**Falsification of observation records in mental health: A closer look at "Outstanding" East London NHS Foundation Trust**

Dr Minh Alexander 29 March 2026

**Summary**

There is a history of enculturated failure to carry out mental health observations and of falsification of records entries about observations at East London NHS Foundation Trust (ELFT). This is not unique to ELFT but there have been repeated, serious ELFT cases that have been criticised by inquest juries and coroners, which have been publicised. The trust's reported governance response to these matters is examined here, and FOI material is provided. This includes a disclosed 2024 Human Factors review report commissioned by ELFT to shed light on how failures of observation arise. Supporting coroners' concerns, the Human Factors review concluded that improvement measures by the trust did not fully address the issues of missed and falsified observations. Via FOIA, the trust reports that it has so far referred twelve staff to the Nursing and Midwifery Council in relation to the falsification of observations. Problems have persisted. As recently as May 2024, staff who were supposed to be conducting 1:1 observations were seated facing away from a patient, whilst using their personal mobile phone. The most recent coroner's Prevention of Future Deaths warning about falsification of observation records was issued on 1 September 2025 and expressed concern about failure of the trust's improvement initiatives. The trust countered with its own research evidence to demonstrate improved metrics and asserted that it had already done a "considerable amount of work". It indicated that it was "reassured that no further action is required". However, some questions and concerns remain. The Care Quality Commission is currently re-inspecting ELFT and has confirmed that it will take into account issues relevant to a recent coroners' Prevention of Future Deaths report of 6 February 2026 which criticised ELFT's serious incident process. In this case, an ELFT investigator had reportedly "neither sought the recollections of treating staff, nor communicated the findings of the report to the same staff", raising additional concerns about the trust's governance.

## How repeatedly falsified observations were exposed at ELFT

East London NHS Foundation Trust (ELFT) is a prominent NHS mental health trust that is rated "Outstanding" by the Care Quality Commission.

In August 2024 local press and the Health Service Journal reported that a coroner's Prevention of Future Deaths report revealed that ELFT had faked/possibly faked the records of up to twelve patients who had died.

Strong coverage by My London emphasised the history of previous related PFDs issued to the trust about falsification of observations:

East London NHS hospital staff 'faked records of 12 dead patients'

The publicised 2024 Prevention of Future Deaths report was on the 2020 death of Mahamoud Ali, a 40 year old young man. He had a fall. Head scans initially reportedly showed no obvious change. But there was behavioural change, so he was admitted to an ELFT psychiatric ward under the Mental Health Act for assessment. Very sadly, after he became unresponsive, an unsurvivable brain haemorrhage was found.

Mahamoud should have been under observations every 15 minutes. There was in fact a gap when he was unobserved, but staff falsely recorded that the missed observations took place.

The coroner asked ELFT for more information on such cases.

This request was revealed by the trust's response to the coroner which referred to "…your request for information about incidents which had taken place after Mr Ali's death in August 2020".

The trust has now informed me via FOIA that it searched for this information thus:

"A member of the Trust legal team reviewed all inquests in the relevant period. Deaths in community settings were sifted out, as patients in those settings would not be observed by staff (in contrast to patients in inpatient settings). Of the identified deaths which took place in inpatient settings, the relevant investigation report was reviewed. A tally was kept of any investigation report which had identified falsified records or a possibility that records had been falsified. The total number of deaths where falsified observations had been identified (or where this was a possibility) via this exercise was eleven."

That is to say, the information provided was confined to inquest material and so represents only a small snapshot of the total malpractice around observations that may have taken place at the trust.

The coroner gave this summary of the information collated by the trust:

"Evidence has been provided by the Trust that since Mr Ali's death on 26 August 2020, there have been 11 fatal incidents where observation records may have been filled in when observations have not been conducted. One of these, in May 2023, was in Lea Ward, the same ward where Mr Ali was detained.

Whilst the date and name of the hospital and/or ward connected with each of these deaths have been provided to me, evidence has not been given by the Trust as to the specific circumstances of each death, nor the subsequent individual investigation and findings and any consequential action taken. Nor has this issue been addressed in the Trust's Action Plan as part of its internal investigation.

The Trust has stated that the majority of the 11 deaths pre-date the work that it has been doing to improve practice around observations that has been progressing since Autumn 2022."

In short, ELFT's senior managers had been in possession of substantial information that observations were repeatedly falsified by staff. In addition to the disclosed inquest material, the trust would have had additional internal incident reports that likely also showed the problem with falsification. But it seems the trust only started responding to the issue in 2022.

The coroner also noted an internal 2023 trust communication which reported that falsification had worsened:

"Despite this work, we have seen an increase in occasions where observation records have not been completed but records falsified to reflect that they had been done."

**Patterns in ELFT's Prevention of Future Death reports (PFDs)**

I have tracked back through ELFT's published PFDs to construct a timeline.

I found a total of five ELFT PFDs currently published by the Chief Coroner which feature falsification by trust staff of observation records.

Inquest juries found that the serious failures amounted to neglect in two of these five cases.

It is unclear how long the falsification of observation records has been an issue at ELFT, but the first PFD was issued on a death that occurred in 2018. The senior coroner for that case concluded that there was a culture of impunity amongst staff regarding observations not being carried out and records of observations being falsified. This implied the practice had been present for some time.

When the most recent PFD featuring falsification of observations was issued in September 2025, misleading staff evidence appeared to be given to the inquest. This was contradicted by CCTV footage.

Despite this apparently false staff evidence to the inquest, the trust's response to this latest PFD was surprisingly confident in tone. It asserted that the trust had done everything necessary to deal with the issue of falsification.

| **Date PFD issued** | **Summarised details** |
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| 30 April 2021 | Death of Rohan Singh on 13 December 2018.<br><br>The inquest jury found multiple care failings which amounted to neglect. Searches by staff failed to find and remove illicit drugs from the patient, and he ultimately died of drug toxicity. The Senior Coroner Graeme Irvine noted: "The patient was made subject to 15 minute observations. The observations were not adequately |

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| | undertaken and records of the observations were falsified." Very seriously, the coroner found that there was a culture of impunity with regard to falsification of observations: "Mr Singh was subject to intermittent observations at 15 minute intervals during his admission. The records of these observations were found to be unreliable, staff accepted that they had failed to undertake observations and made false records, further they had done so in such circumstances that their peers were aware of the falsehood. A culture of impunity existed where inaccurate and misleading recording of clinical records was tolerated." Compounding the toxicity from illicit drugs, Rohan was given rapid tranquillisation under restraint (a risky intervention) but with failure to follow the monitoring protocol afterwards. The coroner flagged this as another serious concern: "Mr Singh was subject to rapid tranquilisation, following administration of this medication, staff failed to follow the Trust's monitoring process or complete relevant documentation. The failure to monitor Rohan was found by the jury to have contributed to his death. Trust evidence demonstrates that beyond this incident, throughout the organisation the processes are not being universally followed."<br><br>Rohan Singh's case attracted media attention because of the falsification:<br><br>Hospital staff 'lied about checks on vulnerable patient', 31, found dead in bedroom, report finds<br><br>The trust's response, issued by the chief medical officer, set out various improvement initiatives such as training, compliance checks, electronic recording and changes to policy including a requirement that eye sight monitoring in the hour after rapid tranquillisation should be undertaken by registered nurse. |
| 10 July 2024 | Death of Mahamoud Hussain Ali on 26 August 2020.<br><br>The patient was detained for assessment after behavioural changes following a head injury with reportedly no obvious abnormalities on brain scans. He later became unresponsive and an unsurvivable brain haemorrhage was found on repeat scan. Assistant Coroner Saba Naqshbandi noted: "Although Mr Ali was meant to be under 15-minute observations, a registered mental health nurse on Lea Ward gave evidence that on 21 August 2020 at around 1740 she saw that the observations board had not been completed for 1700, 1715 and 1730. She then completed it as if she had conducted those observations, recording that Mr Ali was asleep." There was additional information provided at the coroner's request about other trust cases where observation records had been falsified. The coroner noted trust documentation in 2023 which indicated that falsification had worsened. |

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| | The trust's response to the coroner set out various improvement initiatives such as additional staffing establishment (with unqualified staff), staffing escalation protocols and better management of vacancies, training including on honesty in documentation, improvements in induction, regular review of observation practice and data, spot checks, formal handover of "observation boards", zonal observations and twilight shifts. There was also reference to disciplinary processes if necessary. |
| 18 July 2024 | Death of Anna Elliott on 24 November 2021.<br><br>The inquest jury found multiple care failures, including under-staffing. The patient died by self-ligation due to being unobserved, when she was supposed to be observed. The jury concluded the care failures amounted to neglect. Observations were falsified. Assistant Coroner Melanie Lee noted: "In Anna's case, observation records were backfilled despite the observations not having been conducted. All of the witnesses who gave evidence had received training, were aware of a previous PFD on missed and falsified observations, could tell me the purpose and importance of the observations, knew that observations should not be falsified and knew that if observations were missed, this should be reported that to the nurse in charge." The coroner was not satisfied that ELFT was taking sufficient action on this issue: "I was also provided with screenshots of training which included a message from the Chief Nurse appearing to be dated May 2024 which refer to "an increase in occasions where observation records have not been completed but records falsified to reflect that they had been done". As the spot checks described to me only look at the quality and timings of the written observations, I am not reassured that records are not still being falsified or about how this is being identified and addressed."<br><br>In terms of the trust's improvement actions, the coroner noted "I heard evidence about steps that have been put in place to prevent observations being missed but the data provided by the Trust appeared to show that missed observations are rising and not decreasing."<br><br>The trust's response to the coroner set out improvement actions similar to those above, including spot checks on of observations practice, increased staffing by one unregistered Band 3 worker per shift, a Band 4 skills and recovery worker in office hours to support activities, and escalation protocols for when more staffing was required. There was also training on honesty in documentation, handover of allocated observation tasks, twilight shifts to offer therapeutic activities in the evenings and "zonal observations". |
| 28 October 2024 | Death of Kashim Ali on 21 May 2024.<br><br>Whilst Mr Ali was under 1:1 observation, staff sat with their chair facing away from the patient and were noted to be "preoccupied" |

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| | with their personal mobile phones. Observation records were “not always accurate”. Assistant Coroner Ian Potter considered such practices placed future patients at “considerable risk”. PFD issued 28 October 2024.<br><br>The trust’s response to the coroner indicated “The Trust has thoroughly investigated the incident and is following established disciplinary procedures for each staff member who failed to comply with the required observation standards in relation to Mr. Ali's care.” Trust policy was updated and “staff are completely prohibited from using personal mobile phones during shifts” The trust also indicated that spot checks of observation practice were ongoing. |
| 1 September 2025 | Death of unnamed 23 year old patient, on 7 June 2022, Chief Coroner’s reference 2025-0507.<br><br>Assistant Coroner Ian Potter had concerns that: “Despite assurances from the Trust in numerous action plans since, the evidence in this inquest revealed widespread concerns across two wards at THCMH (Brick Lane Ward and Rosebank Ward) about observations that were carried out.” “…observations were often not used as a tool to aid therapeutic engagement with patients; and some observations were inaccurate or possibly falsified.” And “The evidence received and heard during the inquest did not reassure me that this matter has been adequately addressed. Given the importance of observations in keeping patients safe, I remain concerned that significant risks remain.” Moreover, the Assistant Coroner noted: “The CCTV footage played at inquest showed a member of staff who was allocated to ‘within eyesight’ observations of another patient sat on the back of a chair (with their back facing the patient’s bedroom door) and engaged on their mobile telephone. That member of staff initially told the court that they were conducting the ‘within eyesight’ observations correctly and could see the patient in question.” The coroner also noted: “CCTV footage showed, for example, a member of staff (allocated to complete observations and not on a designated break at the material times) checking their mobile telephone and sitting in the lounge reading the newspaper instead of undertaking their clinical role.”<br><br>Assistant coroner Potter additionally was additionally concerned about the trust’s governance about the raising of concerns: “The evidence of a senior nurse was that specific concerns had previously been raised about the consultant in question, including that consultant not being a “very responsive consultant” and there having been “a pattern” with this consultant not reviewing patients in a timely manner. The court was told that those concerns had previously been raised with the Trust’s Clinical Director and Associate Clinical Director and, despite this, no discernible change had been noted. The Trust’s response to this during the inquest was to say that the consultant in question no longer works for the Trust and therefore the risk has been addressed. In my opinion, this is a |

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| | misunderstanding of the risk. I consider that the risk is that senior nursing staff raised a serious issue with very senior (director level) clinicians about a pattern of issues creating risk to patients (some relating to other patient deaths and / or other serious untoward incidents) and little, if any, evidence was provided about how the Trust dealt with this serious issue from a clinical governance and oversight point of view. As such, the concern remains."<br><br>In its response of 27 October 2025 to this PFD warning, ELFT stated:<br><br>**"The Trust has done a considerable amount of work since [REDACTED] very sad death in June 2022 and as such is reassured that no further action is required."**<br><br>The trust cited its own research which reportedly showed a number of improvements in metrics after introducing changes from previous PFD warnings. It added that would be using CCTV footage to audit observation practice.<br><br>I leave it to the reader to draw their own conclusions about whether the trust's response properly addressed the coroner's concern about misleading evidence give to the inquest by trust staff and the fact that staff were in the lounge reading the newspaper instead of carrying out allocated observations. |

**The death of Gary Ottway in ELFT seclusion, 2021**

Gary Ottway was a detained patient. He was supposed to be under constant observation in seclusion, a very serious situation requiring great care. Patients in a high state of arousal requiring seclusion and sometimes high levels of associated psychotropic medication may be at risk of sudden death.

Despite being on purportedly constant observation, Gary was found in cardiac arrest on 1 April 2021, cold and showing signs of hypostasis. That is to say, he had been in arrest long enough for blood to pool in the lowest areas of his body. It is hard to imagine what circumstance on a ward, even a very busy ward, explains such an oversight by carers.

Prevention of Future Deaths report on Gary Ottway, died on 1 April 2021

The **MATTERS OF CONCERN** are as follows.

1. Though Mr Ottway was meant to be under constant nursing observation, not only was he in cardiac arrest but he was also cold and exhibiting hypostasis when he was found. This appears to indicate that either the nursing observation was not constant, or it was not effective. I appreciate that the trust is putting in place a new IT system to monitor signs of life, but nevertheless basic nursing observations must be performed competently.

The coroner's report of 18 March 2022 cites no evidence of any major, unforeseen event on the ward that might account for sudden diversion of staff resource and attention away from the patient's care.

The coroner did not say explicitly in his PFD report if the observation record was falsified. Instead, he stated:

"…either the nursing observation was not constant, or it was not effective."

There is currently no published response by ELFT to this PFD. This does not mean that ELFT did not respond. I have come across past cases where the Chief Coroner for whatever reasons has not published responses.

But this case should have a been a major red flag.

**CQC's response after Gary Ottway's death in seclusion and coroners' findings of falsified observations records**

The CQC last rated January ELFT in 2022 based on an inspection in September 2021. This was after the PFD on Rohan Singh was issued in April 2021, with damning findings by the coroner of a culture of impunity regarding falsification of observation. And it was after Gary Ottway's death in April 2021.

CQC gave ELFT a glowing inspection report with an "Outstanding" rating.

For example: "We found an overwhelmingly positive culture across the trust. Staff told us that they felt proud to work for the trust and we heard many examples of how they put the people who use services at the centre in their work."

CQC noted in very general terms that the trust had made changes following death investigations and coroners' findings, for example:

"There was evidence that changes had been made as a result of investigations. For example, following the death of a patient in another part of the trust, the Coroner had raised concerns about observations of patients and specific observations following rapid tranquilisation. In response, the trust had introduced a competency checklist for

nursing staff and support workers regarding observations of patients along with daily audits to ensure that observations were being recorded accurately".

CQC did not provide clear evidence that such changes were effective. The regulator just tended to describe what new processes comprised.

But there was no explicit mention by CQC of the shocking death of a patient in seclusion under purportedly constant observation, who had been found cold, in cardiac arrest, with hypostasis.

CQC took over the responsibilities of the formerly independent Mental Health Act Commission which inspected and safeguarded the rights of detained patients.

A death of a detained patient in seclusion should have flagged very serious concern given this aspect of CQC's responsibilities.

Neither did CQC's 2022 inspection report explicitly address the falsified observations records and culture of impunity as found by the inquest jury and the coroner in Rohan Singh's 2021 death.

The inspection report thus arguably represented a sanitised picture of ELFT's governance.

**FOI response by ELFT**

I noted that in 2024 ELFT told the local Health Scrutiny Committee that it had commissioned a Human Factors review as part of its response to concerns about its staff falsifying observation records.

"They'd [ELFT] engaged an external consultant to examine more closely the human factors at play here that determine staff behaviour".

I asked the trust for a copy of this report and for general information about ELFT's governance response to the issue of falsified observations records.

This is ELFT's general response:

FOI response from ELFT 26 March 2026 Falsification of observation records

It reiterates some of the information already seen in the trust's responses to coroners' PFD warnings.

The trust reiterates that it only initiated its response in 2022, the year **after** Gary Ottway died, and after the 2021 PFD on Rohan Singh.

The trust's reported response encompassed:

- direct handover of observation tasks between allocated nurses
- enhanced training on observations

- a facility to report missed observations “to foster honesty and a culture of learning”
- weekly observation huddles in all Directorates where observation incidents and data is reviewed

There is potential tension between the drive to encourage open reporting of missed observations and the trust’s disciplinary undertakings:

“Where poor practice is identified, the Trust Disciplinary Policy is enacted with oversight by Lead Nurses and Directors of Nursing to agree the most appropriate and proportionate steps to be taken”.

ELFT disclosed that since 2022, twelve members of staff have been referred to the Nursing and Midwifery Council with regards to the falsification of observation records:

“There have been twelve referrals”

As problems with executing planned observations may stem from short staffing, I asked if ELFT had increased staffing as part of its governance response to the incidents of falsified observation records.

ELFT replied:

“No, any changes to safer staffing requirements are agreed through the process of annual establishment reviews.”

This is somewhat different to ELFT’s responses to coroners in the deaths of Mahamound Ali and Anna Elliott when ELFT implied that part of its relevant response had been to increase staffing, albeit through establishment reviews.

**Human Factors review by Jane Carthey Consulting 11 November 2024**

ELFT disclosed this report as requested:

**Report 2024 of Human Factors review by Jane Carthey on observation practices at ELFT**

This work was commissioned by ELFT as part of its response to the falsification of observation records and the scope given to the contractor by the trust was as follows:

## 2.0 Scope

The scope of the current analysis is to carry out an analysis of the work system around therapeutic and physical health observations, using both past serious incident investigation reports and insights into work as done gleaned from workshops with staff working on adult acute in-patient wards and PICUs at ELFT.

The trust has carried out previous thematic analyses of serious incident investigation reports relating to incidents where the investigation identified 'falsification of observations.' The previous analyses have been reported through ELFT's governance structures. In September 2024, the report, Falsification of Observations Review was discussed at the 2nd September 2024, Quality and Assurance Committee. The Falsification of Observations report included twelve cases of Patient Safety Incident Investigations/Serious Incidents involving inpatient deaths from August 2018 to August 2024 where falsified or potentially falsified observations had been identified. The report also included a summary of on-going improvement work undertaken to improve therapeutic engagement practice in the Trust from 2021 to date.

The Director of Patient Safety & Patient Safety Specialist at ELFT has shared that although previous thematic analyses have been completed, it has proven difficult to identify common themes across the investigation reports. The current analyses focuses on adding to what has already been learnt about practice for therapeutic and physical health observations by applying a human factors lens to gain insights into the work system.

**The human factors-based deductive thematic analysis is not restricted to cases where there was evidence of 'falsification of observations.' Its scope is to take a broader look at the 'work system' around observations practice at ELFT. The report aims to add to and complement current knowledge, and not to replicate previous work that has been completed internally.**

The Human Factors review is quite a technical report with a good deal of specialist terminology, but my reading is that in essence it found that much of the care in question at ELFT deviated from policies.

Care as "done" was very different from care as "imagined" or "prescribed", revealed both by reviewing selected serious incidents and workshops with staff.

This is obviously a contrast to the glowing report from CQC two years previously.

26 inpatient cases were selected by the trust for Human Factors review.

The cases were included if (a) they showed evidence of falsified observation records, incorrectly recorded observations or where it was "it was normal practice for physical or therapeutic observations to not be carried out at the prescribed frequency' (b) resulted in death by suicide or deterioration in physical health, or a homicide (c) these deaths fell in the period 1st January 2020 to 31st December 2023.

Some of the contributory factors identified in these serious incidents by the Human Factors review were issues of cultural norms.

It had become accepted practice for observations records to be filled in retrospectively, for observation records to completed at the end of shifts rather than

contemporaneously, for staff to sign observations for other staff and for staff to sign for observations that had not been done.

Other contributory factors included general acuity of the wards which sometimes disrupted care planned observations, and events such as unforeseen, short notice sickness, emergencies across the inpatient unit or staff shortage due to escort duty.

It was noted that relatively quiet day shifts might mean that no extra staff would be booked for later shifts when in fact more staff might be needed. A night shift when many patients were unexpectedly restless and awake might make observations difficult.

There were also some particularly worrying notes about staff using personal mobile phones or being on headphones whilst on observation duty. And a member of staff who went to collect items from their car when they were supposed to be carrying out observations.

There were problems about ensuring that bank and agency staff were competent in carrying out observations, and notes that temporary staff were not inducted.

There were also many other factors identified such as physical layout of wards and CCTV blind spots, IT, equipment availability and disrepair, overrunning ward rounds and information flow issues.

There was a note of resignation in some of the commentary. Such as a feeling that things would become unmanageable if all NEWS2 scores (indicators of physical deterioration) were escalated, as there was only one duty doctor.

There was concern that the trust policy on observations was not in reality practicable. That is, the policy requirement that staff should conduct observation for no more than one hour at a time and that at least one third of observations should be done by qualified staff.

Workshops held with staff as part of the Human Factors review confirmed that the reality on the ground is that staff may be on observation duty for hours at a time.

For example: “Bank staff are sometimes left for hours and hours doing 1:1s for patients in seclusion. They reported that when this happens, their attention drifts because they are human beings and cannot maintain focus.”

And: “Staff can spend three hours or more on 2:1 observations: This is mentally exhausting because it is three hours plus with a patient who is self-harming or aggressive.”

Staff flagged that small upsets may easily disrupt compliance with the trust observation policy. For example, if for clinical reasons, observations have to be allocated by gender of staff, this may limit the opportunities for giving staff breaks.

There was a possible implication that choices are sometimes made between defusing ward tension by facilitating escorted leave at the expense of observations:

“On ward X there are two patients on 1:1 observations and five patients on intermittent observations. Seven patients are due escorted leave. Staff must facilitate escorted leave because it creates a more relaxed atmosphere on the ward.”

The complexity of the interdependent factors that could affect successful observations was acknowledged:

“Overall, the findings show how the task of carrying out observations (therapeutic and physical health) is embedded within a complex work flow on wards and PICUs: The quality and completeness of observations is influenced by multiple factors including other microsystems and tasks, for example, handovers, MDT meetings, ward rounds, admissions and discharges and escorted leave. Observations practice is also impacted by task distribution across the team, how observations are reallocated when unexpected events occur, staffing levels, the ‘fit’ between staff on shift and patient acuity, whether potential task conflicts are anticipated and managed, (e.g. holding the emergency response bleep whilst being allocated intermittent observations), team cohesiveness and culture, equipment functionality and availability, and how distractions and interruptions are handled.”

The Human Factors specialist considered that the majority of recommendations from internal trust investigations would be “weak” in effecting change. For example, just reminding staff to comply with a policy.

The trust was advised that interventions which addressed issues such as resources, system redesign and culture change are more effective, and that the gap between ‘work as prescribed’ and ‘work as done’ should be closed.

There was varied staff feedback elicited regarding the trust improvement initiatives that had been presented to coroners such as formal handover of observation boards (boards with the observation sheet attached), zonal observations and twilight shifts. There were reported gains such as continuity and reduced interruptions, but zonal observations were not felt to be safe for some of the ward environments. Staff gender mix also limited the use of zonal observations. Some staff were hesitant to take a board out onto the open ward in case it might be used as a weapon. There was no feedback that the twilight shift increasing, therapeutic activity. Staff were reportedly mostly concerned with excessive, unmanageable workload:

“Rather, in every workshop, staff described how workload demands, coupled with staffing and skill mix challenges, left staff feeling exhausted and, at times, with a sense that they could not provide the level of care to patients they wished to provide.”

The workshops identified that staffing levels had not kept pace with “the increasing admissions and flow of patients through wards”.

Confirming coroners’ concerns, the Human Factors specialist concluded that the trust’s improvement initiatives did not fully address the issues of missed and falsified observations:

“The QI interventions of board rounding and zonal observations address some, not all, of the factors which lead to observations being missed, and falsification of observations. The report author acknowledges the interventions were never designed to address the multitude of factors identified in this report.”

**Is there open governance at ELFT?**

Another recent coroner’s PFD warning about ELFT raised serious concern.

In the death of Mansoor Zaman, it was revealed that the trust reportedly conducted an internal investigation without even interviewing its own staff or feeding back the investigation outcome to them.

Prevention of Future Deaths report on Mansoor Zaman 6 February 2026

9. The inadequacy of the Trust patient safety framework investigation which neither sought the recollections of treating staff, nor communicated the findings of the report to the same staff.

This is astonishing and not a good sign of open governance and learning.

The impropriety of ignoring a major swathe of evidence by not interviewing staff during a serious incident investigation is incomprehensible, and raises questions of organisational wilful blindness.

At the time of writing, there is no published trust response to the extremely serious criticism by the coroner about flawed investigation process.

I raised the serious breach of governance with the CQC, which has advised that it is currently completing an reinspection of ELFT and will take the PFD data into consideration and examine ELFT’s handling of this case.

Moreover, CQC advises its reinspection of ELFT will include recent incidents, ELFT’s governance processes for handling incidents and how learning from incidents has been implemented by ELFT:

“We have carried out a recent inspection of acute and psychiatric intensive care wards at East London NHS Foundation Trust. Our inspection report is currently being drafted and will go through our usual quality assurance processes before it is published. As part of this comprehensive inspection we consider recent incidents, how they were managed and how learning from them has been implemented. Our findings will be included in the inspection report when published. We will conclude our current inspection programme of the trust with a well led review in early summer. As part of this review, we will consider the trusts governance processes for identifying, investigating, reporting, taking appropriate action and learning from incidents.”

**Is ELFT unusual?**

It would be fair to acknowledge that ELFT is not the only mental health service that has a history of falsified observation records. The practice has been discovered in other NHS trusts and in private sector providers.

For example, the charity Inquest told the Lampard Inquiry that the practice was “well known” at Essex Partnership University NHS Foundation Trust, and that there was a “high prevalence” of falsified observation records with little observable organisational action.

'Falsifying safety records well known at Essex mental health trust', Lampard Inquiry told

Witness Statement by Deborah Coles on behalf of Inquest to the Lampard Inquiry 1 April 2025:

> 66.2. A high prevalence of falsified observation records, and little observable organisational action to tackle the issue;

Falsification by its nature it is difficult to measure precisely and comparisons are therefore also difficult.

In the ELFT response to the coroner in the death of Mahamoud Ali, the trust argued that a possible explanation for the plethora of incidents of falsification was the effectiveness of trust investigation processes:

“Again, in the interests of context, the Trust notes it is unclear if it is disproportionately prone to observation records being falsified, **or if its investigation processes mean that it is better at detecting when this has occurred”.** [my emphasis]

But repeated criticism by coroners is certainly something to note and track.

**In conclusion**

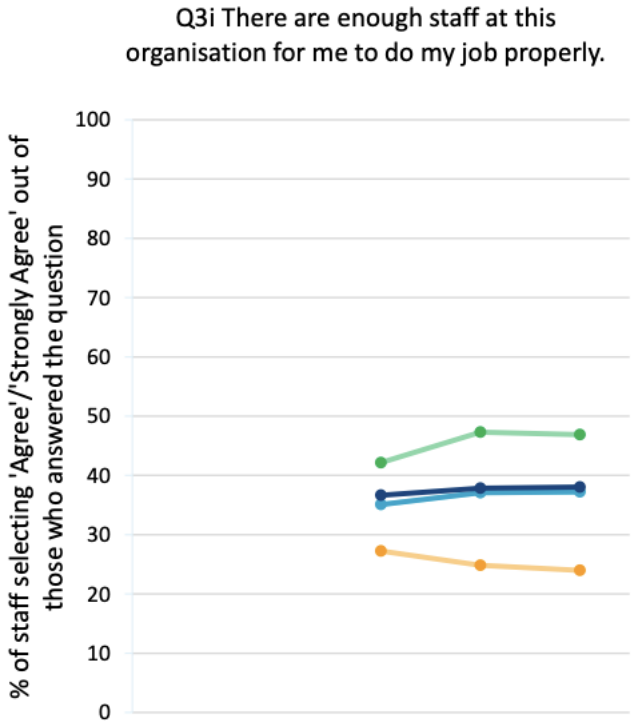
Thanks to Assistant Coroner Saba Naqshbandi’s thorough probing, the very revealing 2024 PFD on Mahamoud Ali’s death showed the serious falsification at ELFT.

It may be that ELFT has made progress in the intervening two years.

I have asked ELFT for statistics regarding its staff reporting of observation errors, to see if it has created an environment that persuades its staff to be more open.

ELFT’s latest annual staff survey results shows mostly average, not “Outstanding”, results.

Importantly, only 38.03% of staff at ELFT feel there are enough staff at the trust for them to do their job properly. This is a slight increase from 2023, when it was 35.65%.




| | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Your org | - | - | 36.65% | 37.84% | 38.03% |
| Best result | - | - | 42.15% | 47.29% | 46.88% |
| Average result | - | - | 35.08% | 37.06% | 37.21% |
| Worst result | - | - | 27.24% | 24.83% | 23.97% |
| Responses | - | - | 2964 | 2480 | 3877 |

No matter how much systems are improved, if mental health remains under-funded and under-staffed – as it will be with further cuts to mental health's share of the NHS budget announced by the Secretary of State – this resource shortfall will likely hamper 'care as done' as opposed to 'care as imagined'.

The persistence of indications of poor culture such as wilful practices which persisted as late as May 2024 in the death of Kashim Ali, which featured observing staff seated facing away from the patient and using their personal mobile phones, is also a worrying sign.

ELFT's bald – if not hubristic - claim of 27 October 2025 to the Coroners Court that it did not need to take "any further action" on the falsification of observation records remains to be tested.