Courts and Tribunals Judiciary

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors. It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's PFD Publication Policy (2026) representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision

	RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013** (Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026)) THIS RESPONSE IS BEING SENT TO: HM Assistant Coroner, Paramdeep Bains, for Birmingham and Solihull in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Trevor John Ridd that concluded on 9th March 2026**.**
1	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, [redacted], Managing Director, Birmingham City Council, provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths
2	**DATE OF RESPONSE** 5th August 2026.

3	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report as follows: 1. It is not clear why the sprinkler system generated two signals (one 'fault' and one 'fire') within seconds of one another and what the procedure was for handling this. 2. It remains unclear as to why the individual operator treated both signals as being part of the same incident and failed to raise a 999 call; it is not clear how a fault notification works alongside a fire notification. 3. It is not clear what training or instruction individual operators receive in relation to how they are to deal with situations where two notification signals are received in quick succession. It is also unclear what information alerts (if any) are communicated to individual operators in respect of the property from which the signals are received. i.e. was it noted that the signals came from Mr Ridd's property who was bed-bound and a known smoker with severe COPD where there had been a previous incident where he had singed his blanket from smoking in his bed? 4. The evidence at Inquest suggested that the two signals received were the wrong way around; however, it was not clear why this was and whether this has since been rectified. 5. There is no evidence of regular testing and maintenance of the sprinkler system. 6. It is not clear what individual operators have been briefed on post-incident regarding situations where two notification signals are received in quick succession from the same property. 7. It is not clear what communications have been issued to staff to reinforce the requirement to verify wording of any notifications received.

4	**DETAILS OF ACTION TAKEN**, how has the concern been addressed. (If no action is proposed please explain why here) Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. **1. It is not clear why the sprinkler system generated two signals (one 'fault' and one 'fire') within seconds of one another and what the procedure was for handling this.** Careline Alarm Receiving Centre (ARC) receives both sprinkler system activation notifications and sprinkler system fault notifications from auto-dialler devices installed across our residential high-rise stock. These notifications are received via the CHUBB Skyresponse platform and are presented to call handling operators for action in accordance with established escalation procedures. Following investigation, it was identified that notifications can be generated in close succession for both a sprinkler activation and a maintenance/fault condition. In this incident, the CHUBB Skyresponse platform recorded a maintenance notification at 21:24:25, followed by a sprinkler activation notification at 21:24:46, a difference of 21 seconds. The CHUBB Skyresponse platform in use at the time had been operational for approximately one month and all Careline staff had received training from CHUBB on the operation of the new system, including the handling of notifications and calls received through the platform. Following the incident, all procedures relating to the management of duplicate notifications and multiple alerts from the same site have been reviewed and updated. The revised procedures now make explicit that each notification must be individually acknowledged, assessed, actioned and closed, regardless of whether another notification has already been received from the same property. **2. It remains unclear as to why the individual operator treated both signals as being part of the same incident and failed to raise a 999 call; it is not clear how a fault notification works alongside a fire notification.** The investigation established that the operator interpreted the second notification as relating to the maintenance/fault notification already being managed. Under the new CHUBB Skyresponse platform, operators are alerted when they are already handling a notification from the same auto-dialler device. As the system had only recently been introduced, this functionality was relatively unfamiliar to operators. The operator subsequently confirmed that the operator believed they were already dealing with the incident and therefore associated the activation notification with the existing maintenance notification. At the time, they contacted the repairs call centre to arrange attendance by an engineer and recorded the activation against the repairs reference already created. While this explanation provides context, the organisation accepts that a human error occurred in the handling of the escalation process and that a call should have been made to West Midlands Fire Service upon receipt of the activation signal.

	Immediately following the incident, management issued written instructions to all operators reinforcing that duplicate notifications from the same site must not be assumed to relate to an existing incident and that each notification must be reviewed and actioned separately. This requirement was further reinforced through verbal briefings at the commencement of shifts and more recently through individual recorded discussions with all call handling operators. **3**. **It is not clear what training or instruction individual operators receive in relation to how they are to deal with situations where two notification signals are received in quick succession. It is also unclear what information alerts (if any) are communicated to individual operators in respect of the property from which the signals are received i.e. was it noted that the signals came from Mr Ridd's property who was bed-bound and a known smoker with severe COPD where there had been a previous incident where he had singed his blanket from smoking in his bed?** Prior to the implementation of the Care Unity system, all Careline operators received training delivered by CHUBB, the system provider. This training covered operation of the CHUBB Skyresponse platform, the management of alarm notifications, call handling requirements, escalation processes and operator actions in response to system-generated alerts. The CHUBB Skyresponse platform had only been operational for approximately one month at the time of the incident. Whilst training had been provided, the incident highlighted that further emphasis was required regarding the management of multiple notifications received from the same auto-dialler device within a short timeframe. In particular, operators required greater clarity that further notifications from the same site must not be assumed to relate to an incident already being managed and must instead be individually assessed and actioned. Following the incident, the organisation undertook an immediate review of operator training, guidance and procedures. This resulted in: • Written clarification instructions were immediately issued to all operators regarding the handling of multiple notifications from the same site and that each notification must be reviewed and assessed individually. • Electronic Pop-Up notifications created in the system as a ***reminder on every call*** to review all notifications even if they are received in close succession from the same property. Each 'Pop-Up' has to be acknowledged & closed by operators before they can continue to handle that or any further calls. • Managers provided verbal briefings to each operator as they commenced duty immediately after the incident. • Further individual discussions have subsequently been undertaken and are ongoing and being formally recorded with each operator. • Written procedures required as part of the TSA accreditation (ARC and technical install providers) have been reviewed and updated to provide the revised information and greater clarity regarding duplicate notifications and escalation requirements. • Written confirmation is being obtained from all operators to confirm they have read, understood and will comply with the revised procedures. This assurance exercise will be completed by the end of August 2026. Operators receive the sprinkler system activation notifications and sprinkler system fault notifications from auto-dialler devices, the notifications do not include any details or alerts relating to tenants.

4. The evidence at Inquest suggested that the two signals received were the wrong way around; however, it was not clear why this was and whether this has since been rectified.

Post-incident investigations undertaken by servicing and maintenance contractors identified that the CHUBB Skyresponse platform transmitter had been correctly configured and wired correctly. There was not an error in installation configuration sending notifications the incorrect way around.

5. There is no evidence of regular testing and maintenance of the sprinkler system.

The sprinkler system at Hobbis House is subject to annual servicing and maintenance in accordance with **BS 9251:2021**, the British Standard Code of Practice for fire sprinkler systems in domestic and residential occupancies.

The most recent annual service prior to the incident was completed on **23 January 2025**. Although the service certificate recorded a fail outcome, this related to minor weeping from ground-floor valves. The identified issues did not affect the operational capability of the sprinkler system and remedial works were subsequently completed.

The sprinkler system remained operational throughout the period and functioned as intended during the incident in January 2026, successfully activating and providing fire suppression.

6. It is not clear what individual operators have been briefed on post-incident regarding situations where two notification signals are received in quick succession from the same property.

The key message communicated to operators is that every alert received must be treated as a separate notification requiring individual assessment and action, regardless of whether another alert from the same property is already being managed.

Immediately following the incident, line management issued written communications to all Control Centre staff highlighting the circumstances of the incident and reminding operators of their responsibilities when receiving multiple notifications from the same property.

The communication specifically reinforced that:

- Each notification received by the system must be treated as a separate event requiring individual review and action.
- Operators must not assume that a subsequent notification relates solely to an incident that is already being handled.
- The wording and classification of each notification must be checked and verified before any action is taken.
- Escalation procedures must be followed in respect of every notification received.
- Activation notifications indicating a potential fire event must be dealt with in accordance with emergency response procedures.

	In addition to the written communication, managers discussed the incident and the revised expectations verbally with operators as they attended for duty. Since that time, individual conversations have been undertaken with each operator to reinforce learning, discuss procedural requirements and ensure a consistent understanding of expectations. The organisation considers that these actions, together with the revision of written procedures, mandatory staff acknowledgement and ongoing management oversight, have significantly strengthened operator awareness and reduced the risk of a similar occurrence in the future. **7. It is not clear what communications have been issued to staff to reinforce the requirement to verify wording of any notifications received.** Following the incident, all staff were reminded of the importance of carefully reviewing the wording and classification of all notifications received through the CHUBB Skyresponse platform and ensuring that notifications are individually assessed rather than assumed to relate to an incident already in progress. This requirement has been incorporated into the revised written procedures and reinforced through management briefings, individual discussions and staff acknowledgement of procedural changes. Written confirmation will be fully completed by end of August 2026. **Additional Assurance Measures** The Careline Alarm Receiving Centre is independently audited annually by the **Technology Enabled Care Services Association (TSA)** as part of its quality assurance and accreditation requirements. As part of the post-incident & annual review, procedures and operator guidance have been reviewed to strengthen compliance and ensure greater clarity in relation to the management of multiple notifications received from the same property. In addition to the procedural changes outlined above, the organisation recognises that effective operator training is fundamental to the safe operation of the Alarm Receiving Centre. Training requirements and operator competency arrangements have therefore been reviewed following this incident to ensure staff clearly understand the distinction between different alarm types, the need to assess each notification and the requirement to follow escalation procedures regardless of whether another notification from the same property is already being managed. This learning has been embedded through written procedures, management briefings, individual supervision and staff acknowledgement processes. The organisation believes these measures significantly reduce the likelihood of a similar occurrence and provide additional assurance regarding operator response, escalation processes and the management of sprinkler system notifications.

5	**DETAILS OF FURTHER ACTION PROPOSED** Please *note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* 1. Written confirmation is being obtained from all operators to confirm that they have read, understood and will comply with the revised procedures. This assurance exercise will be completed by the end of August 2026. 2. Further individual discussions with operators will continue through normal supervision and management arrangements to reinforce learning and maintain compliance with revised procedures. 3. Training requirements and operator competency arrangements will continue to be reviewed as part of the service's continuous improvement framework and TSA accreditation requirements. 4. Annual TSA quality assurance and accreditation audits will continue to provide external scrutiny of procedures, training arrangements and operational compliance.
6	**SIGNATURE**   Managing Director Birmingham City Council