

Research summary

Building Safety Regulator: Insight into high-rise residents with disabilities

Insight and Service Design Team, Health and Safety Executive
Research conducted by Kantar Public

April 2023



Contents

Commissioning	2
Background and objectives	3
Business context	3
Research objectives	3
Research methodology	4
Phase one	4
Phase two	4
Main findings	6
Context for disabled residents and those with a long-term health condition	6
Experiences of high-rise living	7

Commissioning

This report summarises the findings of a qualitative research study conducted by Kantar Public between 1st November 2022 and 29th March 2023. The research was commissioned by the Insight and Service Design team in the Health and Safety Executive (HSE). The contents of the report, including any opinions and/or conclusions expressed, are the views of the agency alone and do not necessarily represent the views of the Health and Safety Executive.

Background and objectives

Business context

Following the Grenfell Tower tragedy in 2017, the Government commissioned an Independent Review of Building Regulations and Fire Safety led by Dame Judith Hackitt. This review found that the current system for ensuring fire and structural safety in high-rise residential buildings was not fit for purpose and made 53 recommendations as part of the Building Safety Act (BSA) to address these failings. One of these was to establish a new, independent Building Safety Regulator (BSR), coming into force in 2023, to ensure that residents of higher-risk buildings (HRBs) are safe, and feel safe, in their homes.

Section 4 of the Building Safety Act explicitly states that BSR must facilitate and secure the safety of disabled people in HRBs. This is because the presence of a disability, or long-term health condition, is likely to have implications for both day-to-day safety (e.g. the ability to raise concerns) as well as safety related emergencies (e.g. the evacuation of a building).

Research objectives

A two-phased qualitative research project was commissioned to help identify the experiences and requirements of disabled residents, and those with long-term health conditions, living in HRBs so that BSR services and interventions can be designed to ensure these residents feel safe and are safe in their homes.

Research methodology

Phase one

Phase one involved a review of existing insight on residents with disabilities living in HRBs¹. Additionally, nine 60-minute online depth interviews with stakeholders within organisations related to social housing or disabilities were conducted.

This phase aimed to understand the profile of the disabled resident population and the extent to which their knowledge, attitudes, and behaviours differ from that of the broader HRB resident population.

It also aimed to identify from stakeholders good practice principles in relation to engaging with, and running services for, disabled users.

Participants were:

- 1 pan-disability stakeholder (Disability Rights UK)
- 3 disability-specific stakeholders representing sight and hearing loss (Visualise Training and Consultancy); mental health conditions (Give us a Shout); and learning disabilities and autism (SeeAbility)
- 2 national government representatives (Cabinet Office and Buro Happold - Government Champion for Disability in the Built Environment)
- 1 occupational therapist operating in the community
- 2 internal stakeholders representing the HSE carers and disability networks

A number of stakeholders had their own lived experience of living with a disability or long-term health condition, or caring for someone with a condition.

Phase two

Phase two involved 20 in-depth interviews with disabled HRB residents and those with long-term health conditions; and four interviews with carers (both paid and non-paid) of disabled HRB residents.

¹ Underpinning Resident Insight Research, BMG and Kantar Public, September 2022: [Insight into High-Rise Building Residents Research Summary \(hse.gov.uk\)](https://www.hse.gov.uk/research/summary/building-residents-research-summary/)

Participants self-identified their conditions from four broad health categories:

- Mobility-related and physical impairments (e.g. partial paralysis, rheumatoid arthritis)
- Sensory loss or impairments (e.g. sight loss, hearing loss, Ménière disease)
- Mental health conditions (e.g. post-traumatic stress disorder, anxiety)
- Neurodivergent disorders (e.g. dyslexia, autism spectrum disorder)

Participants were recruited to include a spread in terms of the severity of their disability/condition and the length of time they had lived with the condition. Nineteen of the interviews were conducted online (90 minutes). A further five were conducted face-to-face at participants' homes (120 minutes), incorporating an ethnographic element in which the interviewer took photographs of aspects of the participant's flat or building that contributed to or hindered feelings of safety.

Interviews explored experiences of high-rise living, including feelings of safety, access to building safety information, experiences of raising and resolving issues with building managers and the impact of the residents' conditions on day-to-day living and in an emergency situation. By exploring these experiences, the research sought to understand the barriers that limit disabled residents' ability to feel safe and engage with building safety.

Main findings

Context for disabled residents and those with a long-term health condition

Research with HRB residents found that 38% of residents report themselves as living with a disability or long-term health condition² which, based on an estimated 1.3 million residents living in HRBs, equates to nearly half a million people³ (494,000). The research highlighted that this group of HRB residents are more likely to be social renters, longer-term residents, older than the wider HRB population, and to live alone. They are also less likely to be in work or education, or to be users of the internet.

Stakeholder interviews during phase one corroborated these findings indicating that, from experience, those with impairments or health conditions were more likely to have lower educational attainment levels, low employment rates, as well as lower rates of wellbeing. They stated that these characteristics would create a broader set of considerations for housing, safety and communication.

In considering communication and interaction needs, stakeholders recognised and pointed to the fact that individuals do not always identify with certain language around disability. For instance, some groups tend not to identify as disabled at all (e.g. those who are neurodiverse), others link themselves specifically to their own condition and use terminology to reflect this (e.g. “I am profoundly deaf” or “I have dyspraxia”); whilst those who acquire an impairment later in life typically consider themselves to have a loss of function rather than a disability. Stakeholders elaborated that a rejection of language may also occur due to negative associations and/or demeaning experiences, possibly stemming from an overall perception that society discriminates against those who are seen as ‘different’. As a result, they reiterated that language used in communications should be neutral to reflect this; and designed to work for all to reflect the broader considerations outlined (e.g. be simple, jargon-free, and involve choice in terms of accessibility).

The findings from phase two of the research indicated that nearly half of the 20 participants interviewed were living with multiple conditions/disabilities from the four broad

² Underpinning Resident Insight Research, BMG and Kantar Public, September 2022: [Insight into High-Rise Building Residents Research Summary \(hse.gov.uk\)](https://www.hse.gov.uk/research/insights/articles-and-features/insight-into-high-rise-building-residents-research-summary/)

³ This is based on 12.5k buildings, an estimated average of 55 dwellings per building and 1.9* residents per dwelling – taken from analysis of DLUHC's Tall Buildings Dataset of in-scope buildings (18m or above), September 2021

* This figure was obtained from the English Housing Survey (2017-18, page 14, para 1.31)

categories, and that many had additional long-term ailments including respiratory and autoimmune conditions, as well as progressive illnesses, such as cancer.

Residents reported that day-to-day living was impacted by their condition/disability in a variety of ways, for instance physical and mental fatigue, movement, and anxiety; and, for some residents, high-rise living further exacerbated this. Examples cited included:

- Poor maintenance of lifts made it challenging for residents with mobility-related and physical impairments to leave their flats, climb stairs and receive deliveries
- Inadequate facilities such as entry systems with no video/visual alerts meant profoundly deaf residents were unable to use them
- Living on higher floors intensified feelings of isolation, low mood, and anxiety for those with mental health conditions, as well as perpetuating phobias and suicidal thoughts
- Long corridors and multiple floors led to confusion in terms of navigation for those with neurodivergent disorders. And increased noise levels required people to control their sensory environment using means such as noise-cancelling headphones.

Although findings from the mainstage research⁴ highlighted that people with mobility or sensory impairments felt as safe from fire and structural risks as non-disabled residents, it showed that those with mental health issues and learning difficulties were *less* likely to feel safe in their high-rise homes.

Experiences of high-rise living

Feelings of safety

Findings from the mainstage research⁵ demonstrated that feelings of safety amongst the broad HRB resident population were most linked to building security and amenity issues, rather than fire and structural safety. The findings from the current research, however, were somewhat different in that residents with a disability primarily associated feelings of safety with fire safety, evacuation plans, and means of escape. The presence or absence of safety systems and procedures, such as emergency lighting, sprinkler systems and visual fire alarms, was seen as an important influencer of feelings of safety, as was living on lower floors.

Responsive building staff on-site also increased feelings of safety. Disabled residents/those with a long-term health condition felt that a responsive concierge or caretaker could genuinely understand them as a person, particularly in relation to their

⁴ Underpinning Resident Insight Research, BMG and Kantar Public, September 2022: [Insight into High-Rise Building Residents Research Summary \(hse.gov.uk\)](#)

⁵ Ibid

condition/disability, offer an important human connection, and play a vital role in informing Fire and Rescue Services of any support requirements in case of an emergency.

In addition to this, a sense of community within a building bolstered feelings of safety for some residents, reducing isolation and low mood; offering a feeling of support when individuals may require it, and providing the possibility of assistance in an emergency to ensure that residents would 'not be forgotten.' Some residents described how community events, informal get-togethers and WhatsApp groups fostered a sense of community.

Building information

People with sensory loss or mental health and neurodivergent conditions reported additional barriers to accessing and processing building information. For example, a British Sign Language (BSL) user, for whom English was a second language, reported difficulty in understanding English because BSL has its own grammatical structure and syntax that differs to English.

Those with mental health conditions and carers also stated that digital information inhibited how they or the person they cared for could engage with building information. In these cases, printed information or in-building notices were preferred as this was seen to enable easier access to information and a more convenient means for referring back to information when needed.

Overall, however there was a lack of clear pattern in resident preferences for accessing information, which varied widely across individuals; highlighting the need to provide communications via multiple channels (e.g. print, face-to-face and digital). This was supported by the views of stakeholders in phase one of the research who emphasised the importance of providing content that is accessible, current, clear, and concise; and delivered via a variety of channels.

Raising and resolving issues

In general, disabled residents reported feeling underserved by their building managers. Views were shaped by past experience of poor responsiveness, a lack of acknowledgement of issues raised, not being kept informed as to the progress of complaints, unsatisfactory resolution of issues, and generally feeling undervalued or like staff did not care.

In addition to this, many disabled residents described factors linked to their condition or disability that magnified these negative experiences and affected their capacity and motivation to pursue complaints. Such factors included chronic pain and fatigue, confusion and memory loss, low mood and depression, and reliance on carers to raise issues on their behalf.

Poor experiences of this sort had led many residents to distrust their building managers. The issue of trust felt particularly important to disabled residents and those with health

conditions as they perceived themselves to be more reliant on building managers to implement effective safety systems and processes to keep them safe.

Emergency plans and means of escape

Residents described a one-size-fits-all approach to evacuation plans that failed to consider individual requirements. They felt that building managers had typically not provided opportunities for residents to contribute to evacuation plans and this meant that they lacked relevance for many. Residents interviewed reported a low belief in the effectiveness of existing plans to keep disabled residents safe in the event of an evacuation.

There were particular concerns for evacuation plans and means of escape across the different broad health groups:

- Residents with mobility impairments were anxious about not being able to leave their flats independently, being reliant on others, not being able to open fire doors and being very slow when taking the stairs
- Residents with hearing loss were apprehensive about not being alerted to an alarm, and people with sight loss worried about inadequate lighting and unclear escape routes
- Residents with mental health conditions were concerned about feeling isolated and not being in touch with other residents or Emergency Services during an emergency
- Residents with neurodivergent disorders expressed concern about possibly freezing or experiencing meltdowns as a response to the intense sensory environment of an emergency situation.

Residents stated that there were no formal processes by which they could inform their building manager about their specific requirements for evacuating their building. This meant residents who were unable to leave their buildings independently were reliant on their neighbours to support them in evacuating or alerting emergency services about their needs. As a result, residents described feeling like they had very little control over their own safety. Some went further and voiced that they felt their lives were implicitly seen to matter less due to this lack of provision. (And, in the absence of a personal plan or agreement, carers also felt like they relied significantly on neighbours or responsive caretakers or concierges to intervene and support the people they cared for to evacuate).

Most residents welcomed a mechanism for working with building managers to co-design evacuation plans. However, awareness of specific adaptations and considerations that could help to improve plans and means of escape was generally low among residents. Stakeholders who were interviewed from phase one highlighted some specific adaptations and considerations for the broad health groups including:

- Help with walking down the stairs and opening residents' own front door and fire doors for people with mobility impairments, as well as installing handrails along corridors

- Wayfinding exit descriptions, tonal contrasting, adequate lighting, and visual and sensory smoke alarms including vibrating alerts for those with sensory loss
- Fire training and demonstrations, frequent fire alarm testing and more information about what happens or what to do in an emergency for those with mental health conditions
- Fire alarms that consider sensory sensitivity and reassurance and support to feel safe for people with neurodivergent disorders.

Residents' responsibilities

New resident responsibilities, such as complying with requests for information or providing reasonable access to home, were generally well-received by disabled residents. However, participants consistently requested more factual and less ambiguous descriptions of these responsibilities. It was also felt that building managers' potential lack of understanding of residents' individual circumstances could hinder residents in meeting these responsibilities fully. For example, residents with mental health conditions may ignore requests for information as a coping mechanism, which may be misunderstood by building managers. And older people, with progressive conditions, may feel lonelier and more vulnerable; and therefore, less likely to want to let others into their homes.

Further information

For information about health and safety, or to report inconsistencies or inaccuracies in this guidance, visit [the HSE website](#).

You can order HSE priced publications at [the HSE books website](#).

HSE priced publications are also available from bookshops.

This publication is available on the HSE website :

<https://www.hse.gov.uk/research/assets/docs/high-rise-residents-disabilities.pdf>

© Crown copyright If you wish to reuse this information visit [the HSE website](#) for details. First published 11/23.

Published by the Health and Safety Executive 11/23