SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT FORT WILLIAM

[2026] FAI 1

FTW-B101-24

DETERMINATION

BY

SHERIFF NEIL WILSON

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the deaths of

DAVID IAIN FOWLER, GRAHAM COX and HAZEL CROMBIE

TAIN, 24 December 2025

The sheriff having considered the information presented at the Inquiry, determines in terms of section 26 of the Act that:

In terms of section 26(2)(a):

That the late David Iain Fowler, born on 2 May 1984, died on the Aonach Eagach ridge, Glencoe, on 5 August 2023.

That the late Graham Cox, born on 29 January 1963, died on the Aonach Eagach ridge, Glencoe, on 5 August 2023.

That the late Hazel Crombie, born on 30 September 1958, died on the Aonach Eagach ridge, Glencoe, on 5 August 2023.

In terms of section 26(2)(b):

That the accident resulting in the deaths of David Iain Fowler, Graham Cox and Hazel Crombie occurred on the Aonach Eagach ridge, Glencoe, on 5 August 2023.

In terms of section 26(2)(c):

That the cause of death of David Iain Fowler, Graham Cox and Hazel Crombie was:

1a: Multiple injuries due to, or as a consequence of

1b: Fall from height whilst roped together and traversing the Aonach Eagach ridge.

In terms of section 26(2)(d):

That the likely cause of the accident resulting in the deaths of David Iain Fowler, Graham Cox and Hazel Crombie was a slip or fall by one of them, resulting in the others being dislodged and all three falling whilst roped together.

In terms of section 26(2)(e):

There were no precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have prevented the deaths of David Iain Fowler, Graham Cox and Hazel Crombie.

In terms of section 26(2)(f):

There was no evidence of any defects in the safety system utilized by David Iain Fowler that contributed to his death and those of Graham Cox and Hazel Crombie.

In terms of section 26(2)(g):

Relevant facts are as follows:

1) There was a lack of detailed information about short roping provided to clients before the excursion, both by way of general online advertising and by specific pro-active discussions regarding the possible utilisation of this rope system, and its inherent risks, on the Aonach Eagach ridge.

2) There was a lack of detailed pro-active discussions with the clients, before the excursion, regarding their weight, level of experience and competence, and their general expectations with regard to the traverse of the Aonach Eagach ridge.

3) There was a lack of information provided to each client of a) the proposed guide:client ratio on the day and b) the experience, competence and weight of the other client if, as was the case on 5 August 2025, the proposed ratio was greater than 1:1 and the clients were not known to each other.

4) There was a lack of detailed information gathering, and resultant advice, before the excursion, regarding the clients' personal equipment – particularly their choice of footwear.

5) There was no assessment of the clients' competence, by way of direct observation rather than merely discussion, prior to 5 August 2023. This point is particularly

relevant on an undertaking such as the Aonach Eagach ridge where there would be little, if any, opportunity to assess clients' competence before one of the most difficult sections of the route requires to be tackled.

RECOMMENDATIONS

In terms of section 26(1)(b):

There are no recommendations to be made.

Introduction

[1] This is a mandatory Inquiry in terms of section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 because Mr Fowler died as a result of an accident in the course of his employment.

[2] This is a discretionary Inquiry in respect of the deaths of Graham Cox and Hazel Crombie in terms of sections 4(1)(a)(ii) and (b) of the 2016 Act, as both died at or around the same time as said David Fowler.

[3] The procurator fiscal, who represents the public interest, issued notice of the Inquiry on 16 December 2024.

[4] A preliminary hearing took place at Fort William Sheriff Court on 10 February 2025, on which occasion Mr Ul-Hassan appeared for the Crown, Mr Kennedy for the first and fourth participants (British Mountain Guides and Association of Mountaineering Instructors respectively), and Mr Littlefair for the second participant

(Collette Cox, the widow of Graham Cox). At this hearing, 18 and 19 August 2025 were assigned as dates for the Inquiry.

[5] A further preliminary hearing took place on 20 March 2025, with the same legal representatives as at the previous hearing, with the addition of Ms Clark now appearing for the third participant, West Coast Mountain Guides (the company owned by David Fowler at the time of his death).

[6] Further preliminary hearings took place on 6 May, 9 June, 15 July and 29 July 2025. As of 8 July 2025, Mr Kennedy intimated that, purely for economic reasons, the Association of Mountaineering Instructors no longer required legal representation, and in lieu of such representation a member of their association would attend subsequent hearings. The deceased David Fowler had been a member of the Association of Mountaineering Instructors at the time of his death. Mr Kennedy had already withdrawn from acting for British Mountain Guides to avoid a potential conflict of interest; Mr Ian Peter, a senior figure in that organization having been instructed as an expert witness by another participant (Collette Cox).

[7] All preliminary hearings were held online. By the time the Inquiry commenced, a substantial amount of evidence had been agreed by way of joint minute of agreement. Representatives of the various participants are to be commended for this, as it allowed the Inquiry to focus on the important issues. More particularly, the agreement of evidence meant potentially distressing details of the deceaseds' injuries did not require to be aired in open court.

[8] The Inquiry took place, in person, at Fort William Sheriff Court, on 18 and 19 August 2025. Mr Ul-Hassan appeared for the Crown, Ms Clark for West Coast Mountain Guides and Mr Langlands, advocate, instructed by Ms Walker, for Collette Cox.

[9] The Inquiry commenced with Mr Ul-Hassan narrating the agreed evidence, followed by his reading of family statements by Rebecca Fowler (David Fowler's sister), Graham Cox's family and Hazel Crombie's family.

[10] Thereafter, on 18 August 2025, the court heard evidence from Brian Bathurst, deputy team leader of Glencoe Mountain Rescue Team, who was involved in the search for, and ultimately the recovery of, the remains of Mr Fowler, Mr Cox and Mrs Crombie.

[11] Ian Peter, mountain guide and executive director of Outward Bound, was thereafter led as an expert witness by Mr Langlands, his evidence continuing on 19 August 2025. His evidence was led out of order, as he was due to travel abroad imminently.

[12] Finally, on 19 August 2025, the Crown led evidence from their expert witness, Shaun Roberts, principal of Glenmore Lodge National Outdoor Training Centre.

[13] The matter was thereafter continued to allow parties to lodge written submissions and for the court to be thereafter addressed on those submissions; this subsequent hearing to be online.

[14] At the hearing on submissions on 13 November 2025, given the potential for there being considerable public interest in the Inquiry, I directed that the written submissions lodged be read into the record, prior to my being addressed on them.

The legal framework

[15] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 and is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (the 2017 rules). The purpose of such an Inquiry is set out in section 1(3) of the 2016 Act and is to: (a) establish the circumstances of the deaths and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[16] The procurator fiscal represents the public interest in a Fatal Accident Inquiry. An Inquiry is an inquisitorial process, and it is not the purpose of an Inquiry to establish either criminal or civil liability.

Summary

[17] Much of the evidence in this Inquiry was admitted by way of joint minute.

[18] In brief, it was a matter of agreement that on 5 August 2023 the deceased David Fowler, a mountain guide and owner/sole director of West Coast Mountain Guides Limited, arranged to meet two clients, Graham Cox and Hazel Crombie, at 8.30am at a car park in Glencoe below the east end of the Aonach Eagach ridge, this being a pre-booked excursion, the aim of which was to traverse the length of the Aonach Eagach ridge from east to west. When David Fowler failed to return, and his partner was unable to reach him by telephone, she called the police, who in turn alerted Glencoe Mountain Rescue Team. Ultimately, at about 2.00am on 6 August David Fowler, Graham Cox and Hazel Crombie were found by members of Glencoe Mountain Rescue

Team, roped together and clearly deceased, on the north side of the Aonach Eagach ridge, below a point just west of the summit of Am Bodach.

[19] Over and above the matters explicitly agreed in the two joint minutes of agreement, by virtue of paragraph 10.1 of Minute No. 1, it was stated that:

a. All productions are what they bear to be;

b. All documents and photographs bearing a date were prepared on or about the date they bear;

c. All typewritten witness statements are to be treated as the equivalent of signed manuscript statements; and

d. Documentary evidence shall be admitted to evidence without the need for it to be spoken to by its author.

[20] Of the evidence thereafter lead in court, that of Brian Bathurst served largely to complement the agreed evidence, and to provide a fuller picture of the site of the accident and the aftermath.

[21] The evidence of the two expert witnesses, Ian Peter and Shaun Roberts, overlapped to a large degree and they were largely in agreement on most matters. The approach taken in considering their evidence will be to deal with a series of topics, with their respective views on each topic thereafter summarized. This will be in conjunction with the agreed evidence covering such matters as West Coast Mountain Guides online advertising and booking process, other copy productions such as the post mortem reports, and the physical evidence recovered from the scene of the accident.

[22] At this stage it is worth noting that Ian Peter, in both his expert report, at paragraph 19, and in the course of his evidence in court, pointed out that the term "Mountain Guide" refers to a particular qualification associated with the International Federation of Mountain Guides (IFMG), and is not to be confused with the generic term of "guide" as someone who leads or directs others. For the avoidance of confusion, any reference to "guide" or "mountain guide" in this determination is to be interpreted in its generic sense and in no way should be taken to refer to an IFMG-qualified Mountain Guide.

[23] Mr Roberts reiterated Mr Peter's evidence on this matter, stating that "guiding" is a commonly used term for the work carried out by mountaineering instructors.

Evidence of Brian Bathurst

[24] Brian Bathhurst, the first witness called by the Crown, stated that he was a self-employed builder who lived in Glencoe, and that he had been a member of Glencoe Mountain Rescue Team for 15 years, the last 11 years as deputy team leader. He gave details of the various courses he and his colleagues regularly attend. Of more significance to this Inquiry, his local knowledge and experience of the Aonoch Eagach ridge was very helpful – he having completed the traverse many times, both on rescue callouts and on personal days out, in both directions and in all weather conditions. He described the ridge as presenting unique challenges, in that it was very steep sided, with limited and sometimes complex access routes and no alternatives to bypass the more difficult sections. He further stated it was 6 miles in length, and was a grade 2/3

scramble with an exposed section comprising three rocky pinnacles in the middle section. In his evidence, Mr Bathurst's advice to anyone contemplating a traverse of the Aonoch Eagach ridge was that some experience of scrambling was required, as the route was exposed, steep and long, and those lacking such experience should go with someone more experienced. Of particular interest to the Inquiry was his description of there being one straightforward approach to the top of Am Bodach, if traversing the ridge east to west.

[25] Mr Bathurst ran the callout arising from Mr Fowler and his clients being reported overdue. In particular, he asked two team members to traverse the Aonoch Eagach ridge west to east to search for the missing party. At about 2.00am on 6 August they found Mr Fowler, Mr Cox and Mrs Crombie, roped together, on steep ground on the north side of the ridge. The evidence of one of these team members, Alistair Docherty, was admitted by way of joint minute, and in his statement he describes making an assessment to start CPR, but it was clear to him that life was extinct, given the nature of the injuries to all three. He checked for pulses and breathing, but noted the onset of rigor mortis in all three.

[26] The decision was then made to delay recovery until later in the morning, when daylight would allow the coastguard helicopter to attend. This happened at around 9.00am on 6 August, with Mr Bathurst and Mr Docherty being amongst those taken to the scene of the accident by helicopter. In his evidence, Mr Bathurst was taken through video footage and photographs of the scene of the accident taken from the

helicopter. This evidence was of significance, as it enabled the Crown expert Mr Roberts to pinpoint the site of the accident in the course of preparing his report.

[27] Mr Bathurst described cutting the ropes linking Mr Fowler, Mr Cox and Mrs Crombie to allow them to be separately placed on stretchers prior to them being evacuated by helicopter. However, the rope system was sufficiently preserved to allow subsequent examination – this will be referred to in consideration of Mr Peter's and Mr Roberts' evidence. Mr Bathurst was also able to confirm that, upon his return to the scene by helicopter, Mr Fowler and his clients were exactly as he found them at 2.00am.

Evidence of Shaun Roberts and Ian Peter

[28] Shaun Roberts, the Crown expert witness, has been principal of Glenmore Lodge, Scotland's National Outdoor Training Centre since 2014. He qualified as a mountaineering and climbing instructor in 1993, and between 1998 and 2014 trained and assessed aspirant mountaineering instructors.

[29] Ian Peter, the expert witness instructed by those representing Collette Cox, is a member of the British Association of Mountain Guides, and had been since 1984. He had held various positions, including working as a guide and instructor at Glenmore Lodge, training and assessing mountain instructor and leaders.

[30] Both Mr Peter and Mr Roberts had access to the entirety of the information before the inquiry, both had inspected the available physical productions (ropes, harnesses, footwear etc.), and each had been made aware of the content of the other's report before giving evidence in court.

The Aonach Eagach ridge

[31] Following on the evidence already heard from Mr Bathurst regarding the Aonach Eagach ridge, both expert witnesses concurred in describing it as a substantial outing involving grade 2/3 scrambling in places. Scrambling was defined as an activity lying between walking and technical climbing, with a difficulty grade running from 1 to 3.

[32] Mr Roberts, having carried out a site visit in the course of preparing his report and with the benefit of the coastguard helicopter video footage, combined with the evidence of Mr Bathurst and Mr Docherty, was able to narrow down the location of the accident to a short section of the ridge, where there is a steep descent of some 10 to 12 metres. This is described in the relevant Scottish Mountaineering Club guidebook (referred to in his report) as follows:

> "Immediately after leaving the summit (of Am Bodach) is one of the most challenging sections: a tricky down-climb zig-zagging north, then back south, down a couple of metres and then back north to the crest".

This section of the ridge was described by Mr Bathurst as being 100 to 200 metres from the summit of Am Bodach and would take no more than 15 minutes to reach from the summit. Of note at this point is Mr Robert's evidence that it is more difficult to climb down than up, as it is difficult to see where one's feet are going.

[33] Mr Bathurst, Mr Peter and Mr Roberts all concurred in describing the route Mr Fowler and his clients would have taken up Am Bodach as being a straightforward

path with no technical difficulties, the 100/200 metre traverse from the summit to the "tricky down-climb" being described as similarly straightforward.

[34] The West Coast Mountain Guides website states that the Aonach Eagach traverse starts with "a steep walk up the South East Spur of Am Bodach", and goes on to describe there being "The initial challenge of descending a short steep chimney".

[35] Mr Roberts, as a result of his site visit, was able to say that there was a large rock, approximately 1 metre by 1 metre, at the top of the tricky section, around which it was possible to place a large sling – and around which he did indeed place such a sling in the course of his visit. Mr Roberts, having inspected the ropes attached to Mr Fowler and his clients, was able to say that no such sling was attached to the rope between them, but Mr Fowler did have a sling attached to his climbing harness.

[36] Mr Roberts also described a ledge, or transition zone, at the bottom of the tricky section, where he would have anticipated Mr Fowler and his clients gathering before embarking on the next section of the ridge, to the south side of the crest. Mr Roberts did not note any obvious rock anchor at this ledge to which the clients could have secured themselves whilst waiting for Mr Fowler to join them.

Aonach Eagach ridge – as an objective

[37] The West Coast Mountain Guides website described the Aonach Eagach ridge as "possibly the most famous ridge challenge in Mainland Britain", and further stated that "The traverse includes some tricky exposed scrambling, but it is accessible to anyone with a head for heights however new to scambling they are".

[38] The Scottish Mountaineering Club guidebook, quoted by Mr Peter in his report, describes the Aonach Eagach ridge as:

> "An outstanding route with breath-taking exposure. Although rarely very technical, it is usually committing and there are long sections where a simple slip could be fatal".

[39] Mr Roberts, in his evidence, described the Aonach Eagach ridge as "a route that features high in the public's view as intimidating" but went on to observe that it is a "wonderful undertaking – feels like a great achievement". He also made reference to its difficulties sometimes being overstated, particularly on social media.

[40] Overall, there was no doubt that, in the eyes of the Scottish hill-going public, the Aonach Eagach ridge was a well-known and worthy objective.

[41] Mr Roberts, in his evidence, stated that he had done the Aonach Eagach ridge with clients without the use of a rope. However, this had been on the third day of a scrambling course and he thus had confidence in his clients' competence.

[42] Mr Peter stated that, in assessing whether clients had the competence to tackle the Aonach Eagach ridge, he would not necessarily be looking for people with rope experience, but rather would want them to have confidence and to understand the limits of the system they would be using.

David Fowler's qualifications and experience

[43] Both expert witnesses were in agreement that Mr Fowler appeared to be a competent mountain guide, with considerable experience, specifically of taking clients along the Aonoch Eagach ridge. It was agreed, by way of joint minute, that Mr Fowler

was a member of the Association of Mountain Leaders. It was further agreed that he was awarded his Mountain Leader Certificate on 20 October 2006, his Winter Mountaineering Leader Certificate on 16 July 2010, his Mountain Instructor Certificate on 17 February 2012, and achieved his Winter Mountaineering and Climbing Instructor qualification on 12 March 2020. Both witnesses were in agreement that Mr Fowler was, to quote Mr Peter's report, "suitably experienced and competent to lead a party of two suitably equipped and experienced clients on a traverse of the Aonach Eagach ridge."

Online booking process - clients' level of experience

[44] Both Mr Cox and Mrs Crombie, in separately making their online bookings with West Coast Guides, provided brief resumes of their respective hill-going experience. Mr Peter and Mr Roberts agreed that the stated level of experience from both clients would not have given them any cause for concern prior to taking them along the Aonach Eagach ridge.

Online booking process - clients' personal gear

[45] Both Mr Cox and Mrs Crombie, subsequent to making their online bookings, were emailed equipment lists and advised in particular that helmets and harnesses would be provided if necessary. There was no suggestion in the evidence heard from either expert that the equipment list was, in itself, in any way inadequate.

Online booking process - overview

[46] There was nothing in the booking form, or in the subsequent emails sent to both clients, pro-actively encouraging them to get in touch to discuss in detail the appropriate personal equipment and the skills needed for a traverse of the Aonach Eagach ridge.

[47] On the basis of the information contained in the online booking forms completed by Mr Cox and Mrs Crombie, there was no evidence that either of them had any experience of short roping, or more generally scrambling with ropes. The website mentions the guide being responsible for all ropework, but does not go into any further detail as to what this ropework would consist of. The detailed email sent to both clients prior to the excursion stated "There will be sections of scrambling, some of which are classed as grade 2. We will have ropes and other safety gear". However, there were no further details as to what use the ropes and safety gear might be put. More specifically, the email provided no definition of short roping, no indication it might be utilized as a safety system, and no explanation of the possible attendant risks of this system.

[48] The email confirming booking of the excursion does end with the sentence "Any further questions, please give me a shout, otherwise, thanks for booking with us".

[49] Mr Cox did get in touch by email on 27 July 2023 with a query about equipment, and received a reply the same day from Sonja Albrecht of West Coast Mountain Guides. That reply ended with "if you have any further queries, please let me know".

[50] Mr Roberts, in his evidence, stated that the email correspondence was just adequate, but that a proper conversation about both equipment and experience, by telephone, would have been better.

[51] Para [54] below considers the clients' footwear; the comments above on the lack of active follow-up regarding clients' personal equipment should be read in conjunction with that paragraph.

[52] The only evidence that the Inquiry had of pre-excursion communication between Mr Fowler and his two clients were the email exchanges. However, it cannot be ruled out that detailed telephone conversations did indeed take place between Mr Fowler and his clients regarding competence, experience and equipment.

Equipment

[53] Both expert witnesses could find no fault with the equipment used by Mr Fowler, and provided by him to Mr Cox and Mrs Crombie, namely climbing harnesses, helmets and rope, stating that they were appropriate to the proposed excursion and in good working order.

[54] However, as regards personal gear, both witnesses noted that the footwear worn by Mr Cox and Mrs Crombie was not ideal for a traverse of the Aonach Eagach ridge. Mr Roberts stated he would have expected a higher quality of footwear rather than the general outdoor shoes/boots worn by both clients, but did confirm that he would not have refused to take either Mr Cox or Mrs Crombie along the ridge as a result of this assessment. Mr Peter reached a similar conclusion, describing Mr Cox's footwear as adequate and Mrs Crombie's as only just adequate, but likewise would not have refused to take them onto the Aonach Eagach ridge. Mr Fowler's footwear was noted as appropriate. It should be noted that these assessments by both experts focused on the

degree of grip footwear would provide on rock and wet vegetation – and given the forecasted and actual weather conditions on the Aonach Eagach ridge on 5 August 2023, the experts' comments on footwear should be read in conjunction with the following para [55].

Weather on 5 August 2023

[55] Both expert witnesses agreed that the weather conditions, both forecast and reported, on 5 August 2023, namely light rain and variable light to moderate winds, did not give them any concerns as to the advisability of traversing the Aonach Eagach ridge on that day. Of note, however, is Mr Bathurst's evidence, given in the course of his general description of the Aonach Eagach ridge, that the rock becomes very slippy when damp or in rain or mist.

Assessment of clients' competence on 5 August 2023

[56] As noted above, all the witnesses who gave evidence concurred in stating that the walk from the agreed meeting place to the summit of Am Bodach, and thereafter to the start of the section of the ridge where the accident occurred, was straightforward and presented no technical difficulties. Mr Peter and Mr Roberts were in agreement in stating that this gave Mr Fowler little, if any, opportunity to assess the competence of Mr Cox and Mrs Crombie in moving over more technical ground.

[57] Mr Peter stated that it would be possible for a guide to form a reliable impression of a client, whom they had only just met, through observing how biddable and

dependable they seemed, watching their footwork, and discussing their experience. He did however go on to say that, in the situation where the guide had not met the client before, it would be preferable to take them out the day before, maybe on a shorter grade 2 scramble, to properly assess their competence before embarking on an objective such as the Aonach Eagach ridge.

[58] Mr Roberts, in his evidence, stated that whilst it may be common practice to meet new clients the day before any excursion, if this were not possible a personal phone call beforehand to discuss experience and competence would be useful.

[59] Neither expert witness was able to say what, if any, assessment of Mr Cox's and Mrs Crombie's competency Mr Fowler was able to carry out in the course of the walk up Am Bodach and the short traverse to the start of the technical difficulties.

Short roping

[60] It was a matter of agreement between the two expert witnesses that, at the time of the accident, Mr Fowler and his clients were using a roping system known as "short roping". This consists of members of the party being attached together by a relatively short length of rope, and thereafter a variety of techniques being deployed to provide differing levels of security.

[61] Mr Peter, in paragraphs 50 – 52 of his report, provides context to the use of short roping, describing it as a compromise between speed and safety. His evidence was that, for an excursion such as the Aonach Eagach ridge it would be possible to provide a high degree of security by doing the entire route in pitches (short sections of climbing), such

that everyone is protected by the rope at all times, but this would be far too slow to complete the traverse in a day. Alternatively, it would be possible to traverse the ridge quickly without any use of a rope, as indeed many experienced climbers do. Short roping lies between the two, with regard to both speed and safety.

[62] Mr Roberts, in his report, quotes the official handbook used by mountain training, namely *Rockclimbing* by Libby Peter, as defining short roping as "We protect hard sections as short (roped) pitches and move together, with great care, on the easier, broken ground. Short roping encompasses both these techniques."

[63] Mr Peter, in paragraph 52 of his report, described short roping as something requiring "very high levels of judgement and concentration from the leader" and in his evidence in court referred to it as amongst the most challenging (guiding) work. He further stated that, when not actually secured to the rock by a sling or similar, the guide must, whenever possible, be in a position to use the rope to prevent a slip turning into a fall, and that this is easier in descent or ascent, where the guide can position themselves above the client or clients, and more difficult on horizontal sections. This was described as a preventative rather than a reactive measure, in that it required the guide to be constantly alert to clients getting out of control, and tension would need to be put on the rope before this happened.

[64] Mr Roberts gave evidence in similar terms, and in describing the various techniques available to the guide, stating that the choice of safety measure at any given time was, to quote paragraph 39 of his report "very situational and consideration

regarding the likelihood and consequences of a potential slip should be at the forefront of the guide's considerations."

[65] Both expert witnesses were in agreement that the level of security provided by short roping could be augmented by, amongst other measures, taking quick belays (anchors) so that short, more difficult, sections could be tackled whilst securely attached to the mountain. This was a technique referred to in evidence as short pitching.

[66] Mr Roberts had the benefit of inspecting the site of the accident and was able to say that the short steep descent, the "tricky down-climb" described in the Scottish Mountaineering Club guide to the Aonach Eagach ridge, would have been amenable to the application of short pitching. More particularly, his report (paragraph 38) described various methods open to the guide to protect clients descending such a feature, including either placing a sling round a rock anchor, or putting the rope around such an anchor, to secure the roped party to the mountain, and having the clients climb down first with the guide above them controlling the rope and in a position to prevent a slip becoming a fall. The presence of a rock feature suitable for use as an anchor at the top of the steep descent was noted by Mr Roberts in the course of his site visit.

[67] Both expert witnesses, in outlining the suitability of the short difficult section for short pitching, assumed that once the clients had descended to the transition zone, Mr Fowler would probably have climbed down to join them unprotected by any form of rock anchor.

Specific rope set up

[68] Whilst Mr Fowler, Mr Cox and Mrs Crombie were cut from their rope prior to being evacuated by helicopter, the rope system being used by Mr Fowler and his clients was sufficiently preserved to allow both Mr Peter and Mr Roberts to subsequently inspect it at Aviemore Police Office. It was a matter of consensus between both expert witnesses that Mr Fowler was at one end of the rope, Mr Cox at the other end, and Mrs Crombie between them on what was described as a 50cm isolation loop, allowing her a degree of freedom to move back and forward. The distance from Mr Fowler to Mrs Crombie was approximately 10 metres, and from Mrs Crombie to Mr Cox was, in all likelihood, 2.4 metres. In addition Mr Fowler had several metres of spare rope coiled around his torso and available for use if required. This was agreed to be indicative of the party using a short roping system at the time of the accident.

[69] There was no evidence of the rope being attached to a sling or similar. Had there been such evidence, this would have been indicative of the short pitching technique being deployed at the time of the accident. There was however evidence of a sling being attached to Mr Fowler's climbing harness and therefore available for use.

[70] It was a matter of agreement that, as gleaned from the post mortem examinations, David Fowler weighed 57 kilograms, Hazel Crombie 52 kilograms and Graham Cox 90 kilograms. The expert witnesses were in agreement, had the clients been of equal ability, they would have expected Mr Cox, as the larger of the two, to have been placed closer to the guide to allow closer control. This was not on the basis that Mr Cox was more likely to slip, but because being larger any slip would have been

harder to arrest. However, this was subject to the caveat that the decision by Mr Fowler to have Mrs Crombie as the closer of the two clients may well have been on the basis that he had assessed her, for reasons of experience, competence or footwear to be the one more in need of advice, monitoring or a tight rope.

[71] It was not possible for either Mr Peter or Mr Roberts to say why Mr Fowler arranged his clients such that the larger one was further away. However, it was not disputed that Mr Fowler was a well-qualified, experienced and competent guide and neither expert witness had any criticism of the decision Mr Fowler reached on this matter.

[72] The guide:client ratio at the time of this accident was 1:2. The West Coast Mountain Guides website state that the ratio would never be higher than that for excursions along the Aonach Eagach ridge. The significance of this ratio is that, in general terms, it was a matter of agreement between both experts that, when short roping, more clients equates to more risk.

[73] A more focused opinion is provided by Mr Peter in his report (paragraph 44):

> "In my view, it is more difficult to safeguard two clients when moving together than it is to safeguard a single client. When the leader only has one person to look after, it is much easier to keep the rope tight and so provide security. Leaders need to think carefully before they short rope two clients. They need to be sure of the terrain to be encountered (i.e. that it isn't too difficult), and of their clients' abilities and their familiarity with the various rope techniques."

Mr Peter gave evidence in similar terms in the course of the Inquiry.

[74] The only evidence the Inquiry had of pre-excursion communication between Mr Fowler and his two clients were the email exchanges. As previously referred to, the

West Coast Mountain Guides website states that the maximum guide:client ratio is 1:2. for their Aonach Eagach excursions. Over and above this general information provided to clients, it is unknown whether, prior to the planned excursion on 5 August 2023, Mr Fowler took any specific steps to: a) ascertain Mr Cox's and Mrs Crombie's weights; b) advise each of them that they would be short-roping with the other; and c) advise each of them of the other's weight and level of competence and experience.

Likely causes

[75] Mr Peter and Mr Roberts were in agreement that, other than that one of the party fell, and in doing so dislodged the others, it is not possible to reach a conclusion as to the immediate cause of the accident. However, both were able to narrow down the likely scenarios to three possibilities:

1) In short roping down the steep descent, without the additional security of short pitching and a secure anchor, one of the clients slipped and fell.
2) Having protected his clients down the steep descent, Mr Fowler fell either in down-climbing to rejoin his clients, or, possibly, climbing back up to retrieve an item left behind.
3) Whilst gathered at the transition zone one of the party slipped and fell off the ledge.

[76] All of these scenarios, it was agreed, could well lead to the other two members of the party being dislodged and all three thereafter falling. In addition, variations of all

three scenarios could have arisen if the party decided, for whatever reason, to retrace their route back up the steep section having successfully descended it.

Submissions

[77] The court had the benefit of both written and oral submissions from the Crown, Ms Clark, solicitor for West Coast Mountain Guides and Mr Langlands, advocate for Mrs Collette Cox.

[78] The proposed determinations presented by all three parties with regard to findings under sections 26(2)(a), (b) and (c) were near identical, and largely accord with my findings on these matters.

Submissions - Crown

[79] The Crown position, with reference to possible section 26(2)(d) and (e) findings, can best be summarized by the conclusion in paragraphs 56, 57 and 69 of their written submissions:

> "56. In conclusion, absent any clear evidence of negligence, it is submitted that all three members of the party took reasonably practicable steps to manage known risks. The tragic outcome, despite these measures, highlights the inherent and avoidable risks that persist in serious mountain environments.
>
> 57. The cause of this tragic accident will never be established beyond any peradventure. An experienced guide, and his two appropriately dressed, equipped and shod clients, all roped together, clearly suffered some catastrophic event whilst descending Am Bodach. In spite of whatever precautions were taken in the mountain environment, the risk of a fall can never be wholly eliminated, as is the case here.

> 69 This (the accident) was not an outcome that resulted from want of reasonable precautions. It was, instead, a terrible accident that occurred despite all reasonable precautions being taken, reinforcing the immutable fact that the inherent risks of mountaineering, however mitigated, can never be entirely eliminated."

[80] These submissions were founded on the assumptions that: a) the precise cause of the fall could not be ascertained; b) the short roping technique being deployed was a tried and tested method of mitigating risk; and c) sufficient reasonable precautions were taken.

[81] Thereafter the Inquiry was invited by the Crown, with regard to section 26(2)(d), to find that, to quote paragraph 57 of their written submissions, "The cause of this tragic accident will never be established beyond any peradventure", and further with regard to section 26(2)(e), that, to again quote the Crown written submissions (paragraph 58), "the tragic loss of life … occurred in spite of, and not due to the absence of, reasonable precautions taken by all parties involved" and that these precautions "may appear granular but when taken together suggest a cumulative framework of diligence".

[82] Thereafter the Crown had no submissions with regard to possible section 26(2)(f) or (g) findings, and advanced no possible recommendations.

Submissions – Collette Cox

[83] The submissions on behalf of Mrs Cox suggested section 26(2)(a),(b) and (c) findings largely in line with those narrated by the Crown. The general line thereafter advanced was that, as the exact details of the accident and resultant deaths could not be ascertained, an exact and specific section 26(2)(d) finding could not be reached.

However, various possible contributory causes were suggested, namely that no members of the party were known to each other before the day of the excursion, the guide to client ratio was 1:2, the difference in weight between the members of the party, the footwear worn by Mr Cox and Mrs Crombie, and the limited information provided on the booking forms.

[84] Thereafter, by way of section 26(2)(e) precautions, it was suggested that the deaths might realistically been avoided if:

a) Mr Fowler had held a practice session prior to the Aonoch Eagach excursion, failing which there had been more communication with the clients before the excursion about their experience and competence.

b) Mr Fowler had insisted that the clients had more suitable footwear, and

c) Consideration had been being given to reducing the guide:client ratio to 1:1.

[85] No section 26(2)(f) defects were suggested, and were no other relevant section 26(2)(g) facts were identified.

[86] However, it was submitted that it would be appropriate to suggest some general recommendations, not so much as to the specific practices involved in short roping, but focused more on preparation for any excursion involving short roping, disseminating information to any potential clients considering any such excursion, and pro-actively, well before any such excursion, assessing clients' experience, expectations, competence and equipment. These proposed recommendations overlapped, to a certain extent, with the suggested precautions detailed above.

Submissions - West Coast Mountain Guides

[87] Submissions on behalf of West Coast Mountain Guides as regards section 26(2)(a), (b), (c) and (d) findings were in similar terms as those advanced by the Crown. In particular, as regards (d) findings, the Inquiry was invited to conclude that, whilst the cause of the deaths was the party falling from the ridge, the source of the fall could not be determined.

[88] There were thereafter detailed submissions with regard to possible section 26(2)(e) findings, which focused on the various precautions taken both during the booking process prior to the excursion and on the day of the accident. These precautions were largely as narrated in the preceding summary. It was also stressed that much of the evidence regarding the accident was conjecture. At paragraph 18, it is submitted that:

> "the possibility that the death might realistically have been avoided by reasonable precautions requires there to be a possibility of substance and genuine potential, rather than a mere fanciful possibility."

The Explanatory Notes to the Act are thereafter quoted in similar terms, namely "a precaution might reasonably have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have done so." In essence, the Inquiry was invited to conclude that all reasonable precautions had been taken to mitigate any real or likely risk.

[89] As regards possible section 26(2)(f) findings, it was submitted that, all reasonable precautions having been taken, there were no defects in the system of working which contributed to the accident and resultant deaths.

[90] It was further submitted that no other facts were relevant to the accident or death, and accordingly no section 26(2)(g) findings were required.

[91] Finally it was submitted, Mr Fowler having taken all reasonable precautions in the circumstances, no recommendations were required.

Discussion and conclusions

Findings

[92] The starting point for any discussion of the evidence led in this Inquiry has to be the concession that it cannot be possible to say exactly what happened somewhere just west of the summit of Am Bodach, at the east end of the Aonach Eagach ridge, on 5 August 2023. There were no witnesses to the accident which took the lives of David Fowler, Graham Cox and Hazel Crombie. What the court is left examining is the aftermath, and the expert evidence on the significance of that aftermath. Nonetheless, the court is required, where possible, to make findings and, where appropriate, recommendations.

[93] Given the evidence led or agreed, it is not disputed that David Fowler, Graham Cox and Hazel Crombie were involved in a mountaineering accident and died on the Aonach Eagach ridge, Glencoe on 5 August 2023. This gives rise to the section 26(2)(a) and (b) findings as narrated above.

[94] Beyond these general findings, the evidence did allow for more precision. It was not disputed that Mr Fowler and his two clients would have, in all probability, arrived at the summit of Am Bodach, at the eastern end of the Aonach Eagach ridge, some time between 10.00am and 11.30am on 5 August 2023. It was established in the course of the Inquiry that the accident occurred on a steep section of the ridge a short distance west from the summit of Am Bodach, resulting in Mr Fowler, Mr Cox and Mrs Crombie thereafter falling, whilst roped together, down a steep grassy area and over a 15 - 20 metre cliff, and coming to rest on a scree slope below on the northern flank of the ridge.

[95] Therefore, for the purposes of section 26(2)(a) and (b) findings, it can be stated that the accident occurred on the steep section of the ridge west of Am Bodach, the deaths thereafter occurring in the course of, or after, the resultant fall down steep ground below.

[96] Whilst Mr Fowler and his clients were found, and pronounced life extinct, at 2.00am on 6 August, in all likelihood the accident, and resultant deaths, would have occurred a short time after they set off from the summit of Am Bodach, i.e. shortly before or after noon on 5 August 2023.

[97] The causes of death of Mr Fowler, Mr Cox and Mrs Crombie were a matter of agreement and give rise to the resultant section 26(2)(c) finding, as narrated above.

[98] It was a consistent theme of all submissions to the Inquiry that it was impossible to come to a conclusion as to the cause of the accident which resulted in the deaths of Mr Fowler, Mr Cox and Mrs Crombie. However, whilst seeking to decide upon the

cause of the accident may involve a degree of conjecture, it does not follow that the possible causes are necessarily infinite. The Inquiry heard evidence from the two expert witnesses, both very experienced mountaineers, that there were three likely causes of the accident.

[99] In the interests of clarity it is worth repeating those three scenarios:

1) In short roping down the steep descent, without the additional security of short pitching and a secure anchor, one of the clients slipped and fell.

2) Having protected his clients down the steep descent, Mr Fowler fell either in down-climbing to rejoin his clients, or, possibly, climbing back up to retrieve an item left behind.

3) Whilst gathered at the transition zone one of the party slipped and fell off the ledge.

[100] All of these scenarios, it was agreed, could well lead to the other two members of the party being dislodged and all three thereafter falling. In addition, variations of all three scenarios could have arisen if the party decided to retrace their route back up the steep section having successfully descended it.

[101] The logical and inevitable result of the finite number of scenarios presented by the experts is that, in terms of section 26(2)(d), the likely cause of the accident resulting in the deaths of David Iain Fowler, Graham Cox and Hazel Crombie was a slip or fall by one of the deceased, resulting in the others being dislodged and all three falling whilst roped together.

[102] This finding does not, however, address the further issues as to what section 26(2)(e)and (f) findings are appropriate, or indeed whether any such finding is possible, given the various possible explanations for the accident.

[103] I had the evidence of the two expert witnesses on the use of, and risks of, short roping. I also had their evidence on the use of short pitching as a way of increasing security on more difficult sections. To repeat the quote, in Mr Peter's report, taken from the official Mountain Training handbook, "We protect hard sections as short (roped) pitches and move together, with great care, on easier, broken ground. Short roping encompasses both these techniques." On these matters I accepted the evidence of the expert witnesses without reservation.

[104] At this point it is appropriate to highlight what I found to be a misunderstanding of the expert evidence contained in the Crown submissions. At paragraph 30 it is stated that "The absence of any sling suggests that the party was likely employing a technique that relies on the rope for security, specifically moving together or short pitching". I took this to be an invitation to treat moving together and short pitching as the same thing. This does not accurately reflect the evidence of Mr Peter or Mr Roberts, and misinterprets the quote from the Mountain Training handbook.

[105] To be clear, this determination takes short roping to be a system whereby two or more people are roped relatively closely together. When no further security features such as rock anchors are utilized, the party can be said to be moving together; when further security in the form of a rock anchor is deployed, this is short pitching. Using

this definition, the absence of a sling implies that the party were not short pitching at the time of the accident.

[106] I thereafter considered the evidence of both expert witnesses, and that of Mr Bathurst, regarding the layout and difficulties of the Aonach Eagach ridge traverse, and in particular their consistent description of a route in which the main difficulties were concentrated in two short sections, one of which was the scene of this fatal accident. In addition, I was told that the party would have reached this difficult section by a straightforward walk, with no opportunity to practice easier scrambling beforehand. I also had the specific evidence of Mr Peter regarding the need to balance speed and safety on a long route such as the Aonach Eagach ridge, the compromise being to increase security on harder sections by short pitching, and moving together on easier ground. All this evidence, combined with what I had heard about the level of experience of the two clients, lead me to the conclusion that the scene of the accident would be an appropriate place to increase security by deploying short pitching.

[107] Mr Roberts gave clear and very helpful evidence about the scene of the accident, as detailed above. Of particular interest to me were two aspects of his evidence. Firstly, he described the difficulties being about 10-12 metre long. This meant Mr Fowler had sufficient rope at his disposal to short pitch the difficulties. Secondly he described a rock anchor at the top of the difficulties which would be suitable if one wished to short pitch down the difficult section, this being the large rock around which he placed a sling in the course of his site visit.

[108] Therefore, I concluded that the short difficult section would be an appropriate place to deploy short pitching, the lack of experience of Mr Cox and Mrs Crombie made it expedient to do so, and both the terrain and available equipment were amenable to doing so.

[109] In terms of section 26(2)(e) or (f) findings, I was thereafter required to consider whether (i) the precaution of short pitching could reasonably have been taken, and (ii) had short pitching been deployed, might the accident and resultant deaths been avoided. I had no difficulty in answering question (i) in the affirmative for the reasons summarized in the previous paragraph. As regards question (ii), the evidence of both experts was clear; a guide short pitching clients can stop a fall. To quote paragraph 62 of Mr Peter's report, "It is really only when short pitching (i.e. using anchors and belays) that it is possible to hold a fall."

[110] Had there been clear evidence that the accident had indeed occurred whilst Mr Fowler was short roping his clients down the difficult section without deploying the additional security of short pitching, my section 26(2)(e) finding would have been:

> "That had the three members of the party been attached, either by the rope between them being placed directly round a rock spike or bollard, or attached to a secure anchor such as a sling around a rock spike or bollard, any slip or fall by one of the deceased would, in all likelihood, have been arrested, thereby avoiding the resultant deaths."

[111] Following on from this finding, and subject to the same caveat, my section 26(2)(f) finding would have been:

> "That the three deceased were not attached to a secure anchor such as rock spike or bollard, either via a sling, or directly by way of the rope around such a feature, or that the rope was placed around such a feature but became dislodged,

> contributed to the deaths of David Iain Fowler, Graham Cox and Hazel Crombie."

[112] However, and this bears repeating, given that there was no conclusive evidence that Mr Fowler was short roping his clients down the tricky descent, without the added security of a rock anchor, when the accident occurred, the above draft findings cannot be sustained.

[113] In light of the evidence of both expert witnesses, I accepted that short pitching would have been the appropriate safety system to use for the tricky descent. There was clear and undisputed evidence that Mr Fowler was an experienced and competent guide who had taken clients along the Aonach Eagach ridge many times. I therefore felt it safe to assume that he knew the route well. Taking these factors together, whilst it would be conjecture to state that Mr Fowler did deploy short pitching as a safety measure on the tricky descent, I nonetheless was able to reach the conclusion that in all probability he did so.

[114] I thereafter considered the second and third scenarios, and whether any section 26(2)(d) and (e) findings might arise from them. With regard to these scenarios, I accepted the evidence of Mr Peter that some accidents cannot be reasonably anticipated. Specifically he stated that a client, or indeed anyone, can do something unexpected such as slipping, or stepping back and falling off the ledge such as in the transition zone. He also stated that it is not impossible that Mr Fowler fell when descending the tricky down-climb. When asked to expand on this he stated that even the most experienced climbers make mistakes and indeed sometimes die as a result.

[115] Therefore, I found that, as neither the second nor third scenario were in themselves reasonably foreseeable, there were no precautions that it would have been reasonable to take to prevent them occurring. Accordingly no section 26(2)(e) or (f) findings arose from these two scenarios.

[116] The Crown, in concluding their submissions, stated that "the inherent risks of mountaineering, however mitigated, can never be eliminated". Submissions for West Coast Mountain Guides were in similar terms. It should be clear from my detailed consideration of the first possible scenario that I do not whole-heartedly adopt this somewhat fatalistic attitude. Nonetheless my concluding that no possible section 26(2)(e) or (f) findings arose from the second and third scenarios does mean that, on the basis of the evidence led in this Inquiry, I have to accept that there are specific risks, particular to the practice of short roping, that cannot be reasonably eliminated.

[117] It should be stressed that submissions on behalf of the family of Mr Cox do not include any observations about the level of risk inherent in mountaineering.

[118] Having concluded that no section 26(2)(e) or (f) findings were possible, it was thereafter necessary to consider if there were any other relevant facts which should properly constitute section 26(2)(g) findings. At this stage, I focused very much on the booking process for the excursion, the level of communication between Mr Fowler and his clients before 5 August 2023 and the opportunities (or lack thereof) for Mr Fowler to properly assess his clients' competence before embarking on the Aonach Eagach ridge traverse.

[119] Based on the evidence heard by the Inquiry, I concluded that there were three relevant general areas of concern:

1) Inadequate information provided to clients, both by way of general advertising and specific pre-excursion briefings, regarding the short roping system and its potential use on the Aonach Eagach ridge.

2) Inadequate detailed pro-active discussions with the clients, before the excursion, regarding their weight, level of experience and competence, equipment and general expectations of the traverse of the Aonach Eagach ridge.

3) Inadequate prior assessment of the clients' competence, by way of direct observation rather than merely discussion, before the planned excursion. This point is particularly relevant on an undertaking such as the Aonach Eagach ridge where there is little, if any, opportunity to assess clients' competence before one of the most difficult sections of the route requires to be tackled.

[120] These conclusions give rise to the more detailed section 26(2)(g) relevant facts as narrated in the appropriate section of this determination. That no specific section 26(2)(e) or (f) findings arise from these relevant facts is because it was not possible to discern any direct causal link between any particular deficiency in the booking and preparation process and the accident on 5 August 2023 on the Aonach Eagach ridge. However, had Mr Fowler known more about his clients, and had his

clients been better informed about the proposed use of a short roping system, the inherent risks of the proposed excursion may have been mitigated.

[121] I should stress that it is important not to confuse absence of proof with proof of absence. By this I mean that it may well be that Mr Fowler's preparations for the excursion on 5 August 2023 did include some or all of the above elements, ie detailed discussions with clients about experience and expectations, and an explanation of the short roping system and its risks. It is simply that the Inquiry was not presented with evidence to that effect.

[122] The section 26(2)(g) relevant facts I settled upon can essentially be summed up by the single proposition that, when embarking on an excursion such as that planned by Mr Fowler for his clients on 5 August 2023, if risk is to be mitigated, preparation is key. In this regard, I do not think that I could improve on Mr Peter's succinct view, as stated in his report:

> "29. However, it is my view that meeting clients for the very first time immediately before beginning a venture like the Aonach Eagach increases the pressure on the leader. There is very little time to evaluate the clients and their equipment and very little opportunity to change the plan. It is very difficult for the leader to alter or cancel the venture when clients have travelled a long way for a single day excursion.
>
> 30. In my view, a better plan would be to meet the clients the day before and to undertake a short familiarization trip. This would give the leader an opportunity to assess the clients' abilities and to introduce the techniques that would be used on the traverse of the Aonach Eagach. It would also provide an opportunity to make any changes to their equipment should they be required."

Recommendations

[123] Having settled upon what I considered to be the relevant facts as supported by the evidence, and as previously stated having failed to discern a direct causal link between any relevant fact and the accident of 5 August 2023, I did not regard it as appropriate to make any specific recommendations. In addition, in the absence of evidence before the Inquiry as to whom any possible recommendations might be addressed, and indeed detailed evidence as to what the current professional standards or best practice might be in the mountain guiding sector, framing appropriate Recommendations would have been problematic.

[124] Nonetheless, I would hope the mountain guiding community in Scotland will reflect on the section 26(2)(g) relevant facts of this determination. These findings are specific to this particular accident. However, if there are general lessons to be learned from the deaths of David Fowler, Graham Cox and Hazel Crombie, this will require those guiding clients in the mountains of Scotland to consider whether their booking and preparation systems avoid the apparent deficiencies highlighted by this determination.

Final observations

[125] It is appropriate to end on a more personal note. I should start by stating that I have over four decades of mountaineering experience, and have been a member of a Mountain Rescue Team for 11 years. The subject matter of this Inquiry are very much of personal interest to me.

[126] When Mr Roberts, in his report, stated "I believe this incident represents the most significant of its kind on UK mountains", I have no reason to doubt him. However, I am well aware of the long tradition of unregulated and unguided access to the Scottish hills. The issues raised in this Inquiry are of significance to those offering mountain guiding services, but are not addressed to those who, independently and unguided, take to the hills of Scotland.

[127] As already referred to, I had the benefit of heartfelt and touching family statements from Rebecca Fowler (David Fowler's sister), Graham Cox's family and Hazel Crombie's family. In addition, I noted that Graham Cox's widow Collette Cox attended the Inquiry in person; and I can only commend her dignity and composure in doing so.

[128] I would wish to extend my condolences to the families of the three deceased. David Fowler, Graham Cox and Hazel Crombie were all clearly very much loved, and continue to be missed.

[129] At the conclusion of Brian Bathurst's evidence I thanked him for the efforts he and his colleagues in Glencoe Mountain Rescue Team made in searching for, and ultimately recovering the remains of, David Fowler, Graham Cox and Hazel Crombie. I would wish to repeat that sentiment now. The members of Glencoe Mountain Rescue Team are volunteers who freely give up their own time to go to the aid of those in difficulty, and are to be commended for doing so.

[130] I would also like to thank Ian Peter and Shaun Roberts for the assistance their detailed and considered evidence provided to the Inquiry. The respective summaries of

their CVs provided above do not do justice to the breadth and depth of their experience and expertise. Their input was crucial to enabling the Inquiry to fully and properly consider both the likely causes of the tragic accident on the Aonach Eagach ridge on 5 August 2023, and the lessons which might be drawn from it.