	Report to Prevent Future Deaths **Regulation 28 of** **The Coroners (Investigations) Regulations 2013** **Najib Ahmed NAAGI (died 04.01.25)**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
2	**DATE OF REPORT** 19 May 2026
3	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
4	**THIS REPORT IS BEING SENT TO:** 1. The Chief Executive North London NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 July 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 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	**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.
7	**INVESTIGATION AND INQUEST** On 7 January 2025, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Najib Naagi, aged 55 years. I concluded that inquest on 12 May 2026. Mr Naagi was found unresponsive in his mental health hospital bed at approximately 7.24am on 3 January 2025. He was resuscitated but died in intensive care the following day. He had been suffering from significant, complex lung disease, but there is no evidence that this developed as a consequence of exposure to asbestos. His medical cause of death was: 1a acute on chronic cardiorespiratory failure 1b interstitial lung disease of uncertain aetiology in an individual with a markedly raised body mass index. I made a determination that death arose from natural causes.
8	**CIRCUMSTANCES OF DEATH**

	Mr Naagi was on general observations in a secure mental health ward. This meant that a member of staff was meant to look through the observation panel of his bedroom once every hour, on the half hour, to make sure that he was safe and well. The member of staff was required to satisfy themselves that their patient was breathing, and then record the fact of the observation.
9	**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: The clinical support worker who had been tasked with conducting Mr Naagi's observations recorded that she had observed Mr Naagi at the following times: • 4.30am • 5.30am • 6.30am She reiterated that in her statement and in her oral evidence at inquest. She did not volunteer the fact that her record was wrong. It was only when I put it to her in quite robust terms that she accepted this. In fact, the ward CCTV showed that she looked through the observation panel at the following times: • 4.48am • 6.18am Thus, the record she made did not reflect the actions she took. The consequences of this are as follows: 1. A patient's medical record was wrong. Any healthcare professional seeking to understand when Mr Naagi had been observed to be well by reading the record would have been given the wrong information. 2. The fact that this record was wrong casts doubt on the remainder of the record, both in terms of this individual (was he actually well at the times recorded?) and the other patients (were they observed when the record indicates that they were observed?). 3. The court was misled.

	Observations should be conducted when they are meant to be conducted, but if they are not then this fact must be recorded contemporaneously. It was put to me by the trust's solicitor that because the clinical support worker later looked through the observation panel at 6.36am, this meant that the number of observations recorded was accurate and so the later observation somehow made good the lack of earlier observation and corrected the wrong recording. That is simply not the case. Proper patient care demands that patient records are accurate and not in any way fabricated. Regarding the giving of inaccurate evidence in court, this may amount to a contempt of court, it may amount to perjury, it may be punishable by a fine or even by a term of imprisonment. For your patients, it obstructs learning from deaths.
10	**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 have sent the report to: • The daughter of Najib Naagi 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 5 above for additional information relating to the publication of reports and responses.
	SIGNATURE *ME Hassell*