary legislation.

Clause 7 — Record keeping The Bill recognises that effective inspection depends upon reliable information.

Asset registers and inspection records therefore become statutory evidence rather than simply good practice.

Clause 8 — Resident reporting Residents are frequently the first people to identify deterioration.

The legislation therefore requires a structured reporting system that ensures concerns are acknowledged, assessed and recorded.

Commentary on Part 4 — Inspection Standards This Part intentionally avoids prescribing detailed engineering methodology.

Instead, the Bill enables technical requirements to be established through regulations and statutory guidance.

This reflects the approach commonly adopted within modern health and safety legislation.

Clause 11 — Technical guidance The clause recognises existing standards including—

(a) Building Regulations; (b) Approved Document K; (c) BS 6180; and (d) future successor standards. Importantly, the legislation does not make BS 6180 itself law.

Rather, compliance should be informed by recognised technical guidance while maintaining flexibility as standards develop.

Commentary on Part 5 — Enforcement The enforcement provisions provide regulators with graduated powers.

These range from improvement notices through to emergency intervention where life is at immediate risk.

The policy seeks proportionate enforcement rather than automatic criminalisation.

Commentary on Part 6 — Offences The offences focus upon serious misconduct including—

(a) deliberate concealment; (b) falsification; (c) obstruction; and (d) reckless non-compliance. The intention is not to criminalise genuine professional judgement or reasonable error.

Commentary on Part 7 — National Learning This Part represents one of the most significant innovations within the legislation.

Current systems frequently investigate incidents individually.

The Joshua Test requires national learning so that failures identified in one building contribute to improved safety across the wider housing stock.

Prevention of Future Deaths Reports The Bill places statutory emphasis upon learning from coronial investigations.

Rather than allowing Prevention of Future Deaths Reports to remain isolated documents, the designated regulator must consider whether they indicate wider systemic risks requiring national action.

Commentary on Part 8 — Regulation-Making Powers Technical matters are delegated to secondary legislation.

This provides flexibility while maintaining Parliamentary oversight through statutory instruments.

It also enables Government to respond more quickly to technological developments and future revisions of engineering standards.

Commentary on Part 9 — Transitional Arrangements The legislation recognises that implementation will require time.

The transitional provisions enable responsible persons to prepare while ensuring that identified life-

4 Residential Fall Protection Bill— Explanatory Notes

threatening risks remain subject to immediate intervention.

Commentary on Part 10 — Commencement and Review The staged commencement powers allow Government to introduce the Act in phases.

The mandatory review provisions ensure Parliament can evaluate whether the legislation has achieved its intended objectives and whether amendment is required.

Human Rights Considerations It is anticipated that the draft Bill would engage rights protected under the European Convention on Human Rights, including—

(a) Article 2 (Right to Life); (b) Article 8 (Respect for Private and Family Life); and (c) Article 1 of Protocol 1 (Peaceful Enjoyment of Possessions). The Bill has been drafted on the basis that any interference with property rights would pursue the legitimate aim of protecting life and would be proportionate to that objective.

A full compatibility assessment should accompany any Government Bill introduced into Parliament.

Equality Considerations The proposal is expected to provide positive benefits for—

(a) older people; (b) disabled residents; (c) children; (d) vulnerable adults; and (e) residents of higher-risk accommodation. The legislation applies irrespective of tenure, ensuring equivalent protection for social housing tenants, lease- holders and private renters.

Financial Effects The principal financial implications arise from—

(a) inspection; (b) record keeping; (c) competency; (d) maintenance; and (e) regulatory implementation. These costs are expected to be proportionate and offset by reductions in emergency interventions, litigation, serious incidents and long-term remediation.

Impact on Public Sector Resources Implementation will require—

(a) preparation of regulations; (b) publication of guidance; (c) regulator training; (d) digital reporting systems; and (e) oversight arrangements. The White Paper concludes that these demands are proportionate and compatible with the existing building safety regulatory framework.

Territorial Extent The draft Bill has been prepared primarily for England, recognising that housing and building safety are devolved matters in other parts of the United Kingdom.

However, the policy principles could be adapted by the devolved administrations should they wish to introduce equivalent legislation.

Chapter 20

Regulatory Impact, Equality and Human Rights Considerations

This chapter records the principal cross-cutting impact considerations identified in the illustrative Bill's Explanatory Notes. Detailed economic analysis is contained in Chapter 14.

Human Rights Considerations It is anticipated that the draft Bill would engage rights protected under the European Convention on Human Rights, including—

(a) Article 2 (Right to Life); (b) Article 8 (Respect for Private and Family Life); and (c) Article 1 of Protocol 1 (Peaceful Enjoyment of Possessions). The Bill has been drafted on the basis that any interference with property rights would pursue the legitimate aim of protecting life and would be proportionate to that objective.

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(a) preparation of regulations; (b) publication of guidance; (c) regulator training; (d) digital reporting systems; and (e) oversight arrangements. The White Paper concludes that these demands are proportionate and compatible with the existing building safety regulatory framework.

20.1 Government assessment before introduction

Any Government Bill would require its own formal equality, human-rights and regulatory impact assessment. Particular attention should be given to proportionality, accessibility, the distribution of costs, provider capacity and interaction with existing statutory regimes.

PART VI

RECOMMENDATIONS AND CONCLUSION

The decisions invited of Government and Parliament.

Chapter 21

Recommendations to Government and Parliament

Recommendations to Government

The evidence presented throughout this White Paper demonstrates that the United Kingdom has a robust regulatory framework governing the design and construction of buildings, but a significant gap remains in relation to the ongoing inspection, maintenance and verification of residential fall-protection structures throughout their operational life.

The Government is therefore invited to consider the following recommendations.

Recommendation 1 – Introduce The Joshua Test

Introduce primary legislation establishing The Joshua Test, creating a statutory duty for Responsible Persons to demonstrate the continuing structural safety of residential fall-protection structures throughout their lifecycle.

Recommendation 2 – Establish a Mandatory Inspection Regime

Introduce regulations requiring periodic inspection of prescribed residential fall-protection structures using a risk-based framework proportionate to the age, construction, environment and condition of each asset.

Recommendation 3 – Require Competent Inspection

Require inspections to be undertaken only by suitably competent persons, with nationally recognised competency standards and continuing professional development requirements.

Recommendation 4 – Create National Inspection Standards

Develop statutory guidance and a national Code of Practice setting out minimum inspection methodologies, reporting standards, record-keeping requirements and verification procedures.

Recommendation 5 – Introduce Digital Asset Registers

Require Responsible Persons to maintain comprehensive digital records for all prescribed fall-protection structures, including inspection histories, maintenance records, repairs, photographs, engineering reports and future inspection schedules.

Recommendation 6 – Strengthen Resident Reporting

Require landlords and Responsible Persons to establish accessible reporting systems enabling residents to report concerns relating to structural safety, with mandatory acknowledgement, investigation and response times.

Recommendation 7 – Improve Regulatory Coordination

Strengthen collaboration between the Building Safety Regulator, local authorities, the Regulator of Social Housing, the Housing Ombudsman and other relevant bodies to promote consistent oversight and effective enforcement.

Recommendation 8 – Establish a National Incident Database

Create a central database for recording structural failures, dangerous occurrences and significant near misses involving residential fall-protection structures, enabling trend analysis and proactive intervention.

Recommendation 9 – Embed Learning from Prevention of Future Deaths Reports

Require systematic review of relevant Prevention of Future Deaths Reports and ensure lessons are translated into regulatory guidance, inspection practice and national safety alerts.

Recommendation 10 – Review Existing Guidance

Undertake a comprehensive review of Approved Document K, BS 6180 and associated guidance to ensure they adequately address the long-term management of existing residential fall-protection structures.

Recommendation 11 – Support Research and Innovation

Promote research into deterioration mechanisms, inspection technologies, non-destructive testing methods and digital asset management to improve future building safety.

Recommendation 12 – Place Residents at the Centre of Building Safety

Recognise residents as key partners in identifying risk and ensure they are provided with clear information regarding inspection programmes, maintenance responsibilities and safety reporting arrangements.

Strategic Recommendation

The Government should adopt a preventative approach to residential fall-protection safety by introducing a lifecycle regulatory framework that prioritises early identification of deterioration, proportionate inspection, transparent record-keeping and continuous national learning.

The Joshua Test provides a practical framework capable of delivering these objectives while complementing existing building safety legislation.

Chapter 22

Conclusion

The death of Joshua Robbins was a profound personal tragedy. It also raises wider questions about how the safety of residential fall-protection structures is managed throughout the life of a building.

This White Paper has not sought to determine legal liability or comment on the circumstances of any individual case. Those matters are rightly the responsibility of the courts, coroners and investigating authorities. Instead, it has examined the broader regulatory landscape and considered whether existing systems provide sufficient assurance that barriers, balustrades and similar structures remain safe long after they are constructed.

The evidence suggests that, while the United Kingdom possesses strong standards governing design and construction, there is no single statutory framework requiring Responsible Persons to demonstrate the continuing structural integrity of residential fall-protection structures throughout their operational life. As buildings age, materials deteriorate, environmental conditions change and maintenance records become fragmented, increasing the importance of robust inspection and verification.

The Joshua Test has been developed as a proportionate response to that gap. It does not seek to replace existing legislation or duplicate established engineering standards. Rather, it provides a coherent lifecycle framework that integrates inspection, maintenance, record-keeping, accountability and national learning into a single preventative system.

The recommendations contained within this White Paper are intended to complement the existing building safety regime and support the Government's wider commitment to protecting residents in higher-risk buildings and improving public confidence in housing safety.

The central principle is straightforward: those responsible for residential fall-protection structures should be able to demonstrate, through evidence rather than assumption, that those structures remain safe throughout their service life.

If adopted, The Joshua Test would represent a significant step towards a more preventative, transparent and accountable approach to building safety. It would honour the memory of Joshua Robbins not only through legislative reform, but by helping to reduce the likelihood of similar tragedies in the future.

Glossary

Term Definition

Accountable Person Person with statutory responsibilities under the Building Safety Act 2022.

Approved Document K

Statutory guidance supporting compliance with Requirement K2 of the Building Regulations.

Asset Register A documented inventory of relevant fall-protection structures and associated inspection records.

Balustrade A protective barrier designed to prevent falls from changes in level.

BS 6180 British Standard providing recommendations for barriers and guarding in buildings.

Building Safety Regulator

National regulator responsible for higher-risk building safety in England.

Competent Person Individual possessing appropriate qualifications, knowledge, skills and experience.

Corrosion Deterioration of metal resulting from chemical or environmental processes.

Lifecycle Management

Ongoing inspection, maintenance and management throughout the operational life of an asset.

Near Miss An incident that could reasonably have resulted in death or serious injury but did not.

Non-Destructive Testing (NDT)

Inspection techniques that assess structural condition without damaging the asset.

Prevention of Future Deaths Report

A report issued by a coroner under Schedule 5 to the Coroners and Justice Act 2009 where action may be needed to prevent future deaths.

Responsible Person Person or organisation with responsibility for inspection, maintenance or management of relevant structures under the proposed legislation.

Risk-Based Inspection

Inspection frequency determined by the level of foreseeable risk rather than fixed intervals alone.

Structural Integrity The ability of a structure to safely perform its intended function.

The Joshua Test The proposed statutory framework for the lifecycle inspection and safety management of residential fall-protection structures.

Bibliography

Primary Legislation

- Building Act 1984.
- Building Safety Act 2022.
- Building Regulations 2010.
- Health and Safety at Work etc. Act 1974.
- Housing Act 2004.
- Regulatory Reform (Fire Safety) Order 2005.
- Coroners and Justice Act 2009.

Statutory Guidance

- Approved Document K: Protection from Falling, Collision and Impact.
- Approved Document B: Fire Safety.
- Building Safety Regulator Guidance.
- Regulator of Social Housing Consumer Standards.

British Standards

- BS 6180:2011 – Barriers in and about buildings.
- Relevant British Standards relating to structural inspection, corrosion assessment and maintenance (as applicable).

Government Publications

- Ministry of Housing, Communities and Local Government publications.
- Building Safety Regulator policy documents.
- National Audit Office reports relating to building safety (where relevant).

Independent Reports

- Grenfell Tower Inquiry reports.
- Relevant Housing Ombudsman reports.
- Relevant Prevention of Future Deaths Reports concerning structural failures.

Case Law

- Relevant case law concerning occupiers' liability, negligence, corporate manslaughter, building safety and structural failures.

Academic and Technical Literature

- James C. Patterson, Beyond the Five Whys.
- Peer-reviewed literature on structural deterioration, corrosion, inspection methodologies and asset management.

Expert and Stakeholder Contributions

- Hughes, Wayne (HQN). Written review of draft barrier-safety and cost-analysis papers, 12 August 2026. Asset-management, regulatory and financial-planning observations. The review was not a structural-engineering opinion and did not constitute endorsement of the final White Paper.

PART VII

SUPPORTING MATERIAL

Technical figures and source evidence retained for the editorial audit.

Appendix Figure 1 – Typical Residential Fall-Protection Structures

APPENDIX FIGURE 1**TYPICAL RESIDENTIAL FALL-PROTECTION STRUCTURES**

Functional examples potentially within scope; final statutory scope would require consultation.

	BALCONY GUARDING Protective barriers at balcony edges.
	COMMUNAL WALKWAY BARRIERS Guarding to external access decks and galleries.
	STAIR AND LANDING GUARDING Protection at stairs, landings and open edges.
	ROOF / TERRACE GUARDING Permanent guarding at accessible roofs and terraces.
	PODIUM / RAMP EDGE PROTECTION Barriers at raised podiums, ramps and level changes.
	LIGHT-WELL / BASEMENT GUARDING Protection around openings and lower-level drops.
	PARAPETS Solid or partially solid edge protection where functioning as fall prevention.
	COMPARABLE PROTECTIVE BARRIERS Other permanent structures whose principal safety function is to prevent a fall from height.

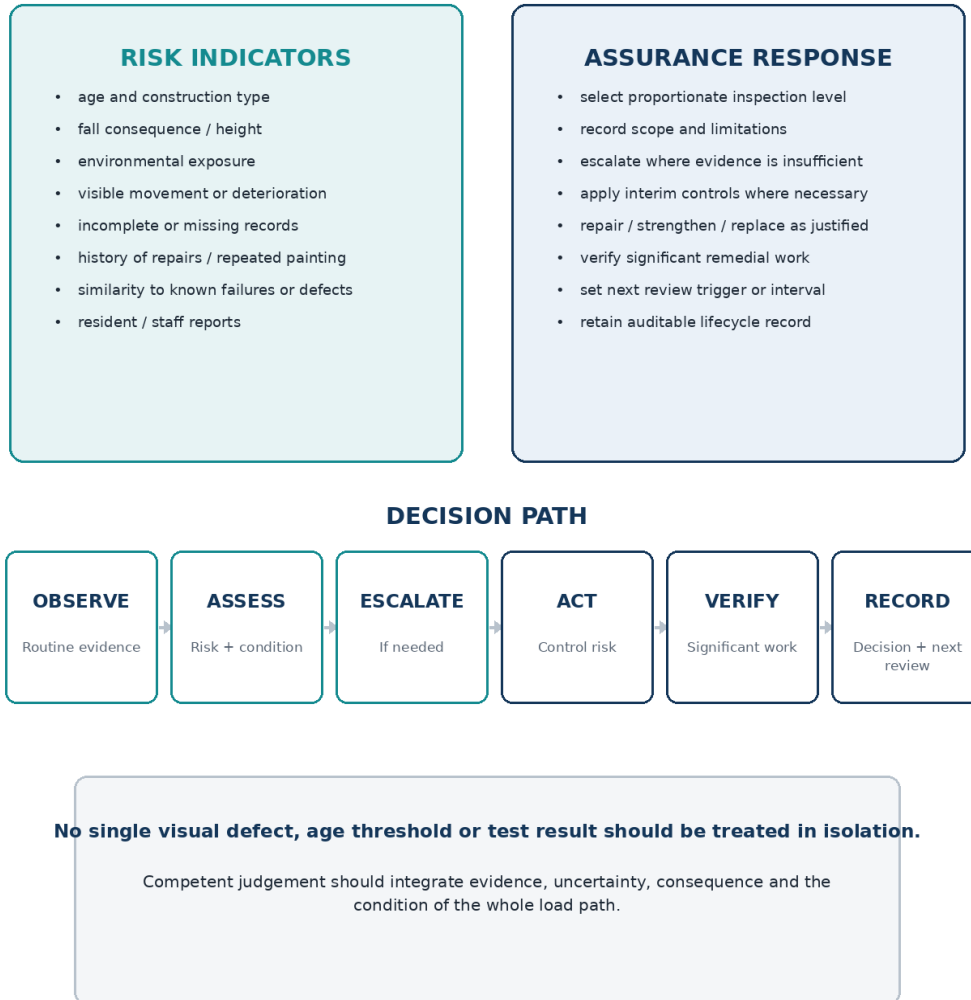
Scope should follow protective function and consequence of failure, not terminology alone.

Appendix Figure 2 – Risk-Based Assurance Summary

APPENDIX FIGURE 2

RISK-BASED ASSURANCE SUMMARY

A practical decision framework for inspection, escalation and records



Appendix A – Source Evidence Register

The following detailed papers were retained as source material for the consolidated manuscript. They are not reproduced in full where their substance is represented in the main White Paper, in order to control duplication.

- Legislative and Regulatory Options.pdf
- Governance, Oversight and Enforcement.pdf
- Resident Rights, Engagement and Transparency.pdf
- Professional Competence, Inspection Methodology and Technical Standards.pdf
- Data, Record Keeping and the Golden Thread.pdf
- Incident Reporting, Investigation and National Learning.pdf
- Risk Classification, Inspection Frequency and Remediation Timescales.pdf
- Procurement, Contracting and Supply Chain Accountability.pdf
- Funding, Financial Responsibility and Protection From Unaffordable Costs.pdf
- Legal Enforcement, Resident Remedies and Access to Justice.pdf
- Scope, Definitions and Buildings Covered.pdf
- Implementation, Costs and Proportionality.pdf
- Regulatory Architecture, Inspection Powers and Enforcement Thresholds.pdf

These papers should remain available during the final legal, technical and references audit so that unique evidence is not lost when duplication is removed.

End of Master Manuscript



Editorial status: consolidated source edition. The next pass should remove duplication, verify current law and technical references, standardise terminology against the glossary, complete source citations and apply final parliamentary typesetting.