SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT PETERHEAD

[2025] FAI 39

PHD-B29-25

DETERMINATION

BY

SHERIFF ALAN SINCLAIR

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

into the death of

ALEC JOHN COWIE

Peterhead, 4 September 2025

FINDINGS

The Sheriff having considered the information presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") that:

1. **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred**):

   The late Alec John Cowie, born 17 January 1970 died at 0710 hours on 3 December 2021 within cell 2B 08 Ellon Hall, HMP Grampian, South Road, Peterhead, with life formally being pronounced extinct by Paramedic John Reid.

2. **In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):**

   No accident occurred, the death having come about by way of completed suicide.

3. **In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):**

That the cause of death was suicide by way of hanging.

4. **In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death):**

No finding can be made, the death not having occurred by way of accident.

5. **In terms of section 26(2)(e) of the 2016 Act (reasonable precautions which may realistically have prevented the death):**

No precautions could have been taken that may have prevented Mr Cowie's death.

6. **In terms of section 26(2)(f) of the 2016 Act (defects in any system of working which contributed to the death):**

Mr Cowie's death was not contributed to by any systemic defect or failure in the management or care of Mr Cowie during his time within HMP Grampian.

7. **In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):**

i) There was a lack of a formal mental health referral process within HMP Grampian at the time of Mr Cowie's death.

ii) The *ad hoc*, informal process that was in place was prone to error.

iii) Ms Jennifer Watt, a substance use nurse employed by Grampian Health Board at the time of the death, identified that a mental health referral was required based on an interaction with Mr Cowie on 28 November 2021.

iv) On 29 November, Ms Watt communicated a concern for Mr Cowie's mental health to Donna Jepson, the mental health team leader at HMP Grampian.

v) In normal circumstances, at this time, the making of a mental health referral would result in an appointment being made with a GP to discuss a prisoner's mental health.

vi) No such appointment was made on this occasion, nor was any other action taken.

RECOMMENDATIONS

That the Scottish Prison Service, as part of the review of the services suicide prevention policy (currently called "Talk To Me") which is currently underway, give consideration to ensuring that:

i) the policy, whatever form it should take, specifies that all decisions of the Parole Board, however they have come about, result in a suicide risk assessment being undertaken; and

ii) that there are mechanisms in place to ensure the results of such assessments are properly recorded and stored.

NOTE

Introduction

[1] This is a mandatory inquiry in terms of section 2(4)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, because Mr Cowie died whilst he was in legal custody.

The participants and their representatives at the Inquiry

[2] The Procurator Fiscal, who represents the public interest, issued notice of the Inquiry dated 17 April 2025. Preliminary Hearings took place at Peterhead Sheriff Court on 23 April, 11 June and 2 July 2025 before the Inquiry took place on 29 and 30 July 2025.

[3] Mr Brown, Procurator Fiscal Depute, appeared for the Crown. Ms Thornton, Solicitor, appeared for the Scottish Ministers on behalf of the Scottish Prison Service ("SPS"). Ms Donnachie, Solicitor, appeared for Grampian Health Board. The family were not represented as an interested party. Some family members were present during the Inquiry.

The evidence

[4] Parties lodged a joint minute of agreement at the commencement of the Inquiry. The terms of the joint minute were read for the recording. The joint minute, *inter alia*, agreed that the content of statements lodged in respect of the following witnesses would form part of the evidence to the Inquiry:

a) Prison Officer W, c/o Police Service of Scotland;

b) Prison Officer X, c/o Police Service of Scotland;

c) Prison Officer Y, c/o Police Service of Scotland;

d) Prison Officer Z, c/o Police Service of Scotland;

e) Craig Mpofu, Staff Nurse, c/o Police Service of Scotland;

f) Shona Murray, Staff Nurse, c/o Police Service of Scotland;

g) Morris Kusotera, General Nurse, c/o Police Service of Scotland;

h) Jennifer Watt, Substance Use Nurse, c/o Police Service of Scotland;

i) Donna Jepson, Mental Health Team Leader, c/o Police Service of Scotland;

j) Dr Adekunle Adeyemi, General Practitioner, c/o Police Service of Scotland;

k) Dr Audrey Hosie, General Practitioner, c/o Police Service of Scotland;

l) John Reid, Paramedic, c/o Police Service of Scotland; and

m) Erin Kilkerr, Ambulance Technician, c/o Police Service of Scotland;

[5] In addition to the evidence contained within these statements, oral evidence was given by:

a) Prison Officer W;

b) Jennifer Watt, Substance Use Nurse;

c) Julie-Anne Stuart, Custody and Prison Services Nurse; and

d) Siobhan Taylor, SPS Policy Manager for National Suicide Prevention

I had no difficulty in accepting the entirety of the evidence from these witnesses.

[6] The Inquiry also had available to it 19 productions lodged by the Crown.

[7] Written submissions were lodged by all parties. On the basis of all this evidence I was able to make my findings.

The legal framework

[8] The Inquiry was held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the 2016 Act) and was 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 death, and; (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. An Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

Mr Cowie's detention at HMP Grampian

[9] At the date of his death, Mr Cowie was a prisoner at HMP Grampian. He had been remanded in custody on 22 November 2021 in relation to charges of abduction and attempted murder.

[10] Immediately prior to being detained on those charges he was at liberty on licence.

[11] On 24 November 2021 the parole board wrote to Mr Cowie care of HMP Grampian to advise that his licence would be revoked and directing that he be detained within HMP Grampian. The effect of the revocation was that Mr Cowie would be detained until 2 November 2028 at the earliest.

The immediate circumstances of Mr Cowie's death

[12] On 2 December 2021 Mr Cowie was locked in his cell for the evening by prison officers X and Z at 1651.

[13] On the morning of 3 December 2021 prison officers X and Y unlocked the door of Mr Cowie's cell and attempted to open it. The door would only open a short distance, and they forced entry.

[14] On entering the cell, prison officer Y found Mr Cowie's body to be upright against the cell door before falling to the floor as the door closed. Mr Cowie was found to be stiff with postmortem staining on his hands and a red ligature around his neck. The red ligature was a shoelace. It has not been possible to establish how the ligature was anchored to the door.

[15] Additional prison officers and medical staff were summoned to the cell. An emergency ambulance was requested, and attempts were made to resuscitate Mr Cowie until the ambulance arrived.

[16] Paramedic John Reid and Ambulance Technician Erin Kilkerr arrived at Mr Cowie's cell at approximately 0710. Mr Cowie was pronounced extinct shortly thereafter by Mr Reid.

[17] On 7 December 2021 a postmortem examination of Mr Cowie's body was concluded by Forensic Pathologist Dr Leighanne Deboys. Dr Deboys confirmed that the cause of death was hanging.

SPS's suicide prevention strategy

[18] The SPS have and, at the time of the death had, a suicide prevention strategy called Talk to Me ("TTM"). The strategy provides for assessments of whether a prisoner

is at risk of suicide and prescribes when such assessments should be carried out. The policy provides for an assessment called a "Reception Risk Assessment" ("RRA").

The Determination

[19] The Procurator Fiscal and the two interested parties invited me to make the formal findings that I have in relation to sections 26(2)(a) to (f) of the 2016 Act. In addition, the Procurator Fiscal asked me to make findings in relation to section 26(2)(g), namely, to record facts that were relevant to the death. The findings I was invited to make related to three issues as follows:

a) that there was a lack of a formal mental health referral process within HMP Grampian at the time of Mr. Cowie's death and that the *ad hoc* process was prone to error;

b) that an RRA ought to have been carried out on 24 November 2021 following receipt of the Parole Board's decision to revoke Mr Cowie's licence; and

c) that the wording contained with the TTM guidance part 2 created ambiguity as to the circumstances in which an RRA ought to be carried out following a decision of the Parole Board.

[20] Both interested parties moved me not to make any findings under section 26(2)(g).

[21] I have determined that findings required to be made in relation to the lack of formal mental health referral process. I have declined to make any findings in relation

to the failure to carry out an RRA on 24 November 2021 or with regards to the contended ambiguity in part 2 of the TTM guidance.

The mental health referral process

[22] The relevant facts are narrated at paragraph 7 of my determination above. It was submitted to me on behalf of Grampian Health Board that the issues of a prisoner's mental health and their suicidality are distinct. Ms Donnachie referred me to evidence of longstanding issues with Mr Cowie's mental health and in particular that he was being medicated for the same. Mr Cowie was assessed on several occasions for signs of suicidality and none were identified. I took her to accept that there was a deficiency in the way that the mental health referral referred to at paragraph 7 had been addressed, but that this was a separate issue to the assessment and management of the risk of suicide.

[23] For the Crown, Mr Brown pointed to the fact that mental health referral on 29 November 2021 which did not result in any action was proximate in time to the completed suicide and that there is a clear link between mental health and suicidality.

[24] I considered that there was a sufficient degree of relevance between the apparent lack of action following the mental health referral and Mr Cowie's completed suicide to make a finding under section 26(2)(g) of the 2016 Act. There appears to me an axiomatic link between poor mental health and suicidality. The relevant circumstances of the death must include the mental health of Mr Cowie and the steps taken to support the same. Given the engagement that Mr Cowie had with various health professionals

between 29 November 2021 and the time of his death, it is very unlikely indeed that, had appropriate action been taken following the referral, Mr Cowie's suicide would have been avoided as the result of such action. That does not render these circumstances irrelevant to the death and, for that reason, formal findings have been made under section 26(2)(g).

Lack of an RRA on 24 November 2021

[25] I was invited by the Crown to make a finding under section 26(2)(g) that an RRA should have been carried out on 24 November 2021 following Mr Cowie receiving the Parole Board's decision to revoke Mr Cowie's licence. It was agreed between the parties that such an assessment should have taken place but that the RRA form could not be located by the SPS.

[26] The facts concerning this issue are agreed in terms of the joint minute and can be summarised as follows:

a) On 15 October 2021, Mr Cowie was released on licence by the Parole Board, having been imprisoned in respect of two convictions: i) one dated 12 December 2008 of attempted murder; and ii) another dated 8 September 2015 of a number of domestic assaults.

b) On 22 November 2021, Mr Cowie appeared from custody at Aberdeen Sheriff Court on petition in relation to charges of abduction and attempted murder.

c) On 24 November 2021 the Parole Board wrote to Mr Cowie care of HMP Grampian to advise that they would recommend to the Scottish Ministers that his licence should be revoked.

d) The effect of the revocation was that Mr Cowie would be detained until at least 2 November 2028.

e) The processes then in place should have resulted in an RRA form being appended to the letter before it was transmitted to the relevant area of the prison for onward transmission to the prisoner.

f) The First Line Manager of the relevant area of the prison should complete the RRA when providing the prisoner with the correspondence.

g) The RRA that should have been completed as part of this process has not been located.

[27] In her statement given to the Police on 16 January 2023, Substance Use Nurse Jennifer Watt spoke of a meeting with Mr Cowie on 28 November 2021. The interaction gave her concerns about his mental health. He had told her that he had been recalled to prison to serve a further seven years and that this had made him feel "totally broken". It appears very likely that any deterioration in Mr Cowie's mental health at that time was materially contributed to by the revocation of his licence.

[28] It was submitted to me by Mr Brown that the most likely explanations for the failure to locate the RRA from 24 November 2021 are i) that it was not done; or ii) that it was done, that Mr Cowie was not assessed as being "at risk" and that it has subsequently been lost. There is another possible set of circumstances, which is that

Mr Cowie was assessed as being at risk and the RRA form has been lost. It was suggested by Mr Brown, and accepted by me, that this was unlikely as no further action took place under the TTM process and the subsequent documents that would have been generated had Mr. Cowie been deemed to have been "at risk" do not exist. The following circumstances mean it is unlikely that Mr Cowie would have been assessed as "at risk" if he had undergone an RRA on 24 November 2021:

a) In her statement, Ms Watt indicated that she asked Mr Cowie whether he was suicidal. His response was to become angry and say "No".

b) On 30 November 2021, following a virtual court appearance at which he was fully committed in relation to the charges of abduction and attempted murder, he was subject to an RRA which concluded that he was not at risk at that time.

[29] I have concluded that none of the facts relating to the "missing" RRA are relevant to the circumstances of Mr Cowie's death. Whilst the events (or lack thereof) are reasonably proximate in time to the completed suicide, the following considerations mean that the requisite level of connection is not present:

a) for the reasons discussed above, it is unlikely that an RRA carried out on 24 November 2021 would have determined Mr Cowie to be at risk of suicide; and

b) there was, in fact, an RRA carried out between the 24 November 2021 and the death (being the one carried out on 30 November 2021).

[30] Taking those considerations into account, it is very unlikely that an RRA conducted on 24 November would have resulted in any intervention in relation to Mr Cowie's mental health or suicide risk. That sits in contrast to the circumstances surrounding the mental health referral discussed above.

Wording contained with the TTM guidance

[31] As at the date of death, guidance was available from the SPS on the Talk to Me policy. The version which was current at the time was dated 2016 and revised in June 2021. Page 10 contains the following wording:

> "Every person who comes into an establishment must be assessed for risk of suicide. A risk assessment must be completed for all admissions, transfers, return from court, return from external escort, Video Conference court appearance & tribunal hearing. A risk assessment must also be completed after a parole hearing and following receipt of the parole decision."

[32] It was submitted for the Crown that the word "the", where it appears between the words "receipt of" and "parole decision" could lead the reader to consider that it was only upon a decision which followed a hearing that an RRA would be required. Such an interpretation would lead to no RRA being performed in the circumstances which pertained to Mr Cowie's case on the 24 November. There was no hearing leading to the parole board's decision on that date.

[33] Reading the part of the guidance referred to above in a vacuum may lead to the conclusion suggested. Ambiguity should be avoided in matters of such importance. I have accordingly made a recommendation that any future policy makes it expressly clear that an assessment of suicide risk should be carried out following any decision of

the parole board. I have declined, however, to make any findings in this regard under section 26(2)(g). The evidence heard at the inquiry suggested that all those who were responsible for ensuring an RRA was carried out following a parole board decision understood that any such decision should be followed by an assessment, not just those which followed upon a hearing. Accordingly, had the guidance been drafted to avoid the ambiguity, there would have been no practical difference to the assessment process for Mr Cowie's risk of suicide.

[34] Finally, I would wish to record my sincere condolences to the family of Mr Cowie for their loss.