

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Jade Eatough a prisoner at HMP Isle of Wight on 19 August 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Jade Eatough was found hanged in her cell at HMP Isle of Wight on 19 August 2017. She was 35 years old. I offer my condolences to Eatough's family and friends.

Ms Eatough was born male but, in 2014, she informed the prison she wanted to live as a woman. The prison generally made commendable efforts to address her needs as a transgender prisoner but some prison and healthcare staff failed to respect this decision consistently. Ms Eatough was also given inaccurate advice about changing her name, something she never managed to achieve, adding to staff's confusion about how to address her. The clinical reviewer also concluded that Ms Eatough's clinical care was not equivalent to that she could have expected to receive in the community due to poor record keeping, particularly in relation to transgender issues.

Ms Eatough had been in prison since 2005 and appeared frustrated at her lack of progress through the system. She had not, however, been assessed as a risk to herself since 2016. Staff and prisoners noticed no change in her mood before her death and she seemed happy about a recent decision to transfer her to another prison. There was nothing to indicate that she was at an increased risk of suicide in the days immediately before her death. We do not consider that staff could have anticipated or prevented Ms Eatough's death.

When Ms Eatough was found, staff responded quickly. However, although it made no difference to the outcome in Ms Eatough's case, we are concerned that some staff believed they should never use their emergency key to enter a cell alone in an emergency. We also found that staff did not give accurate information to the 999 operator when requesting an ambulance.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

May 2018

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Summary

Events

1. Mr Martyn Eatough was arrested in June 2005 and remanded to HMP Preston. In March 2006, he was convicted of rape and sentenced to life imprisonment with a minimum tariff of three years and 99 days. In 2008, Mr Eatough transferred to HMP Albany on the Isle of Wight where he completed the Sex Offender Treatment Programme and the Thinking Skills Programme.
2. On 6 October 2014, Mr Eatough told a nurse that he considered himself transgender. (From this point, we recognise her identity as Ms Jade Eatough, in respect for her wishes.) In January 2015, she was accepted on the transgender pathway. From this point until her death, some staff remained inconsistent in referring to her in line with her wishes and often recorded information using the male pronoun or her birth name. There are also references to her making applications to change her name. These were never processed and she was told (erroneously) that she first needed to change her name by deed poll.
3. Ms Eatough sometimes got into difficulties with other prisoners over debts she had allegedly accrued due to her misuse of prescription medication. This was never proved and staff dealt with it appropriately.
4. Ms Eatough was subject to ACCT suicide and self-harm prevention procedures for short periods, the last being in December 2016. These mainly related to the risk of self-harm she presented rather than thoughts of suicide.
5. In January 2017, in line with her wishes, staff applied for her to transfer to HMP Rye Hill. Ms Eatough's behaviour was changeable; sometimes she would fail to turn up to work and be argumentative with staff while on other occasions she was compliant and apologetic. In July, she lost her gardening job after threatening a member of staff. On 17 August, she was accepted for transfer to Rye Hill. Her offender supervisor said she seemed happy about the move. Prisoners and staff said she had seemed her usual self in the days before her death and noticed no change in mood.
6. On 18 August, shortly before midnight, Ms Eatough rang her cell bell, having accidentally cut her elbow. Staff responded and dressed her wound. They said she seemed cheerful and they had no concerns that she posed a risk to herself. Staff checked her again at 1.45am on 19 August and said Ms Eatough seemed fine.
7. Shortly before 5.00am, during the routine roll check, an Operational Support Grade (OSG), discovered that Ms Eatough had blocked her observation panel. The custodial manager, went straight to Ms Eatough's cell. He looked through the observation panel, could see nothing and immediately unlocked the door. Ms Eatough was hanging from the window by a bed sheet. The custodial manager radioed an emergency code, cut her down and began CPR. Paramedics arrived at 5.20am and took over Ms Eatough's care but pronounced her dead at 5.43am. After some delay in getting a ferry to the mainland, at 4.25pm prison staff informed Ms Eatough's next of kin that she had died.

Findings

Assessment and management of risk of suicide and self-harm

8. Ms Eatough was subject to ACCT monitoring on several occasions, the last of which was in December 2016. We are satisfied that these procedures were managed appropriately. In addition, we have found that there was nothing to indicate that Ms Eatough presented a risk of suicide before she died and staff could not reasonably have been expected to predict Ms Eatough's actions and prevent her death.

Management of Transgender Policy

9. There was much to be commended in the prison's management of Ms Eatough's transgender status. However, the investigation found that some staff sometimes failed to address Ms Eatough in line with her wishes. In addition, applications she made to change her name were not processed and she was given incorrect advice that she needed to change her name by deed poll first.

Sentence Progression

10. Ms Eatough had been in prison for 12 years at the time of her death. She had just been told she was going to move to HMP Rye Hill, a progression she appeared pleased about. We consider that it is possible that both the length of time Ms Eatough had spent in prison and her imminent transfer may have been relevant to her state of mind when she died.

Clinical care

11. The clinical reviewer concluded Ms Eatough's clinical care was not equivalent to that which she could have expected to receive in the community due to the poor level of record keeping, particularly in relation to transgender issues.

Emergency Response

12. Although it did not cause a significant delay in Ms Eatough's care, we are concerned that staff told the investigator that they would never use their emergency keys to enter a cell alone. The emergency response was largely swift and competent, but we are also concerned that prison staff told the 999 operator that they thought Ms Eatough was breathing when this was not the case.

Recommendations

- The Governor and Head of Healthcare at HMP Isle of Wight should ensure that all staff are familiar with their responsibilities in respect of PSI 17/2016, *The Care and Management of Transgender Offenders*.
- The Head of Healthcare should ensure that clinical records are accurate, detailed and include diagnoses and care plans from external appointments.

- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including:
 - that they enter cells as quickly as possible in a life-threatening situation;
and
 - that they give accurate information to the ambulance service.

The Investigation Process

13. The investigator, issued notices to staff and prisoners at HMP Isle of Wight (IoW) informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. She visited HMP IoW on 23 August. She obtained copies of relevant extracts from Ms Eatough's prison and medical records.
15. A clinical reviewer was appointed to review Ms Eatough's clinical care at the prison.
16. The investigator, Assistant Ombudsman, and clinical reviewer interviewed six members of staff and five prisoners at IoW.
17. We informed HM Coroner for the Isle of Wight of the investigation. The Coroner provided the post-mortem results. We have sent the coroner a copy of this report.
18. Ms Eatough was born male but had asked to live as a woman at IoW in 2014. We have referred to her by her preferred name and gender, in line with the Department of Health's guidance for transgender persons, and to respect her wish to be referred to as a woman.
19. One of our family liaison officers, contacted Ms Eatough's mother on 2 November 2017, to explain the investigation. Ms Eatough's mother asked how long Ms Eatough had left to serve and whether she was due to be transferred to another prison.
20. Ms Eatough's mother received a copy of the initial report. She did not make any comments.
21. HM Prison and Probation Service (HMPPS) also received a copy of the report. They accepted all the recommendations.

Background Information

HMP Isle of Wight

22. HMP Isle of Wight (IoW) is an amalgamation of two earlier prisons, Parkhurst and Albany, and holds approximately 1,100 men. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Isle of Wight was conducted in June 2015. Inspectors found that the number of prisoners at risk of suicide or self-harm was higher than in similar prisons but their care was generally good. They commented that relationships between prisoners and staff were good and there was an unusually effective personal officer system.
24. Inspectors concluded that the strategic management of equality was reasonably good but that consultation with lesbian, gay, bisexual and transgender (LGBT) prisoners had recently lapsed. They found that good efforts were made to meet the complex needs of transgender prisoners.

Independent Monitoring Board

25. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to December 2016, the IMB noted that throughout the year the transgender population had varied. Generally 8-12 prisoners were on the 'transgender pathway' at any time. Although this was a relatively small number compared to the general community, the time demands made on the local Board were significant. The IMB noted that the lack of national training to improve the knowledge of wing staff, management and the Board has created concern that members of this "protected characteristic group" (Equality Act 2010) might not be receiving the treatment to which they are entitled.

Previous deaths at HMP Isle of Wight

26. Ms Eatough is the first non-natural death at the prison since 2016. There were no similarities between those earlier deaths and that of Ms Eatough. There has been one self-inflicted death since that of Ms Eatough.

Assessment, Care in Custody and Teamwork (ACCT)

27. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce it and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should

be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.

Transgender Prisoners

28. PSI 17/2016 *The Care and Management of Transgender Offenders*, came into effect in January 2017. This was a revised version of a pre-existing policy on transgender prisoners. It contains instructions on how to determine an individual's correct location within the prison estate and guidance about their care and management. It also sets out how transgender prisoners should be referred to, along with the access they should have to items relevant to their gender, such as clothes and make-up.

Incentives and Earned Privileges (IEP) Scheme

29. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

30. In June 2005, Mr Martyn Eatough was arrested for offences of rape. He was remanded to HMP Preston and a subsequent pre-sentence report noted that he had thoughts of hanging himself. On 6 March 2006, Mr Eatough was found guilty and was sentenced to life imprisonment with a tariff of three years and 99 days. He settled in prison and addressed his drug misuse issues.

Albany site - 2008 to 2014

31. In August 2008, Mr Eatough transferred to HMP Albany on the Isle of Wight. In 2009 HMP Albany and HMP Parkhurst merged and became HMP Isle of Wight (IoW).
32. Mr Eatough started the Sex Offender Treatment Programme (SOTP.) His behaviour was sometimes volatile, as was his attitude to staff. In 2009, the Parole Board did not recommend a transfer for Mr Eatough to open conditions, indicating that they considered his risk to others had not yet been sufficiently addressed.
33. On 23 April 2010, Mr Eatough had a seizure. He was admitted to the local hospital, where he was diagnosed with epilepsy and prescribed medication. Mr Eatough did not suffer from frequent seizures and it is recorded that he was not regularly compliant with his medication.
34. Mr Eatough successfully completed the SOTP in October 2010.
35. On 15 November 2010, Mr Eatough told staff that he had swallowed a large amount of medication, as he felt threatened on the wing. Staff began ACCT suicide and self-harm prevention procedures. Mr Eatough told staff that he had cut himself and tried to hang himself when he was a teenager. Staff closed the ACCT on 9 December after assessing that Mr Eatough was no longer a risk to himself.
36. In July 2011, the Parole Board again recommended that Mr Eatough needed to complete further offending behaviour work before being moved to open conditions. Mr Eatough successfully completed the Thinking Skills Programme in May 2013.
37. Mr Eatough worked in the gardens. During 2014, his behaviour was changeable, and his Incentives and Earned Privileges level reflected this. At times he said he was in debt to other prisoners. In October, he was issued with an IEP warning for wearing clothing (a bra) which did not belong to him.
38. On 6 October, Mr Eatough told a prison GP that he considered himself transgender and wanted to start the process of gender reassignment. (From this point, we recognise her identity as Ms Jade Eatough, in line with her wishes.) Ms Eatough told the doctor that she had also applied to the prison's Equalities Officer.
39. There were no further entries about this in Ms Eatough's record until 28 October when she demanded an officer call her Jade. The officer recorded that, as there was no official paperwork to support this, Ms Eatough would be referred to as

Martyn or Mr Eatough. Prison staff continued to refer to Ms Eatough in documentation as 'he' or 'Mr Eatough'.

40. On 30 October 2014, the Parole Board again denied Ms Eatough's transfer to open conditions as they considered that she needed to complete further offence-focused work.

Parkhurst site – 2014 to 2016

41. On 18 December 2014, staff told Ms Eatough that she would be moving to the Parkhurst site of HMP IoW. She told staff that she did not want to move, as she was concerned that she might be bullied due to being transgender. Ms Eatough said she had razor blades in her mouth and threatened to swallow these if the move went ahead. Staff began ACCT procedures. Staff explained to Ms Eatough that the move was not personal and that all transgender prisoners currently on houseblock 12, were being located across both sites. Ms Eatough agreed to the move. Although the ACCT review referred to Ms Eatough's transgender identity, staff still referred to her as male. During an ACCT assessment, Ms Eatough said that she just wanted to be accepted onto the transgender pathway. The next day, Ms Eatough moved to the Parkhurst site, settled well and staff closed her ACCT on 23 December.
42. On 30 January 2015, staff held a multi-disciplinary transgender review. They recorded that Ms Eatough had now been accepted onto the transgender pathway. However, staff noted concerns that her motivation for becoming transgender might not be genuine and might be an attempt to avoid completing further offending behaviour work. On 11 February, an officer gave Ms Eatough a letter, welcoming her onto the transgender prisoner pathway. The prison record shows that from late March 2015 onwards, staff began referring to her as Ms Eatough more regularly, although this remained inconsistent.
43. On 4 March, a prison GP noted in Ms Eatough's medical record that she had had blood tests but there had been no further progression of her transgender status. She had received a letter from the prison about her request to be treated as transgender but had not signed the consent form. The prison noted that she required a psychiatric assessment and staff would discuss this with the mental health team.
44. On 9 March, a member of staff recorded that he had replied to Ms Eatough's request for support in seeking transgender medical intervention and her application to change her name. He advised her that the form had been sent to the Governor but due to a fire at the Albany site and the officer himself being out of the office, there had been a delay in processing it.
45. On 11 April, an officer who had recently been appointed as Ms Eatough's personal officer, spoke to Ms Eatough. He recorded that Ms Eatough acknowledged that it would take time for staff to start addressing her as 'Ms' consistently. On 1 May, Ms Eatough attended an appointment with the prison GP. During the appointment, the prison GP completed a referral for Ms Eatough to attend a Gender Identity Clinic (GIC.)

46. On 19 May, the Parole Board again did not support Ms Eatough's transfer to open conditions.
47. On 9 July, Ms Eatough submitted a complaint about a drug worker addressing her as 'Martyn'.
48. On 23 October, a prison GP met Ms Eatough and completed the outstanding paperwork for her referral to the GIC. On 26 November 2015, staff received information from another prisoner that Ms Eatough was both the victim and perpetrator of bullying due to debts she had accrued through drug use. It was claimed that she was being bullied for money she owed and was, in turn, bullying other prisoners as a way of paying those debts. Staff monitored Ms Eatough but there was no further information or evidence to support the allegations.
49. Staff recorded that Ms Eatough was challenged by staff for growing facial hair and walking topless on the residential unit. Staff recorded that this was not in keeping with the transgender pathway compact and that Ms Eatough should consistently present in the gender with which she identified.
50. On 17 January 2016, Ms Eatough completed a change of name application with an officer and sent this to the Head of Residence. On 4 March, blood tests were completed in preparation for Ms Eatough's appointment at the GIC. It was also recorded in her medical notes that Ms Eatough would require a psychiatric assessment, which would be discussed with the mental health team.
51. On 1 and 7 April, Ms Eatough asked an officer if he would chase up any progress on her name change and he confirmed that he would. The Head of Offender Management, indicated that he had not received a change of name application and recommended that Ms Eatough make another application once she had received her deed poll. The officer spoke with Ms Eatough again on 10 April and provided her with a copy of the Prison Service Order (PSO) relating to the changing of names, and a form to have her name changed by deed poll. The officer told her that he had spoken with a manager who had advised that Ms Eatough would be better to change her name by deed poll, prior to requesting an update of her name on prison records. Ms Eatough thanked the officer for his help, and explained that she would attempt to get the funds to pay for the name change.
52. On 25 May, Ms Eatough told an officer that she had saved £18.00 towards the £36 cost to change her name. On 25 June, Ms Eatough cut herself. She said she had been thinking about a car accident she had had when she was younger. She said she wanted to be dead. Staff opened an ACCT which they closed four days later when she was no longer assessed as a risk to herself.
53. On 21 July, Ms Eatough spoke with probation staff and said that she was interested in a transfer to HMP Rye Hill to complete an adapted SOTP course. Ms Eatough told staff that she had completed the courses on offer at IoW and felt stuck in the system.
54. On 1 August, a note was pushed under the wing office door. The note stated that Ms Eatough was in debt to other prisoners and was being threatened as a result. Staff spoke with Ms Eatough. They recorded that she did not appear

surprised to be asked about the letter. Ms Eatough said that she was happy to remain on the unit. Staff recorded that morning Ms Eatough was taking part in association and mixing well with her peers; she appeared relaxed and happy.

55. However, the same afternoon Ms Eatough told staff that two masked prisoners had assaulted her after morning unlock. When staff asked her why she had not mentioned it earlier, Ms Eatough said that she had been scared. She told staff that she did not want any action taken and declined a move to another wing. On 4 August, a member of staff was approached by two prisoners who both told the officer that Ms Eatough was likely to be badly assaulted due to debts she had accrued. Although there was no evidence to support the threats that had been made, staff moved Ms Eatough to the Albany site of the prison later that afternoon for her own safety.

Return to Albany site – August to October 2016

56. On 11 August, an administrative officer, noted that Ms Eatough was on the transgender pathway but had not yet been granted a name change by the Governor. She should therefore be referred to by the name in her records – either Martyn or Mr Eatough. On 19 August, Ms Eatough spoke to an offender supervisor, about her name change. The offender supervisor told her she was not to be known as ‘Jade’. Two days later Ms Eatough complained about an officer calling her a ‘guy’ and asking about her gender recognition certificate.
57. Transgender reviews were completed with Ms Eatough while on the Albany site and concerns were raised about her behaviour. It was recorded that she was showering with male prisoners, although separate arrangements were in place for transgender prisoners as part of the compact. Staff also noted that Ms Eatough did not consistently remain in the gender role with which she had identified as she was regularly growing facial hair.

Return to Parkhurst site – from October 2016

58. Ms Eatough remained on the Albany site until 21 October 2016, when she moved back to Parkhurst. An offender supervisor, took over her case at this time. He met with Ms Eatough and they discussed her sentence progression and potential transfer to Rye Hill.
59. On 6 November, Ms Eatough told staff that she had razor blades in her mouth. Staff spoke with Ms Eatough at her door, and noted that her issues appeared to be with her gender identity, but they recorded that she was calm. Staff continued to observe and talk to Ms Eatough who made several superficial cuts to her arm. Staff treated these cuts and opened an ACCT. The next day, Ms Eatough denied any intent to harm herself further. During November, Ms Eatough was volatile and her ACCT remained open. On 23 November, Ms Eatough attended the GIC in London and was assessed by a psychiatrist. The psychiatrist noted that Ms Eatough’s aim was to obtain hormonal treatment and genital surgery. It was intended that Ms Eatough be further assessed at the clinic a few months later.
60. Ms Eatough’s ACCT was closed on 2 December. There were no further incidents of self-harm and no concerns raised by staff or Ms Eatough about her

risk to herself. On 19 January 2017, the offender supervisor sent paperwork to Rye Hill with a view to Ms Eatough transferring there. Over the following months, he pursued this transfer and encountered difficulties in getting Rye Hill to communicate with him directly or to make a decision about Ms Eatough's transfer.

61. A routine transgender review with Ms Eatough took place in May. Reports on her custodial behaviour were mixed. Ms Eatough was reported by other prisoners to be in debt, and was recorded as failing to attend work on a number of occasions. Staff recorded that her behaviour was variable, at times being argumentative and confrontational with staff, but later apologising. This behaviour led to Ms Eatough receiving several warnings from staff and, eventually, the loss of her job in the gardens in July 2017.
62. Prisoners spoken to by the investigator said that some staff and prisoners continued to call Ms Eatough by her birth name or gender. They described her as an energetic, happy prisoner, who talked to lots of different people. None of them had concerns that she posed a risk to herself. They described her as sometimes getting into small amounts of debt to other prisoners due to taking prescription medicine but said that this did not overly concern her, and other prisoners would assist her in repaying the debts.
63. On 12 July, an administrative officer recorded that Ms Eatough was still signing her name as 'Jade' but that no change of name had been approved. She should, therefore, continue to be referred to by the name on her computerised record (Mr Martyn Eatough). In July, Ms Eatough told an IMB member that she was finding her choice of clothing at IoW frustrating. She met Ms Eatough on several occasions and said she never had any concerns that she was a risk to herself.
64. Ms Eatough's personal officer since October said that she mainly spoke to him about transgender issues such as obtaining the makeup and clothing that she wanted. However, he said Ms Eatough never became distressed about this, only frustrated, and staff did all that they could to supply the items. The Head of Equalities and Social Care, said that Ms Eatough was a vocal representative for the transgender community at IoW and she would speak up for others. She was generally a happy prisoner who liked to joke. At the beginning of August, she had contact with Ms Eatough as she was a representative on the LGBT group that she ran. They discussed being able to order women's clothing and the Head of Equalities and Social Care was in the process of acquiring a selection for the transgender prisoners to choose from.
65. On 8 August, an offender supervisor again spoke to Rye Hill about Ms Eatough's transfer. He was told that the prison now had all the necessary paperwork and that he should ring back in two weeks' time. He told Ms Eatough, who was happy about the potential move. On 17 August, he received confirmation that Ms Eatough had been accepted by Rye Hill but needed to wait until a space and transport was available. He informed her of this and, again, said she seemed happy about the move.

18 - 19 August 2017

66. A prisoner, said he had been in a relationship with Ms Eatough for five years. He lived on a different wing. On 18 August, he spoke to her in the exercise yard between 2.00pm and 3.00pm. He said Ms Eatough seemed her usual self and asked him to get her some noodles and juice from his next canteen, which was not an unusual request. Other prisoners reported seeing her at around 4.30pm when she collected her evening meal to eat in her cell. They said she seemed her normal self.
67. The custodial manager was in charge of the prison that evening. During night duty, only the orderly officer carries a full set of keys, for security reasons. Other staff carry an emergency pouch, which contains a single cell key, which they can access in an emergency. An Operational Support Grade (OSG) was the only member of staff on duty on Ms Eatough's wing. He conducted a roll check at 7.50pm, at which point he spoke to Ms Eatough through her observation panel. She raised her hand and said she was 'okay'.
68. At around 11.50pm, Ms Eatough rang her cell bell. The OSG immediately responded and Ms Eatough told him she had hit her elbow on a shelf and it was bleeding. He telephoned the custodial manager and told him what had happened. The custodial manager went straight to Ms Eatough's cell. There are no nursing staff located on the Parkhurst site during the night, as they are all based in the healthcare unit in Albany.
69. The custodial manager said that when he went into her cell, Ms Eatough was sitting at her table, writing a letter. There was a small cut on Ms Eatough's elbow, which he bandaged. He said Ms Eatough seemed happy and jovial and they spoke about Ms Eatough's past military career. He said that when he left the cell, Ms Eatough said that she was fine. The OSG said that he would look in on Ms Eatough when he did his ACCT checks on other prisoners but neither the OSG nor the custodial manager had any concerns that she was a risk to herself.
70. Around 1.45am, the OSG returned to talk to Ms Eatough and asked her for some information he needed to complete his injury form. He told the investigator he already knew this information but wanted an excuse to talk to Ms Eatough. He said that he would come back later to check on her, but Ms Eatough told him that he did not need to, and that she would be watching television. He said that she seemed fine and her bandage was still in place. He said he had no concerns about her.
71. The OSG began his roll check shortly before 5.00am. When he got to Ms Eatough's cell, he looked through the observation panel but it had been blocked. He tried to get a response by kicking the door, but there was no response. He then heard the custodial manager come onto the wing and, as Ms Eatough was not responding, he called to him to come up to the cell.
72. The custodial manager went straight to the cell and looked through the observation panel but this was blocked by Ms Eatough's shower curtain. He opened the cell, the curtain fell to the floor, and he saw Ms Eatough, suspended by a bed sheet from the window at the other end of the cell. He immediately radioed a code blue emergency. (This indicates a medical emergency in

circumstances where a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.) An incident log recorded the code was radioed at 4.51am. An ambulance was requested by the control room at 4.52am. The investigator listened to this telephone call. The 999 operator asked if the patient was breathing, to which the control room member of staff replied, "I believe so, yes." The 999 operator did not ask any further questions and deployed the ambulance.

73. As soon as he went into the cell, the custodial manager supported Ms Eatough's body and lowered her to the floor. He checked for signs of life and started cardiopulmonary resuscitation (CPR). He told the investigator that Ms Eatough felt cold and was floppy. The OSG, who remained standing in the doorway, was extremely distressed by what he had seen and was unable to assist with the emergency response. The custodial manager was keen to ensure that contingency plan had been activated and to ensure a member of staff went to the gate to escort the ambulance. He therefore left Ms Eatough and went to the office telephone (down one flight of stairs) to call the control room.
74. While the custodial manager was on the telephone, other staff arrived to assist, bringing a defibrillator. They all returned to Ms Eatough together, attached the defibrillator and restarted resuscitation. The ambulance arrived at the prison at 5.03am, and paramedics were taken straight to Ms Eatough's cell, where they took over emergency treatment. The paramedics recorded that it took 17 minutes to get from the prison gate to Ms Eatough's cell. They took over Ms Eatough's care but pronounced her dead at 5.43am.

Contact with Ms Eatough's family

75. The prison appointed an officer as the prison's family liaison officer. The officer left the prison to inform Ms Eatough's mother at home, but was unable to get a ferry to the mainland until 12.30pm. She arrived at her mother's address at 4.25pm, and informed her of Ms Eatough's death. The prison contributed to the funeral costs, in line with national policy.

Support for prisoners and staff

76. After Ms Eatough's death, the duty Governor de-briefed the staff involved individually to avoid any delay in their being released from duty. Members of the staff were reassured of the support available from the staff care and welfare team. With the exception of the offender supervisor, all staff said they had felt adequately supported since Ms Eatough's death.
77. The prison posted notices informing other prisoners of Ms Eatough's death, offering support. These notices were initially issued indicating Ms Eatough's birth name and gender. The prison later replaced these with notices indicating Ms Eatough's preferred identity. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by Ms Eatough's death. Four prisoners the investigator spoke to, who lived in neighbouring cells to Ms Eatough, all said that no one had spoken to them since Ms Eatough's death and they had not felt adequately supported.

Post-mortem report

78. The post-mortem concluded that the cause of death was ligature suspension. The toxicology report identified therapeutic levels of sertraline (an antidepressant) in Ms Eatough's blood and below therapeutic levels of gabapentin (an anticonvulsant).

Findings

Assessment and management of risk of suicide and self-harm

79. Guidance on ACCT procedures is set out in PSI 64/2011, *Safer Custody*. During her time at IoW, Ms Eatough was subject to ACCT monitoring on several occasions, the last of which was in December 2016. Full ACCT assessments and case reviews were completed and attended, with subsequent reviews being completed as required, many of which were multidisciplinary. ACCT observations were set at appropriate levels and staff completed these accordingly. When staff opened ACCTs, these were generally related to Ms Eatough's risk of self-harm, rather than due to thoughts of suicide.
80. At the time of her death, Ms Eatough had been in prison for 13 years and had just been accepted for transfer to her preferred prison to continue her offending behaviour work. Ms Eatough's offender supervisor said that she was happy when he told her. Both staff and prisoners noticed no changes in Ms Eatough's behaviour or mood in the weeks leading up to her death. In these circumstances, it was appropriate that Ms Eatough was not subject to suicide and self-harm prevention procedures. We concur with the clinical reviewer's conclusion that staff could not reasonably have been expected to predict Ms Eatough's actions and prevent her death.

Management of Transgender Policy

81. In January 2017, we published a bulletin on the care and management of transgender prisoners. We found that while some prisons took steps to make reasonable adjustments to support transgender prisoners, it was clear that there were still lessons to be learned. These included proactive consideration of where transgender prisoners should be located in the prison estate, proper investigation of transphobic bullying and harassment, improved staff awareness of the often unique set of issues faced by transgender prisoners, and the importance of transgender prisoners having meaningful relationships with their personal officers.
82. IoW is familiar with the needs and management of transgender prisoners, and generally addresses the particular needs of this group proactively, and has an effective support network. We were particularly impressed by the personal commitment of some staff in trying to ensure transgender prisoners' needs were met, endeavouring to do the best they could within the confines of the prison environment.
83. The main frustration Ms Eatough vocalised was staff failing to address her consistently by the gender with which she identified. She complained to staff about this and also contributed to a written report of testimonies from transgender prisoners in which she indicated that she found this casual approach the most difficult thing about being transgender. It is evident that some staff and prisoners did not consistently refer to Ms Eatough as she wished. Even after she had died, the death in custody notices were originally issued in the name of 'Martyn'. Some staff also struggled to refer to Ms Eatough in line with her wishes during the course of this investigation. While some staff seemed apologetic, or genuinely confused, others were more dismissive, indicating that it did not seem to bother Ms Eatough.

84. Ms Eatough's records, right up until her death, refer to her both as Mr Eatough and Ms Eatough. Ms Eatough was told on several occasions that she would need to change her name via deed poll in order to have her chosen name officially recognised. She was also told she would have to pay for this to be completed. It is correct that a transgender prisoner without a Gender Recognition Certificate, wanting to change his or her name legally, would have to do so by deed poll. One way would have been for Ms Eatough to complete her own change of name form. The wording for this can be found on the Government website, and the process is free of charge. The Government website also notes that it is not necessary to obtain a deed poll to start using a new name.
85. Some staff cited the fact that Ms Eatough needed to change her name officially as reason for them not addressing her as 'Jade' or 'Ms.' PSI 17/2016 *The Care and Management of Transgender Offenders*, indicates that "transgender prisoners must be allowed to adopt a gender-appropriate or gender-neutral name and be addressed by others consistent with the gender (or neutral gender) they identify with." While managers at IoW told the investigator they had not received any applications for Ms Eatough to change her name, there are several references to applications she had made in her record. It is clear that Ms Eatough told staff that she wished to be known as 'Ms', and to use the forename 'Jade' from as early as October 2014. Staff should therefore have consistently addressed her as such. There was no requirement for Ms Eatough to change her name by deed poll.
86. While we consider that the majority of Isle of Wight's management of Ms Eatough's transgender status was appropriate and reasonable, there is clearly a lack of awareness amongst some staff, and areas for improvement. We make the following recommendation:

The Governor and Head of Healthcare at HMP Isle of Wight should ensure that all staff are familiar with their responsibilities in respect of PSI 17/2016, *The Care and Management of Transgender Offenders*.

Sentence progression

87. Ms Eatough had been in prison since 2005. She completed the SOTP in 2010 and the Thinking Skills Programme in 2013. The Parole Board refused her transfer to open conditions and considered that she needed to complete further offending behaviour work to reduce her risk to others. In July 2016 Ms Eatough said she felt stuck in the system and wanted to transfer to HMP Rye Hill to complete an adapted SOTP course. This took a year to arrange. On 17 August 2017, staff told her that she had been accepted by Rye Hill and would be moved once a space and transport was available. She seemed pleased about this decision. However, less than 48 hours later she was found hanging in her cell. Although it is impossible to say how the amount of time Ms Eatough had spent in prison or the news of her imminent move impacted her state of mind at the time of her death, it is important to note the potential significance of these factors.

Clinical care

88. The clinical reviewer indicates that the standard of clinical note keeping was not satisfactory and lacked detail. Diagnoses and care plans from hospitals were not documented in the main body of the clinical record for all clinicians to access easily. The clinical reviewer notes that, in particular, the detail around Miss Eatough's decision to live as a female was poorly documented. Even after Ms Eatough had made that decision (and there is no entry in the clinical notes to confirm that it had been taken), most clinical staff still referred to Ms Eatough using the male pronoun. For this reason, the clinical reviewer concludes that Ms Eatough's care was not equivalent to that she could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that clinical records are accurate, detailed and include diagnoses and care plans from external appointments.

Emergency response

89. Instructions about night procedures (PSI 24/2011, *Management and Security of Nights*), and about safer custody (PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from other (Safer Custody)*) are clear that preservation of life takes precedence over the usual arrangements for opening cells. At night, prison staff on wings do not carry standard keys but have a cell key in a sealed pouch for use in such an emergency. Where there appears to be immediate danger to life and subject to a personal risk assessment, prison staff can unlock cells by themselves without the authority of the night manager.
90. Ms Eatough had blocked her observation panel and it was therefore difficult for the OSG to make this assessment. In any event, we do not consider that waiting for the custodial manager to get to the cell caused a significant delay. However, we are concerned that the OSG told the interviewer that he would never use the key in his emergency pouch to enter a cell and that the custodial manager said that OSGs should never go into cells on their own at night.
91. When the custodial manager discovered Ms Eatough, he reacted calmly and competently to the situation. It is unfortunate, but understandable, that the OSG was so distressed by what he had seen that he was unable to assist the custodial manager, and it would be unfair to be critical of this natural reaction. Having started CPR, the custodial manager left Ms Eatough and, while this is far from ideal, it was a considered decision that he needed to ensure that the contingency plans had been activated and staff deployed correctly.
92. The ambulance was called in line with protocol but when the 999 operator asked whether the patient was breathing, prison staff replied, "I believe so, yes." This was not correct and while, in this case, it did not delay the ambulance, it could do so in future emergencies. The paramedics commented that they had not been briefed on the severity of the situation. While it is crucial to request an ambulance immediately once a code blue has been called, it is also important to make sure that the information relayed to the ambulance service is accurate.
93. Paramedics commented that it took them 17 minutes to get from the prison gate to Ms Eatough's cell. The investigator and clinical reviewer subsequently walked

the route that the ambulance would have taken through the prison, from the gate to reach Ms Eatough's wing and then up to her cell. Both concluded that 17 minutes was not unreasonable, with an officer walking ahead of the ambulance having to unlock and lock multiple sets of gates. The clinical reviewer concludes that the resuscitation attempt was satisfactory, given the circumstances. He considered it possible, or likely, that Ms Eatough had been dead for some time before staff found her and that success in resuscitation was highly unlikely. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including:

- **that they enter cells as quickly as possible in a life-threatening situation; and**
- **that they give accurate information to the ambulance service.**

Informing Ms Eatough's next of kin

94. There was a delay of nearly 12 hours between Ms Eatough's death and informing her next of kin. This was due to the family liaison officer (FLO) having difficulty getting a ferry from the Isle of Wight and the long distance she had to travel. The Deputy Governor, said that he had decided that prison staff should inform Ms Eatough's next of kin in person. He felt that, in the circumstances, to ask the police to do so would have caused Ms Eatough's family additional distress. From previous experience, he believed that, as it was the weekend, other prisons nearer to Ms Eatough's next of kin were unlikely to be able to provide a FLO to break the news. Given the circumstances, the swift deployment of the FLO, the Governor's considered decision on informing the next of kin and the concerted effort to reach her as soon as they could, we are not critical of this decision. In addition, Ms Eatough's next of kin said she was very happy with the support the family had received from the FLO following Ms Eatough's death.

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