



East London
NHS Foundation Trust
Information Governance
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26th March 2026

Our reference: FOI DA6494

We are responding to your request for information received 23rd February 2026. We are sorry for the delay in responding to your request. This has been treated as a request under the Freedom of Information Act 2000.

We are now enclosing a response which is attached to the end of this letter. Please do not hesitate to contact us on the contact details above if you have any further queries.

Yours sincerely,

FOI Team

If you are dissatisfied with the Trust's response to your FOIA request then you should contact us and we will arrange for an internal review of this decision.

If you remain dissatisfied with the decision following our response to your complaint, you may write to the Information Commissioner for a decision under Section 50 of the Freedom of Information Act 2000. The Information Commissioner can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Tel: 0303 123 1113
Web: www.ico.org.uk

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Chief Executive Officer: Lorraine Sunduza
Chair: Eileen Taylor

Request: FOI request: Falsification of observation records

Question 1: Please disclose what work the trust has undertaken since 2022 on the falsification of observation records by trust staff

Answer: The Trust initiated a Trustwide Quality Improvement Project on Therapeutic engagement and Observations in 2022. This work is ongoing and in the first phase improvement actions were agreed and have been implemented to improve completion and reporting of missed observations. The change idea that have moved into standard practice that contributes to a reduction in falsified observations:

- Board relay which ensures the task of observations is directly handed over and reducing the risk of missed observation or falsification of observation records where this has not been completed.

Additionally we have developed enhanced training modules on our learning platform on Therapeutic engagement and observations and honesty in documentation. These modules refer to expected practice as per policy and reinforce individual practitioners' responsibilities and accountability. It outlines action to be taken where observations cannot or are not completed including escalation and reporting on the Trust incident reporting system InPhase

We have developed categories on InPhase to allow staff to report occasions of missed observations to foster honesty and a culture of learning. This data is pulled into a dashboard for oversight that can be used to support learning or identify common trends in factors that impact on observation completion

Observation huddles take place weekly in all Directorates where observation incidents and data is reviewed. This is attended by staff across all wards and chaired by the Lead Nurses

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

Question 2: Please disclose a copy of the report arising from the human factors work that the trust commissioned, as cited in the minutes of 2024 Health in Hackney Scrutiny Commission minutes:

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

Please disclose who was commissioned to undertake this human factors work, the terms of reference for this work, when this work took place and the cost of this work.

Answer: Please see Appendix 1, which includes commissioned author name, dates of the work being undertaken and scope (Terms of Reference). The cost of the work was for ten days consultancy services - £10,200 (inclusive of £1,700 VAT).

Question 3: Please disclose if since 2022 ELFT has referred any staff to the NMC for falsification of patient records with respect to observations records. If staff have been referred to the NMC, please disclose how many were referred

Answer: Yes. There have been twelve referrals.



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Question 4: Please disclose if since 2022 ELFT has increased inpatient staffing resource as a result of reviewing incidents of falsification of observations records, and if so, on how many occasions has staffing resource been increased and what the increases comprised

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

Question 5: With respect to information supplied by the Trust to coroner Saba Naqshbandi KC in the death of patient Mahamoud Ali, aged 40:

"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"

<https://minhalexander.com/wp-content/uploads/2026/02/mahamoud-ali-prevention-of-future-death-report-2024-0379.pdf>

Please disclose how the trust derived this data on the eleven cases. How was it determined that their case records may have been falsified to show that observations were conducted, when in reality no observations were conducted?

Answer: 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.



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