Courts and Tribunals Judiciary

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

If during an investigation, a coroner becomes concerned about circumstances that create a risk of future deaths, Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. That report is called a Prevention of Future Deaths Report (PFD report).

The Chief Coroner provides this template to support coroners in the effective and consistent exercise of their statutory duties under the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The purpose of the template is to provide a clear and structured framework for setting out the matters of concern identified during an investigation which, in the coroner's opinion, give rise to a risk of future deaths. It is designed to promote clarity, ensure that reports are formulated in a way that enables recipients to understand and address the concerns raised, and to support good practice across jurisdictions.

The template does not fetter judicial independence: coroners remain responsible for determining the facts, identifying the matters of concern, and drafting reports that accurately reflect the circumstances of each individual case. The template may be adapted as necessary to ensure that the report properly and precisely records the coroner's views.

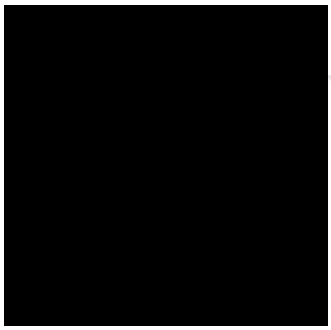
In accordance with the Chief Coroner's PFD Publication Policy (2026) any applications for redactions to content or general publication of the report must be sent to the coroner. The coroner will provide the representations to the Chief Coroner for a decision.

	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))
1	**CORONER** I am Paramdeep Bains HM Assistant Coroner for the coroner area of Birmingham and Solihull
2	**DATE OF REPORT** **16 June 2026**

3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4	**THIS REPORT IS BEING SENT TO** **1.** Birmingham City Council **2.** **3.** **4.** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 August 2026. I, the coroner, may extend the period if an appropriate application is made.
5	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding the publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	**SUMMARY OF THE CORONER'S CONCERN** I remain concerned that despite two signals being generated within seconds of one another by the sprinkler system (a 'fault' and then a 'fire' signal), the individual operator failed to put a 999 call through to West Midlands Fire Service as it was treated as being part of the same incident. It is not clear to me as to why this was treated as being part of the same incident and even so, why the individual operator still failed to put a 999 call through. I am concerned that were it not for the 999 call from Mr Ridd's diligent neighbour reporting a water leak, no call would have been put through to West Midlands Fire Service, when this should have been done by the individual operator once the Alarm Receiving Centre had received both a 'fault' and 'fire' signal from the same sprinkler system.
7	**ACTION SHOULD BE TAKEN**

	In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	**INVESTIGATION and INQUEST** On 9 March 2026, I commenced an investigation into the death of Trevor John Ridd, aged 87 Years The **medical cause of death** was 1a Chronic obstructive pulmonary disease 1b 1c 1d II Burns, Old Age **How, when and where** - see below **Conclusion** The investigation concluded at the end of the inquest . The conclusion of the inquest was Accident.
9	**CIRCUMSTANCES OF DEATH** On 04 January 2026, Mr Ridd's bedding caught fire however he was unable to leave his bed due to mobility issues. The sprinkler system activated a 'fault' signal and a 'fire' signal within seconds of one another. The Alarm Receiving Centre received both signals however the individual operator did not raise a 999 call as both signals were treated as being part of the same incident. Mr Ridd lived in a one-bedroom self-contained flat in an 11 storey purpose-built residential block which was managed by Birmingham City Council's sheltered housing team. West Midlands Fire Services mobilised at Mr Ridd's property following a 999 call from a downstairs neighbour reporting a water leak, which was coming from the sprinkler system and damaging the electrics. When West Midlands Fire Services arrived, they heard the smoke alarm from upstairs and attended Mr Ridd's property. Mr Ridd had been located in his bed in the living room which had been on fire and subsequently extinguished by the actuation of the sprinkler system. He had suffered burns to his lower body. Ambulance Services administered first response emergency care, however Mr Ridd began to decline and went into cardiac arrest. A decision was made not to resuscitate due to the ReSPECT form in place and he passed away. The West Midlands Fire Service Fire Report opined the fire was caused by the naked flame from a cigarette lighter which had ignited the bedding. Mr Ridd had a history of severe COPD and was bed-bound. He was a smoker and was known to smoke cigarettes whilst in bed.
10	**CORONER'S CONCERNS**

	During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are 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 with regards to 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 secondary signals, nor is it clear how staff are to verify the wording of secondary signals.
11	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every interested person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *(please do not use individual's names, but instead roles/titles)* 1. Birmingham City Council.

	2. Mr Ridd's next of kin 3. 4. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE  Paramdeep Bains Assistant Coroner for Birmingham and Solihull