North London
NHS Foundation Trust

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[redacted]

Ms. ME Hassell
HM senior Coroner
Inner North London Coroner's Court

Date: 10th July 2026

By email only

Dear HM Senior Coroner Hassell,

Re: Inquest touching the death of Najib Ahmed Naagi

I write on behalf of North London NHS Foundation Trust ('The Trust') in response to your Regulation 28 Prevention of Future Deaths Report issued on 19th May 2026 following the inquest touching the death of Mr Najib Ahmed Naagi. I would like to express my sincere condolences to Mr Naagi's family and friends. The matters of concern raised are as follows:

The clinical support worker responsible for carrying out overnight observations recorded that observations had taken place at:

- 04:30 A.M
- 05:30 A.M
- 06:30 A.M

She repeated these times in both her witness statement and oral evidence to the court. However, CCTV evidence showed observations occurred at:

- 04:48 A.M
- 06:18 A.M

The support worker only accepted that the records were inaccurate after being challenged directly while giving evidence.

The observations in question should have been made every hour, on the half hour, to ensure that Mr Naagi was safe and well. The records made did not reflect the actions taken by the support worker. As a result, the following specific concerns have been reported:

1. The medical record was wrong
2. This situation casts doubt on the remainder of the record both in terms of Mr Naagi's care and the care of other individuals
3. The court was misled
4. Observations should be conducted when they are meant to be but if not, then this fact must be recorded contemporaneously
5. It was put to the court that the number of observations recorded was accurate… which somehow made good the lack of earlier observation and corrected the wrongdoing
6. The giving of inaccurate evidence may amount to contempt of court and / or perjury and obstructs learning from deaths.

The Trust acknowledges the gravity of the concerns being raised and it recognises that these issues go towards matters of honesty and probity, which are essential for maintaining the public's trust in the medical profession and ensuring the delivery of safe and effective care. Taking each concern in turn, and in this context, I respond as follows:

1. **<u>The medical record was wrong</u>**

The Trust acknowledges that the medical record was wrong insofar that observations were not undertaken at the times recorded. The Trust's Supportive Observation and Engagement policy sets out the standards expected of staff in relation to record keeping. Specifically, it states that '*documentation must be done immediately when carrying out general observations and staff must only document what they personally have observed. No part of the general observation form should be incomplete after a round of general observation. Data must not be entered retrospectively, as to do so is falsification of records and therefore serious misconduct'*.

This guidance is available to all staff, including staff engaged through NHS Professionals ('NHSP'), as was the case in relation to the clinical support worker involved in this incident.

On 19.05.2026 the Trust referred the clinical support worker to NHSP citing the concerns identified during the inquest hearing and specifically setting out that she may have acted dishonestly by falsifying the observation record and providing misleading evidence to the court both in the form of a signed witness statement and oral evidence given under oath. NHSP has conducted a full investigation into the support worker's conduct (which the Trust has had sight of) and a Remedial Mandatory Action Plan has been put in place, to include:

- Reflective discussion (completed)
- Repeat Trust training on observations & a competency check
- A records keeping learning exercise
- Review of the NHSP Code of Behaviour

In addition, the support worker has been issued a Standards & Expectations letter, which is the equivalent of a formal written warning. In deciding the nature and extent of any action to be taken, it has been recognised that the format of the Trust's Observation Record Form does not support staff to record observations contemporaneously (please see below). It is understood that this does not absolve the clinical support worker from her individual responsibility to uphold professional standards (which she understands) but has been considered when determining the degree to which she intended to be misleading.

2. **<u>This situation casts doubt on the remainder of the record both in terms of Mr Naagi's care and the care of other individuals</u>**

As part of the investigation undertaken by NHSP, the CCTV was reviewed. This shows that no observations were conducted at 05:30. The Trust understands the importance of observations to support safe, person-centred care and the formulation of risk assessment. The Trust has reviewed observation competency compliance across substantive and temporary staff and has reinforced the requirement that all staff undertaking supportive observations complete observation training, competency assessment, and ward induction before undertaking observation duties.

Compliance with observation practice and documentation standards will be reviewed through monthly observation audits, Matron quality visits and daily safety huddles, out-of-hours senior manager reviews and reporting through the Care Group Quality and Safety governance structure. Any themes and findings will be escalated further through the Trust's governance arrangements where required.

3. **The Court was misled**

The Observation Record Form in use at the time of this incident consists of a prepopulated form comprising of a table with columns at 30 minutes past each hour. It requires observations for all patients to be undertaken at precisely the same time. There is no space for staff to record the actual time an observation is completed, and this means that CCTV evidence often does not align. If observations are delayed, the form itself must be amended (or annotated) and guidance to staff regarding what to do in this situation is not clear. It is believed that the use of this form contributed to the clinical support worker documenting that the 05:30 observation had been completed at this time, when it had not, and ultimately the court being misled. Both the Trust and the clinical support worker acknowledge the seriousness of this situation and wish to sincerely apologise in respect of it.

To reinforce a culture of openness, transparency, and accountability at all times, learning from this case has been shared across all inpatient services and management teams. In addition, staff have been reminded of their professional responsibilities when providing witness statements and evidence during investigations and legal processes.

4. **Observations should be conducted when they are meant to be but, if not, then this fact must be recorded contemporaneously**

As explained, the Trust recognises that the existing observation record form does not support staff to record observations contemporaneously. As a result, the Supportive Observations Policy has been amended to state that '*staff must record the exact time that each patient is observed on every check, rather than relying solely on the hourly observation column. Accurate timings provide an auditable record of when observations took place and are essential for patient safety, incident investigations, CCTV reviews and other reviews of care. Recording a time that does not reflect when the observation occurred may constitute falsification of records and could result in disciplinary action'*. In conjunction, the general observation form has been amended to allow staff to record the exact time they check each patient. A copy of the revised Supportive Observations Policy is attached to this correspondence. The updated observation form is located at Appendix 3.

5. **It was put to the court that the number of observations recorded was accurate… which somehow made good the lack of earlier observation and corrected the wrong doing**

The Trust acknowledges that there are no circumstances in which the completion of an observation at 06:18 can ever be interpreted to represent the completion of an observation required at 05:30 and nowhere in Trust policy is this accepted to represent acceptable practice. By referring the court to the number of observations completed, the Trust's Solicitor was not seeking to suggest that the Trust endorses any such approach, or in any way makes light of this situation. This information was provided only to offer a possible

explanation as to why the clinical support worker maintained that the 05:30 observation was completed. Namely, that it was conceivable she was considerably mistaken as to its timing of occurrence and not knowingly seeking to mislead the court.

6. **That the giving of inaccurate evidence may amount to contempt of court and or perjury and obstructs learning from deaths.**

As explained at the outset of this Response, the Trust fully accepts the gravity of this situation and that incidents involving significant departures from professional standards of conduct and / or, most significantly, dishonesty can have regulatory and / or legal consequences. Please be assured that the Trust has in place procedures to ensure that, following appropriate investigation, where incidents of this nature are established or strongly suspected referrals to regulators, the DBS and / or the police are completed as required. This is to ensure that conduct of this nature is appropriately sanctioned and does not represent a continued risk to patient safety.

I hope that the above response provides assurance that the Trust is committed to providing high quality care and that this response addresses the concerns you hold. Please contact me if you have any remaining queries.

Yours sincerely,

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Chief Medical Officer