I had raised Clinical concerns about Yarlswood over the course of my employment there from 2012 to 2013 and after my employment had ended. I notified both SERCO home affairs and SERCO healthcare of these concerns. I had raised these concerns with my line management… the contract manager [Serco], The Regional Healthcare Director [Serco], The Executive Director of prisons [Serco], The Associated Director of legal counsel [Serco], The Chair of Serco, The Director of HR [Serco], The CEO of Serco, The Serco Home Affairs Director, The CQC, the RCN, the Home office, the CCG, the Health Select Committee, labour and conservative MP's, and not one individual asked for detail or how the patients (who my concerns related to) were…

The following concerns below are what I had raised to SERCO:

1. Staffing within healthcare was not adequate to the needs of the detention centre capacity of 400 residents; in particular they failed to implement their own SERCO policy which stated that 25% of the work force should be allocated to the mental health needs of the centre, this equated to 5 full time qualified nursing staff working and ensuring that the mental wellbeing for residents is maintained. However there was only one dedicated mental health professional working 30 hours a week for a population of over 400 residents both male and female young and old with different complex needs including drug and alcohol addiction, dementia, learning disabilities, older adults, transsexual needs, PTSD, people at risk having blood or infectious disorders such as TB and Aids, victims of torture, victims of female genital mutilation, and under age individuals. This was a unique micro environment and the health services available did not meet their needs, some individuals were

removed without a full and proper assessment of mental health needs; some were returned to the place of origin where they had suffered initially.

2. The Home affairs side of Yarlswood that is run by SERCO had a weak policy on mental health awareness training. At the time it was an option for mental health training - it was not compulsory or mandatory for officers to train in this area. The record of officers' attendance to this awareness, one day training, was very low indeed.
3. Home affairs officers did not recognise symptoms of mental illness such as depression, schizophrenia, PDST, personality disorder or at risk patients, self-harming behaviour, suicidal ideation, general anxiety etc. as according to NICE guidelines, this therefore meant patient went without full and proper assessments and treatment plans.
4. It was Reported to me in 2012, that a resident was abused by an employee [a male domestic working at Yarlswood]. This was disclosed to me during a meeting that I had arranged for this resident who had made a wish to see her children [who were being adopted]. It was confirmed by the associate director and one other that she indeed had been abused. I asked if this was raised to the safeguarding team within local social services; this was confirmed and that the abuse would be investigated. I also notified this disclosure to the contract manager of healthcare and documented within the patient's medical notes what was raised. The following day, however I had noticed the alleged abuser, remained working within the main centre.
5. There was a manipulation of figures for mental health assessments (mental health assessments were reported for KPI's) by recording all brief and full assessments along with self-harming incidents where an ACDT risk

assessment was started. These had all been captured as mental health assessments. Despite me raising this as a concern to the Healthcare contract manager – that in fact most residents did not get a full mental health assessment as needed therefore this manipulation of figures did not give a true picture of services provided for residents or of their needs – the contract manager reinforced that it needed to continue. This was a clear manipulation of the figures.

6. On one occasion I was instructed to carry out a 12 point ECG assessment of a Muslim female, after she reported pain to her shoulder and chest area. I therefore asked that staff gain her consent (via language line service) first for a male to complete this as it would involve removing her clothing and me having contact with her bare skin. The contract manager and clinical lead (both female, registered general nurses and trained and competent to complete the procedure), stated that consent was not necessary insisting that I should complete the procedure, however as I stated I was not willing unless her consent was clear particularly because she was Muslim and I am male, the contract manager then indicated that she would perform the assessment, There was a demonstration that day due to a resident being deported, and relocated by forced, this lady was literally picked up and removed to the seclusion area , no evidence or reordering was documented according to policy
7. I raised concerns daily around the quality of mental health assessments for patients (where a mental health issue had been identified at initial triage assessment or where residents had been at the centre for longer than 60 days and potential for mental health needs is recognised to be higher). The

healthcare contract manager insisted that I should only take 10 to 15 minutes maximum to carry out an assessment as ‘the clock was ticking’ to fulfil the contract requirements. It was suggested by the manager that 5 minutes was adequate for a mental health assessment. I complained this was not adequate.

8. I carried out an assessment of a patient who I had identified as having possible meningitis. It was reported to me by the officers that the patient was in her room for up to two days before I assessed her and that when they had first contacted healthcare in the previous days some healthcare staff had suggested to officers when they said that she was unable to attend the clinic in person, that the patient should take Paracetamol but no one had outreached to assess the individual apart from myself some two days later, this was despite many attempts by an officer to engage the healthcare professional. With my persistence, this patient eventually went to A&E, however I did not receive any feedback of the outcome of this patient - this was common regarding outcome of care. When I had inquired as to what had happened to this patient, I was told “I don’t know” this was a common occurrence, patients going off the radar without any feedback to staff about the outcome of care .
9. The UKBA reported that victims of torture where in fact not being appropriately assessed as according to rules of UKBA requirements under VoT rule 35, and that further training was necessary. This training had followed after these failures, however none of the patients received full assessment through the mental health pathway and therefore were deported and removed inappropriately without a full and proper assessment by a

mental health specialist. It was also raised by myself within a safer detention meeting and clinical team meeting that victims of torture were not getting assessed by mental health services, but nothing was done to address this. I raised the concern that victims mental health were not getting assessed at all, and they were then getting deported or removed and therefore any symptoms would not be treated or they would not receive adequate care, and therefore this left these individuals vulnerable and at risk.

10. There was a lack of engagement from A&E within Bedfordshire NHS for Yarlswood patients with emergency mental health needs. There was also a lack of engagement from local social services and lack of engagement from SEPT mental health services which caused a big gap in service needs
11. There was a lack of understanding of the ACDT document used to assess risk wellbeing and safety. There was a disconnect between healthcare and operational staff both of which worked for SERCO regarding handing over at risk patients under ACDT and this was poorly lead.
12. Medication management was very poor, the reliance weighed heavily on the resident and needs were not adequately established.
13. Male officers walking into female rooms without any fore warning or risk assessment carried out was a common occurrence. In some cases no attempt was made to consider the dignity of the resident. In some cases officers did have compassion, and an understanding of need but this seemed to be down to personality rather than training of the officers
14. Observation of at risk residents were not fully implemented correctly, several events raised as near misses involved individuals whilst on constant observation. One to one observation in some cases involved males observing

females, this was simply down to a lack of female staff. I believe there were many many more near misses however these were not documented accurately, and lacked good auditing processes due to the disconnect between Home affairs and Healthcare systems .

15. There was a lack of urgency in responding to incidents of which most were self-harming or attempted suicide etc. One individual resident managed to tie bedding together, walk across her room then across the corridor, throw the bedding over the stairs from the second floor, and then try hanging herself. It was suggested by officers (whilst observing the CCTV recording of this incident which was agreed at the request of the director of the centre at the time) that she (the patient) was acting out only to get attention. It was pointed out by myself that this individual managed to carry on ‘acting out’ [attempting to hang herself] for over 20 minutes. I raised the fact that not one officer including the director had picked up on the time she was able to do this unobserved or monitored by officers. Furthermore when she was eventually seen by an officer it was the same individual who had found the last person to have completed suicide by hanging within Yarlswood, and in the very same place.
16. The wellbeing of officers were not addressed or discussed within safer detention meetings.
17. There were no clinical supervision structures in place in healthcare to support clinical staff.
18. Staff individual performance reviews were not full carried out according to policy.

19. Regarding the incident of a lady who had poured boiling hot water over herself due to her separation from her children and husband when she was taken into Yarlswood. This lady's injuries were only seen and properly assessed at healthcare some 16 hours after the incident despite her being seen at the time of the incident, around 12 midnight of the night before by operational and nursing staff. By the time that she was eventually seen at 16:00hrs she had third degree burns and signs of serious infection which required her to be transferred to hospital. No health care staff were reprimanded or reported to NMC as far as I am aware, despite this being evidence of this severe neglect of duty of care, and not one manager was disciplined within the operational staff despite failing the safety and care of this individual
20. The contract manager alluded that most individual within the centre complaining of mental health symptoms, were putting it on to avoid deportation and removal, the same attitude included physical symptoms unless observable symptoms were present and due to a lack of outreach (from the healthcare staff to residents) the burden of reliance to recognise and report symptoms was placed on the officers within Yarlswood.
21. ACDT policy was limited on mental health guidance
22. There was no involvement of Mental Health professionals within the daily case conference of ACDT risk assessments
23. The raised concerns around the demand for mental health services outweighed the capacity of healthcare staff to address this and there were additional unmet needs raised which are not able to be addressed due to this limited capacity.

24. The healthcare clinic did not to provide a timely, responsive, proactive seven day mental health service
25. The culture within Yarlswood was a place of disbelief. From senior management right down to the junior staff, it was the consistent line “they [residents] are only doing this because they don’t want to be removed” this was also said after self-harming incidents and victims of torture disclosures etc.
26. The healthcare clinic did not provide full mental health assessments in a timely manner.
27. The healthcare clinic did not provide mental health promotion
28. The healthcare clinic did not provide a consistent follow up through a pathway of care.
29. There was no senior leadership or management for mental health services equivalent to that in primary care services particularly with regards to clinical supervision structure, strategic meetings, and steering groups.
30. The healthcare clinic did not meet the assessment target for individuals who have been detained from more than 60 days or for Victims of torture due to the lack of dedicated mental health staff and lack of equal priority to mental health care as to physical health care.
31. The healthcare clinic was unable to provide crisis or inpatient mental healthcare through local NHS services, and as there are no 24 hour dedicated services for mental health in Yarlswood further resources are required to meet this support.

32. There was limited availability to support safeguarding needs relating to residents experiencing and witnessing distressing symptoms and acts of self-harm.
33. There was no psychology therapeutic provision as according to the Stepped care model or IAPT primary care wellbeing servicer to meet mental health needs.

The organisation took great steps to prevent my concerns being heard or addressed. I am presently trying to engage regulatory bodies who were made aware at the time but did not and have not acted on these concerns. To date nobody has sought the details of my complaints or concerns from me or investigated further.

I have since obtained an apology from Serco and they recognise I had raised concerns in the public interest, yet still the investigation of these concerns remain outstanding.

I wish to be called upon to give evidence to this inquiry into the safety of vulnerable residents within detention centre.

Kind Regards

Mr Noel Finn

07824601564