SHERIFFDOM OF SOUTH STRATHCLYDE DUMFRIES AND GALLOWAY AT HAMILTON

[2025] FAI 35

HAM-B342-23

DETERMINATION

BY

SHERIFF LINDA MARGARET NICOLSON

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

into the death of

ROBYN GOLDIE

HAMILTON, 10 July 2025

DETERMINATION

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):

Robyn Goldie (the deceased), born 20 February 2005, died at approximately 1925 hours on 26 July 2018 at 19 Lomond Drive, Wishaw, North Lanarkshire.

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

No accident occurred which resulted in the death.

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

> The cause of death was 1a) peritonitis, 1b) perforated duodenal ulcer, with contributory factor ii. Acute pyelonephritis with Group B streptococcal infection.

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

> A precaution which could reasonably have been taken was for her mother, Sharron Goldie, to have sought medical attention for her or, at least, allowed her to access medical attention. Had that precaution been taken, it might realistically have resulted in the death being avoided.

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

> There were no defects in any system of working which contributed to the death.

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

> North Lanarkshire Council social work policies and procedures, in place at the time, were not complied with in that there was an absence of a written comprehensive assessment, a written child's plan, and adequate supervision of workers. Child protection measures should have been put in place, and a referral made to the Scottish Children's Reporter Administration, at an earlier stage than they were.

RECOMMENDATIONS

Having considered changes implemented by North Lanarkshire Council since the death, the sheriff makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE

Introduction

[1] This Inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 into the death of Robyn Goldie.

[2] Preliminary hearings were held on 3 July, 27 September, 22 November, and 20 December 2023, and on 27 February, 26 April, 24 June, 19 August, and 2 September 2024. Inquiry hearings were held from 9 to 17 September 2024, 30 October 2024, and 13 November 2024, with submissions heard on 6 March 2025.

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Appendices

1. List of witnesses
2. Amended charge to which Sharron Goldie pleaded guilty
3. Sentencing Statement of Lord Beckett

[3] The participants in the Inquiry were:

The Procurator Fiscal, represented by Ms S Brown, Procurator Fiscal Depute;

North Lanarkshire Council (NLC), represented by Mr S Blair, advocate;

NHS Lanarkshire (NHS), represented by Ms L Jardine, advocate;

Christian Anderson, Brian McNott and Victoria Logan, all social work staff, represented by Mr A Rodgers, solicitor; and

Ms Sharron Goldie, the deceased's mother, represented by Mr D Nicolson, KC, advocate.

During preliminary hearings of the Inquiry, the Scottish Children's Reporter Administration (SCRA) participated and were represented by Mr S Flannigan, solicitor. However, by the time of the hearing of evidence, SCRA concluded that it did not require to participate further and withdrew from participation at the commencement of the hearing of evidence.

[4] The witnesses to the Inquiry are listed at Appendix 1. The Inquiry had affidavits from each of the witnesses, aside from the two expert witnesses who gave evidence. The Inquiry also heard the parole evidence of witnesses 1 to 13 on the list. It was agreed that affidavits for the remaining witnesses should be admitted as evidence and treated as if they were the parole evidence of the witnesses.

[5] The Inquiry heard expert evidence from Maggie Mellon, social worker, called by the Crown and Colin Anderson, social worker, called by NLC. Each produced a report and supplementary report for the Inquiry.

[6] A substantial amount of documentary productions were lodged which included social work, education, and health records.

[7] A lengthy joint minute was produced, setting out substantive agreement of the factual background and I am grateful to parties' representatives for their diligent work in preparing and agreeing it. It has been of much assistance to the Inquiry.

The legal framework

[8] This Inquiry was held under section 1 of the Act. The Inquiry is a discretionary one in terms of section 4 of the Act, the Lord Advocate having considered that the death

of Robyn Goldie occurred in circumstances giving rise to serious public concern and that it was in the public interest for a public inquiry to be held into the circumstances of the death.

[9] The Inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[10] In terms of section 1(3) of the Act, the purpose of this Inquiry is to establish the circumstances of Robyn's death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[11] Section 26 of the Act sets out the matters to be covered in the determination. These include setting out findings on the following:

(a) when and where the death occurred;

(b) when and where any accident resulting the death occurred;

(c) the cause or causes of the death;

(d) the cause of causes of any accident resulting in the death;

(e) any precautions which – (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

(f) any defects in any system of working which contributed to the death or any accident resulting in the death;

(g) any other facts which are relevant to the circumstances of the death.

They also include setting out such recommendations (if any) in relation to:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working;

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

[12] The procurator fiscal represents the public interest in an Inquiry. An Inquiry is an inquisitorial process, not adversarial. It is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

Overview

[13] Robyn Goldie was born on 20 February 2005 and was 13 years of age at the time of her death. After her birth, Robyn lived with her mother, Sharron Goldie. Robyn had no contact with her father during her lifetime. Due to concerns about Ms Goldie's care of Robyn, in 2009, when Robyn was 4 years old, she went to live with her maternal grandmother, JD. This arrangement was made on the intervention of social work services at NLC. Robyn's name was placed on the Child Protection Register. A referral was made to SCRA. JD provided a very good level of care to Robyn and, after monitoring the situation for a period, social work ended their involvement and SCRA decided that it was not necessary to arrange a children's hearing.

[14] JD continued to provide a high standard of care for Robyn. In 2017, when Robyn was 12 years old, she went back to live with her mother, Ms Goldie. The decision about this was made without the family notifying social work services. NLC social work

services became aware of Robyn's move after the event and became involved in Robyn's life again in September 2017. Numerous concerns about Robyn's wellbeing were recorded from September 2017. Social work remained involved with Robyn until her death in July 2018. Robyn died after her mother prevented her from accessing medical attention and treatment. Questions arose as to whether there was adequate assessment of Robyn's circumstances, whether there was an effective plan in place to safeguard Robyn's welfare, whether child protection measures and a referral to SCRA should have been deployed at an earlier stage than they were and whether there was a failure to supervise and scrutinise social workers' decisions. The Inquiry had to consider these and other matters in determining the matters set out at section 26 of the Act.

Background of Robyn's mother

[15] In 1984, when Ms Goldie was around 9 years of age, she was involved in a road traffic accident which caused a brain injury resulting in vision difficulties, mobility issues, and slurred speech. After this injury Ms Goldie had difficulties with cooking, bathing, walking and using stairs. A referral for assessment of Ms Goldie was made by social work services in 2001 to a brain injury unit. Ms Goldie had a long history of abusing cannabis and alcohol. It was noted in social work records that, in 2003, Ms Goldie spent 11 weeks in Monklands Hospital for psychiatric issues. She was detained in terms of mental health legislation. It was noted that she had delusional beliefs. On her discharge from hospital, Ms Goldie did not take antipsychotic medication prescribed to her. During at least the period from when Robyn Goldie

returned to the care of Ms Goldie in 2017 and until her death, Ms Goldie was not open to mental health services. In August 2016, Ms Goldie was referred by her GP to a neurologist for neuropsychological testing. Ms Goldie did not attend the appointment offered.

[16] In addition to Robyn, Ms Goldie had two older children, Elizabeth, born in 1995 and a son, born in 1998, who were children from her marriage to AS which broke down in 2003. Tragically, in 2019, Ms Goldie's daughter Elizabeth took her own life while working as an English language teacher in China.

[17] During Ms Goldie's marriage to AS there were issues which were brought to the attention of social work, which culminated in AS seeking custody of their children. The issues included an allegation that Ms Goldie assaulted her daughter Elizabeth, aged 9 years old at the time, Ms Goldie's use of alcohol and cannabis, and domestic violence in the relationship. Ms Goldie was charged with serious assault of AS by stabbing him. It was noted by social work staff involved with Ms Goldie's older children, that Ms Goldie was often vague in conversations and would go off at tangents.

[18] When Ms Goldie was examined in October 2020 by Dr Raja, a consultant forensic psychiatrist, she still held delusional beliefs, believing that cameras had been implanted in her brain in a conspiracy and having grandiose beliefs. Her conversation was noted to be tangential. She was found to have limitations to her emotional intelligence and limited insight into the events preceding Robyn's death, and did not comprehend that aspects of her parental care could have differed. Dr Raja noted that there is evidence that traumatic brain injury effects emotional intelligence including the ability to

recognise, understand and respond to emotions and empathise with others. She found Ms Goldie was not sufficiently responsive, sensitive and in control to gauge a child's emotional needs. Dr Raja concluded that emotional immaturity and cognitive difficulties emanating from traumatic brain injury contributed to her ill treatment and neglect of Robyn. Ms Goldie's ability to understand and judge situations along with problem solving is impacted by these factors. Dr Raja considered that the true extent of cognitive difficulties could be better assessed by a neuropsychiatric assessment.

Children and families team

[19] In North Lanarkshire Council, children and families social work provide mainly targeted interventions and supports focussed on children and young people and their families at "additional" and "intensive" levels but also work with partners to provide and commission early help and support for families. The service is delivered principally through six locality teams, one of which is Wishaw, as well as through area-wide intensive services, one of which is Community Alternatives.

[20] The service provides holistic support, assessment and interventions in response to "requests for assistance" and "notifications of concern" received both directly from the public and from other professionals. Within the "Getting it Right for Every Child" (GIRFEC) framework, children and families social work are the lead professionals for a range of children and their families including those who are the subject of child protection processes, children and young people experiencing care (or who are care experienced) and children "in need", including some children with

disabilities/additional support needs, young carers and children on the "edges of care" or whose wider circumstances otherwise require a co-ordinated multi-agency plan and support.

[21] Children and families social work services are delivered in partnership with key agencies and organisations including health, education, and police and aim to assist, support and promote the welfare, wellbeing, and rights of children and their families through relationship based practice. The areas of support include:

- Early help and support including crisis intervention
- Support for children "in need"
- Child protection including familial and extra-familial harm
- Residential childcare
- Kinship support

[22] Community Alternatives provide an intensive level of support for young people and their families where there is a risk that the young person may become looked after and accommodated away from home. The service is generally aimed at teenagers with the over 12s being the main age group. The goal of the service is to support families to remain together. The service can support parents to promote positive parenting.

Early social work involvement with Robyn

2007

[23] On 19 May 2007 at approximately 2000 hours, police received a telephone call from a pub landlord reporting that Sharron Goldie and her then partner, TL, were on the premises and were drunk in charge of Robyn, then aged 2. They had been in the pub

since 3pm. When police officers attended they witnessed TL falling against the buggy and tipping the table over. Ms Goldie was verbally abusive to the police officers. They arrested Ms Goldie and removed her to Bellshill Police Office.

[24] In response to the incident, a Child Protection Multi-Agency Case Discussion took place on 18 July 2007 at Wishaw social work locality office.

[25] A health visitor advised that there were no historical or present concerns in relation to Robyn's health, that Robyn was up to date with her immunisations, and that there were no parenting concerns. Ms Goldie had not yet registered herself or Robyn with a GP in the area where she was then residing. The importance of registering with a GP was emphasised to Ms Goldie and she was advised to do so as a matter of urgency. It was recommended that Ms Goldie work with social work's children and families team for a short period of time to allow monitoring of the situation. Robyn was noted as being "safe and secure in the care of her mother and there are no immediate concerns for her welfare". Ms Goldie was in agreement with this recommendation and agreed to work with social work on a voluntary basis. There was no focus for work on a statutory basis. A referral was to be made to SCRA with the recommendation being that the family engage with the social work department on a voluntary basis.

[26] Ms Goldie had been described as being "in total denial" of the incident, when she met with a social worker 1 days after the incident, stating "she is the victim of conspiracy theory and entrapment". However, at their next scheduled meeting on 7 September 2007, Ms Goldie accepted that her partner was intoxicated and had tripped over the buggy. She said that the said incident was a "one off" and that there was now a

plan in place whereby her mother, JD, would look after Robyn to allow Ms Goldie and TL to have a night out. The issue of registering Robyn and Ms Goldie with a GP had been resolved.

[27] As requested, a report was sent to SCRA on 5 September 2007. A letter was received by Wishaw social work locality office from SCRA dated 10 September 2007, which advised that, having considered the information provided, the Children's Reporter had decided not to arrange a children's hearing for Robyn.

2011

[28] Robyn's allocated social worker, Karen Ramage, visited Ms Goldie at her home address on 24 February 2009 in response to a report of Robyn's non-attendance at Windmill Nursery, Motherwell.

[29] Ms Ramage noted the home was relatively tidy and clean but was lacking in floor covering. A lack of interaction between Ms Goldie and Robyn was noted and, although Robyn was very vocal with Ms Ramage and attempted to interact throughout the visit, her speech was unclear. During the visit Ms Goldie required direction and prompting from Ms Ramage to keep Robyn safe when Robyn went into the kitchen, closed the door and climbed onto the work tops on several occasions. When Robyn accidentally banged her head on the floor on Ms Goldie removing her from the work top, Ms Goldie sent Robyn to her room with no attempt to ascertain if Robyn had been injured.

[30] Ms Goldie was very resistant to support being offered by social work. Given her poor attendance at nursery school, Robyn had not met some of her developmental milestones and as such her attendance at school was deferred for 1 year. Ms Goldie was advised that Robyn had to lawfully attend nursery as, given her age, she should have been attending school.

[31] On 15 March 2009 at around 10.00pm, a call handler at Saltire (Gas Maintenance Company) contacted the social work out of hours service (SWES) to advise that a young child (Robyn) had contacted the company's call centre numerous times that evening. During each phone call the child was asked to get an adult to come to the telephone and had been unable to do this. The child was complaining that she was cold. The gas company sent a heating engineer to the child's home. When he arrived at the property, he found the child at home with her mother (Ms Goldie) who was allegedly drunk and very aggressive towards both the child and engineer. Police were contacted. An update was received by SWES from police at 10.50pm advising that Ms Goldie was heavily intoxicated and had become very aggressive and verbally abusive to police officers.

[32] Ms Goldie was charged under section 12 of the Children and Young Persons (Scotland) Act 1937 (a charge of ill treatment or neglect of a child) and was detained in custody at the police office. Ms Goldie admitted to drinking seven to eight cans of beer and police officers also found a piece of cannabis resin within the property. Robyn was upset and distressed by Ms Goldie's behaviour as Ms Goldie shouted and swore at the police officers and attempted to kick a police officer. The home conditions were poor

with no carpets within the property, clothes strewn about, food lying on the cooker and a limited supply of food in the cupboards and fridge.

[33] Robyn was looked after by her grandmother, JD, from that night on. The circumstances of this incident were shared with the social work locality team office at Wishaw and SCRA. Social work told JD that she must supervise any contact Robyn had with Ms Goldie.

[34] A Child Protection Initial Case Conference convened on 23 March 2009. Various decisions were made, including:

- Robyn's name to be placed on the child protection register under the category of risk of physical neglect.
- A referral to be made to SCRA requesting formal measures of supervision in relation to Robyn.
- Robyn to remain in the care of her grandmother until a parenting capacity assessment has been carried out in relation to Ms Goldie.
- Contact to be supervised by JD.

[35] On 5 May 2009, Ms Goldie was referred to the North Lanarkshire Integrated Addiction Service in relation to her alcohol consumption.

[36] On 15 June 2009 Robyn's name was removed from the Child Protection Register.

[37] On or around 10 July 2009, following Robyn having moved to stay with JD, the referral to SCRA was closed and on 13 July 2009 the Children's Reporter took the decision not to arrange a children's hearing in respect of Robyn.

[38] Social work notes from 2009 until 2011 record that Ms Goldie had not addressed issues of concern in relation to her parenting of Robyn. In 2011, social work noted that Ms Goldie had limited insight into her own mental health and the impact of that and her continued use of alcohol and cannabis. It was noted that Robyn was happy and settled in JD's care and doing well at school. Social work were content that Robyn remain living with JD and noted that both Ms Goldie and JD were in agreement that this arrangement should remain in place. A decision was taken on 15 July 2011 to close Robyn's case.

Events 2017 to 2018

[39] The following section sets out information about events, and agencies' interactions, from the point that Robyn returned to her mother's care in 2017. It is not an exhaustive account of all events and interactions. It is set out in chronological order with information taken from the joint minute, witness evidence, and productions, including contemporaneous notes made by workers on the social work database.

[40] **13 September 2017** An anonymous referral was received by social work services advising that Robyn had recently returned to her mother's care. The information was that Robyn was spending periods of time outside the house. She had found her mother drunk. She had been seen outside a pub with her mother, who was shouting at her. Her mother had deliberately locked her out of the house by removing Robyn's house keys, while her mother remained in a pub. Robyn was truanting from school. Robyn had returned home on one occasion with another young person to find her mother drunk on

the sofa with a drunk man who had no pants on. The man had remarked to Ms Goldie, in Robyn's hearing, that she "better not be pregnant".

[41] Ms Goldie had not advised social work or any other agency of North Lanarkshire Council that Robyn had returned to live with her. When the referral about Robyn came in on 13 September 2017, Christian Anderson was the senior social worker on duty in the children and families team at the Wishaw locality office and she then became the senior social worker for the case until Robyn's death. Stephanie O'Hara, a support worker from the locality office, was initially allocated to Robyn's case. In October 2017 she was replaced by Brian McNott, a social worker at the Wishaw office. He and Victoria Logan, a support worker with Community Alternatives, were involved extensively with Robyn from October 2017 until her death.

[42] The senior social worker oversaw the management of Robyn's case by Stephanie O'Hara and Brian McNott. Supervision sessions were not recorded on any system. She had discussions with them, and Victoria Logan when they were in the office and wanted to share information.

[43] **14 September 2017** A social worker visited Ms Goldie to discuss the referral. It was noted that Ms Goldie seemed unable to focus on anything but her own perspective and gave no consideration to Robyn's safety and wellbeing. Ms Goldie did advise that Robyn had asked to return to live with her full time and had moved in with her on 12 July 2017 to allow for transition to high school in the Wishaw area.

[44] After the first visit on 14 September 2017, Ms Anderson agreed that a support worker be allocated to assist Ms Goldie and Robyn with parenting difficulties by undertaking focused work.

[45] Ms Anderson checked the earlier social work records for Robyn and for Ms Goldie's older children, Elizabeth and Andrew. From the records, it was known that Ms Goldie had an acquired brain injury. It was not known to Ms Anderson that a referral had been made to a brain injury unit in 2001/02 for an assessment of Ms Goldie, nor that Ms Goldie had been detained in terms of mental health legislation in 2003, nor that Ms Goldie had a history of paranoid and delusional thoughts. Ms Anderson was aware that Ms Goldie had been charged with stabbing her ex-husband. Ms Anderson was aware that alcohol use was an issue for Ms Goldie, both historically and in the present.

[46] The social work team needed to get an understanding of Robyn's needs and the risks she faced. They were aware of the previous Child Protection Registration of Robyn when she was younger. However, it was perceived that Robyn's needs would be different now that she was an older child. An assessment of Ms Goldie's parenting capacity was needed as a part of an overall assessment of Robyn's situation. Such an assessment should be an ongoing assessment which evolves over time. At the time, there was not an exact format or a specific document for compiling a parenting capacity assessment and different social workers would use different formats based either on a risk assessment framework, or on the basis of indicators from GIRFEC.

[47] It was recognised that support would be needed to help mother and daughter adjust to living together in a parent/child dynamic when that had not been the case for a number of years. Robyn and Ms Goldie expressed a willingness to accept support.

[48] Although social work commenced work with the family, there was no written assessment or written child's plan. The mechanism for recording assessments and plans was different to the mechanism now in place.

[49] **15 September 2017** Another home visit was carried out by a social worker and a support worker and Robyn was spoken to. She had not attended school that day and said that she had not attended for a complete week since term had commenced. She was unhappy with her mother consuming alcohol to excess and going to the pub. She said that she did not have breakfast and often did not have dinner. Although food was seen when the social worker checked the kitchen, it appeared that Ms Goldie was not preparing meals and instead was offering quick options like pot noodles. Ms Goldie was told that they would be given support. The worker provided Ms Goldie with an initial list of areas which required to be worked on, such as Robyn's personal hygiene, school attendance, meals, reduction of Ms Goldie's alcohol consumption and prioritisation of Robyn in how Ms Goldie organised her lifestyle.

[50] **26 September 2017** The original referrer called to inform that Robyn had waited outside a pub for her mother before leaving to get something to eat. She then went to a friend's house. Robyn was apparently accompanied home later in the evening, where Ms Goldie was found to be intoxicated. Robyn stayed with a friend overnight.

[51] **27 September 2017** Social work made contact with Robyn's school, Clyde Valley High School. They reported concerns outlined in the paragraph below. They noted a significant deterioration in presentation from when she lived with her grandmother.

[52] **29 September 2017** Robyn's school held a HART (health and wellbeing review team) meeting. It was noted that there were "major concerns" that Robyn was at risk. Robyn's primary school had reported to the high school that she had been very settled there. She had a great relationship with her grandmother. Robyn's mother had taken her away from her grandmother, leaving her grandmother heartbroken. Towards the end of primary seven, Robyn's mother had been taking her away at weekends and she would return to school with bleached hair and caked in makeup. Pamela Ferry, pupil support teacher, advised that Robyn was appearing in school caked in makeup. Robyn's mother had alcohol issues, there had been incidents when Robyn was locked out of the house when mum was at the pub. Mum had been in the house with a man, drunk. Robyn had explained that she felt very uncomfortable when her mother was so drunk. She was frequently late and her attendance rate was 80% at that point in the term. The primary school had no concerns when she lived with her grandmother. The depute head teacher, Evelyn Neilson, felt there was significant risk of harm/neglect and considered it appropriate that a Notification of Child Protection Concern be made.

[53] **4 October 2017** Social work visited after a call from Robyn's friend to say that Ms Goldie was at home drinking with a man. Ms Goldie was intoxicated and drinking in the living room with a man in his sixties. Robyn was noted to be anxious and when

spoken to on her own said that she wanted to go and stay with her friend, which she subsequently did that night.

[54] **6 October 2017** Robyn attended school with a large bag of clothes, said that she was going to stay with her grandmother for the weekend and would be travelling straight there from school. The school were concerned as the journey involved two buses and they considered Robyn to be very emotionally and physically immature.

[55] **9 October 2017** The school reported their concerns from 6 October. Robyn was absent from school. Social work visited Ms Goldie to discuss the concerns arising from the earlier incident on 4 October. Ms Goldie accepted no responsibility and had no insight into her role as a parent and how her own and Robyn's needs differed. She appeared to deflect from the concerns being raised. When asked, Ms Goldie told social workers that Robyn was absent from school as she had earache. She had not registered Robyn with a GP. Ms Goldie became upset when asked why she had not yet registered Robyn with a GP, and blamed Robyn for not attending the GP for registration. The importance of this, given Robyn's hearing issue, was stressed. As a younger child she had been diagnosed with profound congenital right sensorineural hearing loss with posterior tympanic membrane retraction. Robyn had been attending ear nose and throat appointments since May 2012. Ms Goldie made bizarre remarks regarding a deceased child she knew and about "body snatchers", which caused the worker to query whether her mental health was deteriorating. Robyn had absconded from home the previous Saturday to an older man's house, to get changed in his bedroom with two of her friends. Ms Goldie was told that she should contact police and/or the social work out of

hours service should Robyn abscond again. The worker was concerned about the lack of protective factors for Robyn and that she was becoming out with parental control.

[56] **12 October 2017** Ms Anderson had a discussion with the police regarding the Notification of Child Protection Concern received from Robyn's school. At that time, there was a protocol in place which allowed a Notification of Child Protection Concern to be screened out of an Inter-Agency Referral Discussion (IRD). An IRD involved a meeting with not only social work and police present but other agencies such as education and health to discuss notifications. The notification from the school was screened out as one which would not trigger an IRD being held. This decision was based on Ms Anderson's assessment of the situation at the time. She considered that all the issues raised in the notification were known to social work and that social work were working with Ms Goldie and Robyn. A GIRFEC meeting was scheduled to take place 2 weeks' later. Social work would continue to support Robyn and Ms Goldie intensively meantime. The police raised no opposition to the notification being screened out. Ms Anderson was of the view that the school should have raised a request for assistance rather than a Notification of Child Protection Concern. The school did not agree and refused to withdraw the notification. Throughout the time Robyn attended Clyde Valley High School in 2017 to 2018, the school kept in touch with social work and updated them on relevant issues and events. The school did not refer Robyn to SCRA.

[57] **13 October 2017** Robyn was referred to Community Alternatives.

[58] **16 October 2017** Social work out of hours service had several out of hours calls from and to Ms Goldie and Robyn. They were shouting over each other and Ms Goldie

advised that Robyn had been hitting her. Ms Goldie declined a visit from the duty social worker as she was concerned they may mistake her speech and mobility issues as her being under the influence of alcohol. Eventually the situation appeared to have calmed.

[59] **17 October 2017** At 5:40am, a call was received by the out of hours service from Ms Goldie advising that Robyn had stayed up all night talking to someone on Facebook messenger. Robyn could be overheard shouting in the background. At 10.00am the same day, a home visit was made by social workers. Ms Goldie advised that Robyn was not following instructions and was hitting her. She admitted hitting Robyn back. Robyn and Ms Goldie were in bed when workers visited. Robyn was noted to be wearing full makeup and fake tan. Robyn was in the habit of travelling to Airdrie to visit friends and it was suggested that she spend more time with local friends to avoid travelling on her own. Both reported that Ms Goldie's alcohol consumption had reduced. They were encouraged to spend more quality time together. The social worker noted that Robyn was a 12 year old child who was acting and dressing much older than her years but still appeared childlike. She was of the view that Ms Goldie did not set sufficient boundaries and routines. She had allowed Robyn to be befriended by a 49 year old male neighbour and did not recognise the seriousness of this.

[60] **23 October 2017** Ms Goldie reported she had left Robyn with her grandmother the previous Saturday to allow Ms Goldie to go on a day trip with her local pub. She sprained her ankle four times on the trip. A 39 year old male friend of Ms Goldie babysat Robyn on two evenings to allow Ms Goldie to go out and socialise. Ms Goldie

declined participation in a "handling teenage behaviour" parenting group run by Community Alternatives.

[61] **26 October 2017** Two support workers visited. A neighbour, Billy, walked past the window and Ms Goldie said that he would stand outside Robyn's bedroom window at night. Robyn had gone out to tell him to go away. Ms Goldie was advised that it was her responsibility to deal with this. Robyn's bedroom door was off its hinges after Ms Goldie had forced her way in to the room when Robyn was inside. The workers contacted the housing association to arrange for it to be repaired on 31 October. The housing association were unable to gain access and the door remained unrepaired.

[62] **27 October 2017** A GIRFEC meeting was held. The attendees were Christian Anderson, Stephanie O'Hara, Brian McNott, Tony Scott (Community Alternatives senior social worker), Victoria Logan, Pamela Ferry, JD, Sharron Goldie, and Robyn. There were no representatives from health or the police at the meeting. Robyn's case was allocated to Brian McNott, taking over from the support worker Stephanie O'Hara. It was agreed that Community Alternatives would also continue to be involved. No child protection investigation was initiated, nor any referral to SCRA. A GIRFEC review was assigned for 26 January 2018. Community Alternatives spoke at the meeting about how they could provide intensive support to Ms Goldie in parenting and in understanding the pressures on children now from social media, bullying, and interactions with their peers.

[63] The decisions recorded at the end of the meeting, other than identifying the workers who would be involved as Brian McNott, Victoria Logan, and Pamela Ferry,

were that Brian McNott would continue to focus on one to one work with Robyn, Victoria Logan would work individually with Robyn, Robyn would continue to attend Clyde Valley High School and JD would provide the family with support.

[64] Around this time it was noted by workers on various mornings that Robyn was not ready on time to go to school and would be putting on make-up when they arrived. Ms Goldie reported that she was refusing to go to school. Robyn would often be awake for most of the night. Robyn and Ms Goldie were encouraged by Ms Logan to put routines in place. There were reports of Robyn finding Ms Goldie drunk, and with men in the house. This was known to make Robyn anxious. Ms Goldie reported that she could not cope with Robyn and that Robyn would hit Ms Goldie at times. There were reports of Ms Goldie assaulting Robyn. The violence between them was described by social work as "sibling fighting".

[65] **30 October 2017** After prompting by a worker, Ms Goldie advised that police had visited her at the weekend to inform her that a male was in contact with Robyn over social media and he was in possession of a photograph of Robyn in the bath. However, the photograph was apparently of Robyn's face only. Ms Goldie did not know the male's age.

[66] **2 November 2017** A report was received of Robyn being involved in an altercation with another child at school. Ms Goldie said that Robyn had tried to take a knife from home. Robyn said that she was being bullied and that she had been told the other girl carried a knife. She had intended to take a knife to school. Robyn reported that her mother had been absent from home on the evening of 31 October 2017.

Ms Goldie denied this but said that she had waited at home for Robyn to come home and, after allowing her to stay with her friend that night, returned to the pub. Ms Goldie said she was struggling to cope with Robyn's behaviour. It was reported to social work that Robyn had been chatting on social media sites to older men, claiming she is 22 years old, and becoming involved in sexual and other inappropriate conversations. The mother of Robyn's friend R was in agreement that Robyn would be allowed to stay overnight with her from time to time if required.

[67] **3 November 2017** Robyn reported that, around 2 weeks before, Ms Goldie had hit her repeatedly with her walking stick as Ms Goldie had been annoyed at Robyn playing with the walking stick.

[68] **6 November 2017** Ms Goldie reported to Victoria Logan, support worker with Community Alternatives, that she had pulled Robyn by the hair to the floor in retaliation for Robyn hitting her. Ms Logan told her this was not appropriate. Robyn was not in school. She was in her pyjamas at 10.30am, and was refusing to go to school until she had done her eyebrow make up to her satisfaction.

[69] **7 November 2017** Robyn was not in school. Ms Goldie reported that it was because her friend James had visited the previous night and was feeling suicidal over the death of his toddler son. Robyn had overheard the conversation. Ms Goldie and Robyn were upset about Ms Goldie's friend, Ms Goldie had wanted to talk to Robyn about it and Robyn did not get to sleep until 2.00am. It was acknowledged that this was a trauma for Ms Goldie but she was told that as a parent she should shield Robyn from conversations about this.

[70] **10 November 2017** Ms Goldie was heavily under the influence of alcohol and Robyn called social work. Ms Goldie could be heard shouting abusively at Robyn. She had slurred speech and was very angry. Duty workers attended the home and found Ms Goldie intoxicated and Robyn distressed. Robyn reported that when her mother discovered her telephoning social work, her mother had grabbed her by the hair and dragged her into the living room. She advised that her head was "thumping". Robyn was taken to her grandmother's house. Her grandmother assured Robyn that she loved her and told her that if she was to stay with her long-term she would have to follow rules.

[71] Robyn showed insight when discussing the situation involving her mother, pointing out that Ms Goldie's alcohol misuse was the reason that Robyn was removed from her care when Robyn was younger. Robyn was observed to be concerned about this. She expressed a preference to stay with her grandmother at that time and remarked that her grandmother would insist that she ate healthily. She said that her mother drank alcohol on a regular basis and did not heat the house. Ms Goldie was observed to blame Robyn for the difficulties and Robyn displayed anger and upset towards Ms Goldie, telling her that she had to stop blaming her. Robyn stayed with her grandmother for 1 week, the plan being to return Robyn to Ms Goldie's care on 19 November. Robyn was ready each morning that week for workers who arrived to transport her to school.

[72] **19 November 2017** Robyn returned to live with her mother. Her school attendance slipped again, with Robyn refusing to go to school. At times over this

period, as well as at other times, Ms Goldie and Robyn appeared to be getting on better and engaged positively with each other. However, at other times Ms Goldie would say that she could not cope with Robyn, including at times shouting in a dysregulated way in Robyn's hearing that social workers would need to take Robyn away.

[73] **30 November 2017** Ms Logan spoke to Ms Goldie on the phone. She reported that Robyn did not want to go to school. Ms Goldie was shouting at Robyn and said, in Robyn's hearing, that she wanted Robyn removed from her care. She was asked to calm down and it was explained it was not helpful to make such comments in front of Robyn. Robyn reported that the previous week her mother had told her "I've stabbed people like you". Robyn said that she was struggling to sleep as she was worried that her mother might hurt her. Ms Goldie had also told her that she was going to get drunk and go to the pub so that she did not need to look after Robyn.

[74] **7 December 2017** Robyn told Ms Logan that her boyfriend had been in the house the night before and had pulled down his trousers, showed her his penis and asked her "do you want to shag". Robyn told Ms Goldie. Ms Goldie told the boyfriend that 12 year olds did not do that but she did not tell the boyfriend to leave. She decided to sit in the room with him and Robyn until it was time for him to go for his bus at 9.00pm. She felt this was safer than Robyn being outside with the boy. Robyn was heard to ask Ms Goldie if they could shut the blinds that night and not answer the door if anyone called. When on her own with Ms Logan, Robyn said that she felt sick and confirmed she would want to speak to police about what happened the night before.

[75] **10 December 2017** Robyn and Ms Goldie informed the out of hours service that they had hit each other. When Robyn hit her mother with implements and grabbed her mother by the neck, Ms Goldie hit Robyn to the eye and dragged her by the hair to the floor. Robyn had sustained a cut to her lip during the altercation. Robyn's eye was painful but workers could not see any injury, thought to be because of the amount of make-up she was wearing. Ms Goldie intended to go out to the pub as she said she needed some space. They reluctantly agreed that Robyn would go to stay with her grandmother overnight. Robyn and her mother did not want to report matters to the police. Robyn reported later that Ms Goldie had punched her in the eye because she was "in her mum's face". Robyn had later written her mother a letter of apology however Ms Goldie refused to open it.

[76] **13 December 2025** Ms Logan spoke to Robyn about devising a "safety plan" involving techniques to use to try to calm herself down when angry. That same day, Ms Anderson contacted the Police Service of Scotland Lanarkshire Concern Hub with a Notification of Child Protection Concern because of the incident over the preceding weekend and the incident on 10 November 2017. The notification allowed Ms Anderson to discuss the situation with the police. She was of the view that the matter should not be treated as requiring child protection procedures. The reason for this was that she considered that there was a very good support network already in place, with social work staff and school seeing her daily, and there was very little additional assistance that could be offered. An IRD was not held and no child protection investigation or referral to SCRA was initiated. Chris Anderson thought that the threshold of significant

harm had not been reached. After discussion with the police, it was screened out as not requiring an IRD.

[77] **15 December 2017** Robyn was refusing to go to school and Ms Goldie reported that Robyn was threatening to kill her. The allocated social worker, Brian McNott, visited and noted that Ms Goldie was struggling with raising Robyn and putting in boundaries. There was concern at that time that Robyn was still in a relationship with the boyfriend who had exposed himself to her.

[78] **18 December 2017** Ms Goldie contacted Ms Logan to tell her that Robyn was refusing to go to school and had been threatening her all weekend. She was insistent that Robyn had to leave the home. Ms Logan visited. Ms Goldie had kicked Robyn and Robyn had retaliated. Robyn's boyfriend had been at the house the day before and had ran in and out of it and had trapped Robyn and tried to stop her getting past him and into the house. He had said to Robyn "I'm going to shag you." Ms Goldie had thought about calling the police but had not done so.

[79] **20 December 2017** At this time, workers visiting Robyn and Ms Goldie noticed that their relationship continued to be strained and that Ms Goldie reported to be unable to ensure Robyn did what she was told. She reported that Robyn was often up for most of the night and was angry and aggressive. Ms Goldie reported being exhausted with the situation and said that Robyn had to go back to live with her grandmother. Robyn's boyfriend was seen to be loitering outside their home. Robyn went out with friends one night and drank a can of "Dragon Soup" alcohol.

[80] In late December 2017, Mr McNott noted the strained relationship between Robyn and her mother and was concerned that the situation could completely break down. Although Christmas Day was reported to be peaceful, with Robyn spending the day at her grandmother's home, the situation remained strained over the rest of the festive period.

[81] **31 December 2017** Ms Goldie called the out of hours service as Robyn had taken her house key from her. Robyn had thrown a phone across the room, striking a window and nearly breaking it. Robyn could be heard shouting in the background. Robyn then explained over the call that her mother was going out to buy alcohol and .planned to get drunk that evening. Ms Goldie was heard shouting in the background. Robyn took the key to ensure she would be able to get back into the house to use the toilet, and to eat and drink if Ms Goldie was out.

[82] **4 January 2018** Ms Goldie reported that Robyn's boyfriend had been allowed back in and about the house and Robyn had asked her to give him a second chance. Robyn had taken a knife out of the kitchen drawer and said that she wanted to harm herself. She was upset about comments from her peers on social media. On a previous occasion, Robyn had asked for a needle, claiming she wanted to self-harm. She did not harm herself with the knife. Robyn had continued to stay up most of the night over the festive period and would sleep during the day.

[83] **5 January 2018** Robyn showed Ms Logan superficial scratches on her arm which had not broken the skin. She said she did not want to make herself bleed. She had done this because of the situation at home and the comments she received on social media.

Robyn later reported that on the evening of 5 January 2018, Ms Goldie had 10 glasses of alcoholic spirits and that she was drunk.

[84] **7 January 2018** Ms Goldie phoned the out of hours service to complain Robyn was provoking her and not doing as she was told.

[85] **8 January 2018** Ms Goldie told Ms Logan that the previous evening she had a drink of alcohol and that Robyn had told her that she was not allowed to have any alcohol. Ms Logan reminded Ms Goldie that Robyn worried about her alcohol use. Ms Goldie said she did not know how much longer she could put up with Robyn's behaviour.

[86] **9 January 2018** Ms Goldie called Ms Logan to advise Robyn was refusing to go to school and was threatening to throw ornaments at her.

[87] **10 January 2018** Ms Logan received a text from Robyn, out of hours, informing that Ms Goldie was drunk and had hit Robyn several times. Robyn later detailed that she was punched several times to the arm but did not want to involve the police as she did not want her mother to get into trouble. Police officers attended and informed that Ms Goldie had been drinking but was not intoxicated. The home was noted to be in a poor condition with stacks of dirty dishes piled up and rubbish in the kitchen. Robyn did not wish to go to her grandmother's home. Her grandmother had a broken collarbone.

[88] **11 January 2018** Ms Logan observed a number of empty bottles and cans of alcohol lying on surfaces. It had earlier been agreed with Ms Goldie that Robyn would go to her grandmother's home each weekend for respite. Ms Goldie expressed feeling

relief at the prospect that Robyn might be removed from her care. Later that day, Robyn refused to go to her grandmother's home for the weekend. She ran away from the social worker who had come to collect her and threatened to kill herself.

[89] **15 January 2018** Robyn's bedroom window had been broken by her boyfriend. He had been "hanging around" and trying to open the window. Ms Goldie reported the matter to the police but did not want Robyn's boyfriend to be charged. Robyn was not in school. Robyn reported that, on Friday 12 January, Ms Goldie had been drinking quite a lot with her friend Tony. Ms Goldie said that she had a few glasses of whisky but that she was not intoxicated. The worker reminded her of the anxiety caused to Robyn by her drinking. Ms Goldie's response was that she should be able to drink when she wanted to.

[90] **16 January 2018** Ms Goldie informed that Robyn had stayed over at her friend's house without her permission the night before and had not gone to school that day.

[91] **18 January 2018** Robyn reported that her mother had been punching her the day before. On Ms Logan's arrival at the home at 11.00am she woke Ms Goldie who advised that Robyn did not go to bed until 3.00am. Robyn refused to go to school. She showed Ms Logan scratch marks to her arms where the skin was broken. She reported that her mother had grabbed her the night before and dug her fingernails into her skin.
Ms Goldie said that she could not cope with Robyn and that Robyn needed to "get to fuck" and "is going back to stay with her granny". This caused Robyn to shout and say that she was not going to live with her grandmother.

[92] **23 January 2018** A worker visited at 11.30am. Robyn was not in school. The worker drove her to school. Robyn reported that at the weekend her mother had been drunk and had brought an old man called Pat, who was a stranger, back to the house from the pub. Robyn had taken a video of them engaged in an intimate act in the living room. In the video, Robyn could be heard swearing at them and Ms Goldie was heard telling her off for this. Robyn went to her friend's house to stay that night. The worker noted that Robyn seemed to be inconveniencing her mother by interrupting her habits of dr inking alcohol and bringing strange men back to the house. She observed that fortunately Robyn's friend and the friend's mother were supportive and local, and provided a protective factor. When Ms Goldie was spoken to by a worker about the incident, her response was that Robyn could go back to live with her grandmother.

[93] **26 January 2018** The mother of Robyn's friend contacted social work to inform that Ms Goldie had invited a number of males to her property and that Robyn had witnessed these visits. There were videos showing Ms Goldie engaged in intimate acts with them and one of the males is heard to shout at Robyn, calling her names. A male is heard to say that Robyn was "just jealous". Robyn had admitted that the 14 year old boy who smashed her window had been in the house alone with her. Ms Goldie admitted that she had been drinking that day and so the friend's mother was going to collect Robyn. The friend's mother had the phone number of the out of hours service and was happy to have social work contact her over the weekend.

[94] **28 January 2018** Ms Goldie admitted to drinking more at that time and said it was caused by her struggling to cope with Robyn. She declined to attend a "Handling

Teenage Behaviour" group and said she did not need support and did not need to make alternative care arrangements if she was going to drink or have men visiting the house. Robyn had been staying with her friend's mother for the last couple of days. Robyn reported that she did not feel safe when her mother brought men back, as had been happening repeatedly over the past 2 weeks. As Ms Goldie seemed sober and was being encouraged to take responsibility for Robyn, Robyn and her friend's mother were told that she must return to her mother's care. Robyn was not happy about this. The friend's mother agreed to support this. That evening the out of hours service received a call from Robyn to advise that her mother had pushed her off a chair as she was trying to reach her paracetamol medication. She agreed that it was because her mother was trying to prevent her taking too much of the medication. She reported that her mother had punched her twice on the arm. Ms Goldie reported that Robyn intended to take an overdose and she was trying to stop her. Ms Goldie said that at another point she had passed Robyn in the hall and said to her that she owed her two punches.

[95] **29 January 201** Mr McNott visited at 10.30am to take Robyn to school as Ms Goldie reported that she was refusing to go. He noted the level of discord between Robyn and her mother.

[96] **30 January 2018** Police received a call from Ms Goldie, stating her Robyn had been throwing things at her. Ms Goldie reported Robyn had been kicking and punching her all weekend and had refused to go to school that morning, throwing items at Ms Goldie and hitting her with a phone charger. Ms Goldie phoned back to advise officers that Robyn had left the home address by jumping out of the ground floor

bedroom window. Ms Goldie said that Robyn had no money, had been smoking, and had asked Ms Goldie to buy her alcohol in the past. She said that Robyn had run off before and had been at a friend's house. A call was received from Robyn stating she fled the home address after a fight with her mother. Robyn was advised by the police call handler to return home. A further call was received from Robyn who told the call handler that she had returned home and Ms Goldie was refusing to let her into the property. Police then attended at the home and spoke with Ms Goldie who advised them Robyn was aggressive and had been banging on the door. Ms Goldie advised the officer that Robyn was often aggressive and could lash out but there had been no assault that day. Officers were shown a video of Robyn shouting through the letterbox "Let me in I need to go to school". Officers located Robyn with neighbours who had taken her in. Robyn told the officers "I don't want to stay anywhere else I want to stay with my mum."

[97] Mr McNott visited and noted that the home remained a hostile and poor environment. On planning for any further difficulties arising out of hours at that time, he noted that Robyn should go to her grandmother's as a contingency plan should it not be possible for her to remain at home. He said that Robyn should go to her friend's house as a last resort and noted that Robyn had been trying to generate reasons to stay with her friend overnight. He spent an hour trying to discuss with Ms Goldie the impact of her behaviour on Robyn's however Ms Goldie consistently returned to Robyn's behaviour. Robyn had completed a task which social work had set of formulating "house rules" but Ms Goldie had failed to complete the task.

[98] **1 February 2018** Robyn was not at school. Mr McNott spoke to her about her contributing to improving the home situation but noted that she did not show insight. She at first refused to go to her grandmother's home that day for respite but later agreed to.

[99] **5 February 2018** Ms Goldie reported that Robyn would not get up for school. She said she had had enough of Robyn. Robyn complained she felt dizzy and had heart burn. Ms Goldie and Robyn were arguing, with Ms Goldie shouting at Robyn. Ms Goldie put her hand up to Robyn's face and Robyn reciprocated. Robyn went to her grandmother's home for respite. She told Ms Logan that her mother had been drinking the previous Friday, 2 February.

[100] **6 February 2018** Ms Logan returned Robyn from her grandmother's home in the morning. Ms Goldie was immediately hostile to Robyn, telling her she was not looking after her anymore and that Robyn could "get to fuck". Ms Logan spoke to Ms Goldie about the negative comments she made about Robyn, in Robyn's presence. Robyn walked out of school later that day.

[101] **8 February 2018** Robyn was refusing to go to school and was aggressive to Ms Goldie and to Ms Logan, flicking Ms Goldie's hair and waving her hands in Ms Goldie's face. Ms Goldie retaliated.

[102] **9 February 2018** Ms Goldie texted Brian McNott, telling him that she was "officially" putting Robyn out of the house. Ms Goldie refused to answer the door to Mr McNott and Ms Logan. Robyn was in a neighbour's house. Robyn was noted to be angry with her mother but to be directing the anger towards Mr McNott. Robyn refused

to go to her grandmother's house and wished to go to her friend's house. Mr McNott considered this interfered with what he was attempting to achieve which was for Robyn to stay at home and work with Ms Goldie. His opinion was that Robyn's friend could manipulate her into saying she wished to stay with her. Robyn was very distressed and crying at not being allowed to stay with her friend and, considering she had no other option but to go back to her mother's. She called her mother who then came out of her house and comforted her. Further time was spent with Robyn, trying to persuade her to go to her grandmother's home for respite. Robyn alternated between being verbally aggressive and crying inconsolably. Mr McNott noted her to be completely vulnerable at times and needing the support of everyone. It was eventually agreed that Ms Goldie would not put her out and Robyn resumed being rude. The allocated worker was of the view that little progress was made as no consistent parenting was shown.

[103] **14 February 2018** Robyn returned from a 3-day visit to her grandmother's home. She told Ms Logan that her mother planned on inviting a man round that night. This was the same man whom Robyn had videoed before. Ms Logan later spoke to Ms Goldie when Robyn was there. Ms Goldie was dismissive of the advice that Robyn was uncomfortable with men being in the house. She had also told Robyn that she had sex with a man at their home the previous night.

[104] **15 February 2018** Brian McNott visited as Robyn and Ms Goldie were arguing and Robyn had not gone to school. They had received a visit from the local authority's antisocial behaviour team because of complaints of constant shouting and fighting in the house. They continued shouting throughout Mr McNott's visit. Mr McNott noted that

the home environment remained extremely erratic, that Robyn was not thriving, and that her personal situation was deteriorating.

[105] **20 February 2018** Robyn called Ms Logan to tell her it was her birthday that day. She was now 13 years old. She was not at school. Ms Goldie said that she had a meeting at school the next day but did not see the point in going. Ms Logan explained the importance of her attending.

[106] Near midnight, Ms Goldie called the out of hours service to report that Robyn was throwing things about, wrecking the house, and threatening her. Robyn was heard shouting and swearing at her mother. Ms Goldie reported that Robyn drank alcohol and smoked. She also claimed that Robyn assaulted her grandmother when she went to stay with her. She then reported that Robyn was attempting to tie a dressing gown belt round her own neck. Ms Goldie was told to end the call and ensure that Robyn was safe. The worker spoke to Robyn just after midnight. Robyn said that she hated her life and had previously tried to kill herself and self-harm. She wanted to stay with her mother. She did not want to return to live with her grandmother and was worried that she may have to go into foster care. Robyn had been at school on only 5 days out of the last 8 weeks. At a later date, Robyn told a worker that she had pushed her mother that night and in retaliation her mother had chased her to the bathroom and punched her on the arm.

[107] **22 February 2018** Ms Logan spoke to Robyn who reported that she had spent the night before at her friend's house as Ms Goldie had been drunk.

[108] **26 February 2018** A Notification of Child Protection Concern was made by police regarding Robyn having been home alone the previous night until 12.45am. Police had been called out after neighbours complained of Ms Goldie shouting abuse at Robyn. Police officers found Ms Goldie was highly intoxicated. She had been at a pub and drinking from 4.00pm. Robyn told the officers that her mother had returned from the pub and begun arguing with her. Robyn wanted her mum to stop annoying her to enable her to get to sleep before school the next morning. Officers noted that although Robyn's bedroom was unkempt, the property was kept to an acceptable standard with adequate heating, lighting and food. Police conveyed Robyn to her grandmother's house at around 1.00am. An IRD was not held because at a GIRFEC meeting later that day, the decision was made that Robyn would go to live with her grandmother. Robyn's return to her mother from her grandmother's care in April 2018 did not prompt an IRD.

[109] At the GIRFEC meeting the decision was that Robyn would move to live with her grandmother. Robyn was unhappy on being taken to her grandmother's house and blamed Mr McNott for making her mother cry. Ms Goldie responded that it was not the worker who made her cry but Robyn. Robyn told Mr McNott that she would not be staying with her grandmother for long.

[110] **5 March 2018** Ms Goldie agreed to Robyn's accommodation in terms of section 25 of the Children (Scotland) Act 1995. Robyn was hostile and abusive to Mr McNott and her mother. She then said that the social worker "better not fucking tell my gran about any of this", referring to her behaviour. When Mr McNott told Robyn that as her

grandmother was now her primary carer, he would always update her grandmother about Robyn's behaviour, Robyns immediately desisted from behaving abusively.

[111] **6 March 201** Robyn's school reported that she was isolated, with pupils not wanting to consort with her. They noted that she befriended other girls who are "as vulnerable as she is". The school reported that she had scabies. It later transpired that Robyn did not have scabies but had cat fleas picked up when she stayed with her mother. Her grandmother dealt with it appropriately.

[112] **14 March 2018** Ms Goldie mentioned to Ms Logan that when Robyn visited her, Robyn would spend time with an older male neighbour, at his house. When Ms Logan questioned this, Ms Goldie replied simply that Robyn always did this.

[113] **19 March 2018** Robyn's school reported that she seemed to be behaving badly so that she would be sent to the Learning Base and not mainstream classes.

[114] **26 March 2018** Mr McNott had a conversation with Robyn about alleged trouble with other young persons in the community. Robyn told the worker that she would "end up fighting" with another young person. When the worker returned Robyn to her grandmother's home, her grandmother was upset about Robyn's reported behaviour. Robyn swore at her grandmother but within minutes became kind and warm to her.

[115] **27 March 2018** Robyn's grandmother spoke despondently of the home situation being strained, with Robyn having stayed out until 11.15pm the previous night. She had told Robyn to "pack a bag" but the grandmother's brother had been visiting and assisted in calming the situation down. At 10.45pm that day, the out of hours service were contacted by police who had received a call from a neighbour of Ms Goldie, reporting

that there was shouting coming from the property. On attending, police found Ms Goldie to be drunk. Robyn had returned home at 9.00pm to find her mother drunk. Robyn was staying with her mother, overnight, to have contact with her. Police officers returned Robyn to her grandmother's house. She told police officers that when "this kind of thing" happened, she could not settle and sleep. Robyn also told police that while she was out with a friend, her mother was at the pub.

[116] **29 March 2018** Ms Logan spoke to Ms Goldie about the previous night. Ms Goldie minimised her alcohol use. Ms Goldie said that Robyn had attacked her and that she had pulled Robyn's hair in retaliation.

[117] **31 March 2018** Robyn put her grandmother's address on social media as a venue for a fight to take place. Young people had approached her door on more than one occasion and Robyn's grandmother felt intimidated. Her grandmother sent Robyn back to live with her mother. She later told Ms Logan that she was no longer willing to care for Robyn.

[118] **2 April 2018** Robyn had not returned home by 4.30pm and Ms Goldie told Ms Logan that she thought Robyn was with friends in her grandmother's local area.

[119] **3 April 2018** In a discussion with Robyn's grandmother, Mr McNott identified an uncle of Robyn as a potential alternative carer. Robyn's older half-sister, Elizabeth, was present and she told Mr McNott that her mother could not look after Robyn and was not able to change.

[120] **6 April 2018** Mr McNott noted that Robyn was now going out in the community without telling Ms Goldie where she was, or that she lied about where she was.

[121] **8 April 2018** Ms Goldie reported that Robyn did not return home the previous Friday night and had stayed at the house of two young people with whom she had been involved in fighting. She had gone to a party on Friday night and had been drinking alcohol. A neighbour had reported Ms Goldie to the antisocial behaviour team for making noise on the previous Thursday as she had been singing on returning from the pub. She said that Robyn had assaulted her at the weekend and showed bruises. Ms Logan noted that Robyn appeared volatile towards her mother.

[122] **11 April 2018** Ms Goldie called Ms Logan. Robyn could be heard shouting and screaming in the background and seemed to be assaulting Ms Goldie. On Ms Logan's arrival at the house, the situation was calmer. Robyn complained she was hungry and that there was nothing to eat. Ms Goldie showed Ms Logan various food options in the cupboards and the fridge/ freezer, however Robyn said she did not like any of the options.

[123] **15 April 2018** Another worker visited at 4.40pm. Robyn was at home and Ms Goldie was under the influence of alcohol and with a male friend. Robyn reportedthat she had been at a party on Friday night (13 April) and got home at around 5.00am.

[124] **16 April 2018** Robyn refused to go to school. She reported that her mother had gone out to the pub with her male friend the previous night and had not returned home until midnight. Ms Goldie did not focus on Ms Logan's conversation with her about her responsibility to ensure that Robyn remained safe and was unable to repeat advice given to her by Ms Logan.

[125] **17 April 2018** Mr McNott discussed with Ms Goldie her failure to put strategies in place to check for Robyn's safety when she was out in the community. She had said on a number of occasions in recent times that she was unable to cope with Robyn's behaviour but was now contacting social work and police far less frequently, causing concern that safeguards were not in place.

[126] **19 April 2018** Ms Logan visited in the afternoon. Robyn was just out of bed. A male friend of Ms Goldie was present and drinking from a bottle of Buckfast wine. There was a strong smell of cannabis. Ms Goldie insisted the male stay throughout the discussion as she did not want him to leave. Robyn reported that her mother had returned home drunk from the pub the day before and that they had argued. Ms Goldie denied she was drunk saying that she did not get drunk on five pints. Ms Goldie did not acknowledge the anxiety her drinking caused Robyn. Ms Goldie had bought Robyn a travel card which allowed her to travel beyond the local area, despite concerns about Robyn being out with the local area and in the company of young people who were unsuitable company for Robyn.

[127] **21 April 2018** Another worker visited. Robyn refused to get out of her bed at 11.30am. There were cigarettes and ash lying in her bedroom. The living room was in an unclean condition.

[128] **24 April 2018** Ms Goldie called the out of hours service as Robyn had been up all of the previous night and was assaulting her. The police were also called.

[129] **30 April 2018** Ms Goldie called Ms Logan to report that Robyn has assaulted her and that Robyn had to leave. Ms Logan visited and, from outside, heard mother and

daughter shouting. Robyn reported that her mother had been out at the pub at the weekend and did not return home when she said she would. Robyn had gone to the pub to look for her. Robyn and her mother's argument escalated and Ms Logan had to intervene. She took Robyn out for food. Robyn played in a swing park.

[130] **1 May 2018** Mr McNott wrote to SCRA asking for a children's hearing to be convened in respect of Robyn. The progress of this was: on or around 8 May 2018, Children's Reporter Martin Jess wrote to Wishaw locality office requesting a social background report in relation to Robyn. A social background report dated 30 May 2018 was received by SCRA on that same date. On or around 30 May 2018, Mr Jess requested a school report. A school report was received by SCRA on or around 16 June 2018. On 6 July 2018, Mr Jess spoke with Mr McNott who advised him of recent developments and Mr Jess requested a written update. A supplementary report was produced by Mr McNott on or around 13 July 2018. A copy of that report has not been recovered. On 23 July 2018, Mr Jess recorded his decision to arrange a children's hearing.

[131] **2 May 2018** When Mr McNott visited, Ms Goldie reported that she had to hide her handbag from Robyn as she tried to take money from her and that Robyn hit her. She showed bruises which she had sustained from being hit. She said she was struggling and could not cope with Robyn.

[132] **9 May 2018** Robyn was in a neighbour's garden when Ms Logan came to visit during school hours. She swore at Ms Logan when she asked her to come in to the house to talk. Robyn was wearing a very revealing top and was in the company of the older male neighbour. Ms Goldie told Ms Logan that Robyn had continued to be violent

towards her and she showed Ms Logan bruises. Robyn took money from a table and said she was going out to meet her boyfriend. Ms Goldie said that she could not cope with Robyn.

[133] **16 May 2018** Police received a report from neighbours that Robyn and Ms Goldie were arguing and that Robyn appeared to be locked out of the house and was punching the windows. They had argued over Robyn wanting to bathe the cat. Ms Goldie told police that Robyn regularly took tobacco from her tin. Although police informed social work of the incident, their report did not refer to an allegation that "Robyn appeared to have been locked out of the property at 19 Lomond Drive, Wishaw and was punching the windows."

[134] **17 May 2018** Ms Goldie called police and the out of hours service to report that Robyn had assaulted her. When police attended they ascertained that Ms Goldie and Robyn had argued over a ball Robyn was playing with and, in fact, Robyn had not assaulted Ms Goldie. They formed the view that Ms Goldie had made the report in an attempt to have Robyn removed from the house. Ms Goldie said social work were not helping her with having Robyn removed from the house.

[135] The police reported to the out of hours service that they were frequent visitors and were of the view that the issues arose through Ms Goldie's poor parenting. Extended family refused to have Robyn stay with them. A Notification of Child Protection Concern was made by police. This was said to be the third incident which the police had been called to in 30 days. Police observed Robyn was very upset at the

thought of social work being contacted and potentially leaving the house for the evening.

[136] **19 May 2018** Ms Logan visited the home. Ms Goldie again complained about Robyn's behaviour and not being able to cope. When Robyn entered the room Ms Goldie told her to tell Ms Logan what had happened at a caravan. Robyn was unhappy and Ms Logan asked Ms Goldie to explain. Ms Goldie said that Robyn had had sex with someone at a caravan. Robyn then explained that, on 15 May 2018, she had been with a person in a caravan. She had been penetrated by him against her will and when she had told him to stop. She had been very upset about this but she had not told her mother that she had not consented as she thought her mother would be "annoyed". Penetration had happened four times and without contraception. Neither Ms Goldie nor Robyn wanted to involve the police. Ms Logan spoke to her senior social worker who advised that she should allow them to take time over the weekend to think about it but that she should inform the allocated worker on Monday.

[137] **20 May 2018** Ms Goldie said that she had had enough of Robyn who had just spat on her. She reported that Robyn had taken her period the day before and that neither she nor Robyn wanted to report the alleged rape to the police.

[138] **21 May 2018** Mr McNott spoke to Robyn. He told Robyn that the police would have to be informed about the alleged rape. She did not want to tell him about it but told him that everything she had told Ms Logan was true. Her presentation was notably different in that she was quiet and subdued. She said that her friend had mocked her when she told her friend of the incident. When Mr McNott and Robyn returned to the

home, Ms Goldie was immediately challenging to Robyn. She also reacted as if she did not know of the lack of consent which Robyn had described in the sexual incident and Mr McNott's view at the time was that this was not what would be expected of a parent in this circumstance.

[139] **22 May 2018** Ms Goldie again complained to Ms Logan about Robyn assaulting her. Robyn had earlier claimed that Ms Goldie had assaulted her. Ms Anderson contacted the Lanarkshire Police Concern Hub expressing concerns in relation to Ms Goldie's parenting ability in relation to the incident of sexual assault. It appeared that Ms Goldie was actively dissuading Robyn from speaking to police officers about the sexual assault and dissuading her from having a medical examination.

[140] **23 May 2018** police submitted a Notification of Child Protection Concern due to the alleged rape of Robyn and what they perceived to be a lack of reaction by Ms Goldie.

[141] **29 May 2018** Robyn asked Ms Goldie to tell Ms Logan that Robyn had pain in passing urine and blood in her urine. Ms Goldie had not sought medical attention for this. Further, she said that she did not want Robyn to be tested for sexually transmitted diseases. Ms Logan told Ms Goldie that Robyn could have an infection, that it was concerning that Robyn was passing blood and that she should get a GP appointment for Robyn, failing which she should call NHS 24 for advice. Robyn complained that she also had stomach pain and had not slept for three nights because of this. Robyn wished an appointment to be made with the GP.

[142] **30 May 2018** Ms Goldie had not contacted the GP and questioned with Ms Logan why Robyn would need an emergency appointment. Ms Logan reiterated that Robyn

could have an infection given her symptoms. Ms Goldie then said that Robyn had been experiencing these symptoms since the alleged rape. Ms Goldie was again reluctant for Robyn to be tested for sexually transmitted disease. Ms Goldie reluctantly agreed to call the GP on Ms Logan's prompting and had still not arranged an appointment later that day when Ms Logan called back to check. Ms Goldie remained reluctant to do so although eventually she made an appointment. Ms Goldie spoke to Dr Janice Crofts in a telephone triage when Ms Goldie advised that Robyn had had a UTI for the last few weeks. At the face-to-face appointment later that day it is noted in Robyn's GP records: "patient describes symptoms as per triage but says all has now settled today". Dr Crofts tested Robyn for a UTI but no evidence of one was present. Dr Crofts provided Robyn with a further sample bottle and advised her to come back if the symptoms returned. Ms Goldie did not report the sexual assault on Robyn to the GP.

[143] **31 May 2017** Mr McNott described Ms Goldie to be defensive about the fact that she had not reported the sexual assault to the GP and that Robyn would not then have been tested for pregnancy or sexually transmitted diseases. He noted with concern that Ms Goldie lacked insight into the situation Robyn faced. She had talked Robyn out of speaking to the police when Robyn had asked for the police to be involved.

[144] **1 June 2018** Mr McNott met with Ms Logan and her manager, senior social worker, Tony Scott. They agreed that an IRD should be requested. They met with Ms Anderson. It was agreed that an IRD should take place. This was in relation to the disclosure Robyn made about the sexual assault.

[145] **4 June 2018** Robyn reported that her mother had left her on her own for most of the weekend. Robyn went to the pub where her mother was and found her highly intoxicated. Robyn had sufficient food in the house. Robyn reported she had gone with a friend to meet males as she wanted to make sure her friend was safe. That same day, Robyn failed to attend an Ear, Nose, and Throat out-patient review appointment. She had last attended an ENT appointment on 2 February 2018.

[146] **6 June 2018** Ms Goldie called Ms Logan saying she was "sick" of Robyn, complained that Robyn had woken her early that morning and threatened to pour water over her. Ms Goldie called Robyn a "mongo". Robyn was in the background during the call and could be heard calling her mother a "stupid cow". Ms Goldie asked when Robyn would be taken into care.

[147] **8 June 2018** An IRD was held. The agencies involved were social work, police, a child protection health adviser, and education. It was agreed by all agencies to proceed with a child protection investigation due to the significant concerns surrounding Robyn. It was considered that the fractious relationship between Robyn and her mother and the lack of appropriate action and responsibility afforded by Sharon to Robyn, put Robyn at significant risk of harm. It was considered that the threshold for a child protection investigation had been met.

[148] Around 11.50pm that same day, Robyn went into a Tesco supermarket in Airdrie saying that she had no way of getting home and thought she had been reported missing. Robyn had not been reported missing and was returned to her home address by police who were called. She told police that she had left her home address as her mother was

going to the pub and she wanted to visit her gran in Airdrie. She got a train to Airdrie however her grandmother was not at home. She had wandered the streets for several hours before going into Tesco. Several calls made to her mother had gone unanswered. Ms Goldie was at home when the police returned Robyn and she and Robyn began to argue. Police had to warn Ms Goldie regarding the language of remarks directed to Robyn. She called Robyn a "cunt". Ms Goldie was found to be under the influence of alcohol however deemed to have capacity to care for Robyn. The house was also checked and found to have electricity and running water in operation. There was also food within the fridge and cupboard. Robyn was left in the care of her mother.

[149] **26 June 2018** Robyn was visited at her home by Karen Murray, Sexual Health nurse in relation to a referral from Leeann Hoskins, School Nurse about the alleged sexual assault on 15 May 2018. Ms Goldie thought that Robyn was too young to have contraception. Nurse Murray administered tests for sexually transmitted diseases. Ms Goldie did not appear to understand the need for such testing. Nurse Murray explained this to her. Nurse Murray noticed the wheelie bin to be overflowing with alcohol bottles.

[150] **2 July 2018** Ms Logan visited the house at 4.15pm for a planned visit. She had to knock loudly for some time to get Robyn to answer the door. Ms Goldie was not in the house. Robyn was of the view that her mother would be in a pub. There were a significant number of alcohol bottles in the bin. Robyn had been given £20 by the next door neighbour for helping him in his garden, despite Ms Goldie having been advised to ensure that this relationship was discontinued.

[151] **4 July 2018** Ms Logan attended the home on being asked to by Robyn. A male friend of Ms Goldie remained throughout the time that Ms Logan sat in the living room with Robyn and Ms Goldie. Ms Logan took Robyn out in her car. Robyn informed her that she had refused contraception when she spoke to Ms Murray. However, Robyn confirmed that she intended to have sex with her new boyfriend and asked what would happen if she had a baby. Ms Logan spoke of the negative impact it would have on her life. Robyn acknowledged this and said she would reconsider contraception.

[152] **10 July 2018** At 11.30am Robyn called Mr McNott to say that she was struggling to get to sleep and had not slept for 3 nights. She said that she had been having nightmares. Ms Logan visited at 4.30pm. Robyn was in bed sleeping. Ms Logan pointed out to Ms Goldie that if she let Robyn sleep all day then Robyn would be awake all night. Ms Goldie agreed with this but made no attempt to wake Robyn. Ms Goldie said that Robyn was having nightmares in which she saw the face of the person who allegedly raped her. Ms Logan suggested she speak to the GP about getting help with this however Ms Goldie was of the view that as it had only been a month since the incident, Robyn needed more time to "get over it". Ms Goldie reported that things were going well in the house.

[153] **14 July 2018** Police received a phone call from Ms Goldie's neighbour reporting shouting and banging coming from the property. The caller advised that Robyn had been kicked out of the property and was standing on the pavement at the front of the house crying. The caller stated that Ms Goldie was at the front of the house shouting and the caller thought Ms Goldie was intoxicated. When officers attended the property

they established that Ms Goldie had asked Robyn's boyfriend to leave the property which had prompted Robyn to also leave the house as she was upset by this. Ms Goldie was warned about the noise. Officers established that Robyn was safe and well and that there were no child protection issues and consequently there was no need to raise a Police Concern Report. This incident was not reported to North Lanarkshire Council.

[154] **17 July 2018** Ms Logan visited at 12 noon, waking both Robyn and Ms Goldie. Both advised that things were "ok" at home. At 3.00pm, Ms Logan received a call from Robyn. Ms Goldie was shouting in the background. Ms Goldie said that Robyn was spitting on her. She also claimed that Robyn had been smoking cannabis, which Robyn admitted. A few days before this Ms Goldie had admitted that she had smoked cannabis for a number of years.

[155] **18 July 2018** Mr McNott visited. Robyn was asleep at 2.30pm. Mr McNott spoke to Ms Goldie about the child protection investigation and a case conference to be convened. Ms Goldie spoke of her discomfort at what would be discussed at the meeting.

The week leading to Robyn's death

[156] The following health and social work encounters with Robyn took place in the week leading up to her death.

[157] **19 July 2018** Robyn attended a café group, which had been arranged through Community Alternatives as a summer activity for her. Robyn participated well. An appointment with Nurse Murray had been arranged for the following day. Ms Goldie

expressed again that she was unhappy at the prospect of Robyn being prescribed contraception. On her return from this group Robyn complained of some pain in her arms and legs and by the evening Robyn was vomiting. That Robyn was vomiting was not disclosed by Ms Goldie or Robyn to anyone within North Lanarkshire Council on that day nor, indeed, subsequently. The extent of any report of pain is as set out in the following paragraph.

[158] **20 July 2018** At 9.45am, Ms Goldie telephoned Ms Logan and advised that Robyn had been using a climbing frame the day before and was sore therefore just wanted to stay in her bed that day. She was going to give her anti-inflammatory tablets. Ms Logan cautioned against that as they would not have been prescribed for Robyn and she advised Ms Goldie to call the GP or a pharmacy for advice about giving Robyn anti-inflammatory medication.

[159] Later that day Ms Logan collected Robyn and took her to the appointment with the sexual health nurse, Karen Murray, at Viewpark Health Centre. Robyn's clinical presentation did not prompt any concern in Nurse Murray or Ms Logan. She did not complain of feeling unwell when Nurse Murray greeted her and asked her how she was. At the appointment she declined contraception, saying that her boyfriend had moved to England. No report of vomiting, or pain in Robyn's arms and legs, was made to Nurse Murray at the sexual health clinic appointment on 20 July 2018.

[160] **25 July 2018** Ms Logan made an unarranged visit to the home at 11.00am. There was no answer at the door and the blinds were drawn. That day Ms Goldie phoned Logan Practice Health Centre and spoke with the receptionist. Ms Goldie did not give

her name or that of Robyn but told the receptionist the reason she was phoning was that her daughter was unwell. Ms Goldie told the receptionist that her daughter was 13 years-old and that she had a sore tummy and was being sick or feeling sick. The receptionist advised Ms Goldie to bring her daughter in to see a doctor but Ms Goldie refused. The receptionist offered several times to make an appointment with a doctor, but Ms Goldie refused to make an appointment. None of this information was provided to North Lanarkshire Council or any of its officers or employees at the time. It was not made known to the council until the Inquiry process.

[161] **26 July 2018** At 9.30am, a support worker from Community Alternatives attended at the home to take Robyn to the café group again, as had been arranged. The worker had to knock loudly for some time before Ms Goldie came to the door and shouted through the letterbox. She said that Robyn would not be attending the group as she had not been well since the previous Thursday (19 July 2018). Another child was waiting in the worker's car. The worker took the other child to the café group. She made a note of her visit in Robyn's case file as soon as she returned to the office that day.

Crown narration

[162] Sharron Goldie was prosecuted at the High Court. The original indictment contained two charges. The first was a contravention of section 12(1) of the Children's and Young Persons (Scotland) Act 1937 (ill treatment or neglect of a child) and the second was a charge of culpable homicide. At a preliminary hearing on 20 August 2020 before The Honourable Lord Beckett at the High Court of Justiciary at Glasgow, the

advocate depute amended charge one of the indictment. It terms appear at appears at Appendix 2. Ms Goldie pleaded guilty to charge one and her plea of not guilty to charge 2 was accepted by the Crown. On 29 October 2020 at Edinburgh High Court, Lord Beckett sentenced Sharron Goldie to a period of 3 years and 6 months imprisonment. The Sentencing Statement of Lord Beckett is at Appendix 3.

[163] An agreed written narrative adjusted by the Crown and legal representatives acting on the instructions of Ms Goldie was lodged by the advocate depute and read out in court. The following are excerpts from the narration:

> "On Saturday 21st July 2018 the accused attended the Melody Bar, Wishaw. The accused told one of the bar staff that she had locked the deceased in the house so she couldn't get out. The accused was asked what would happen if there was a fire and said it was ok the house was on the ground floor.
>
> Sunday 22nd July 2018 the deceased's friend (aged 15) spoke to the deceased around 5pm. The deceased told her that she had been sick and had not eaten for several days. The witness told the deceased to tell her mother to take her to hospital and she agreed that she would.
>
> On Tuesday 24th July 2018 at around 14:40 hours the deceased text messaged a friend saying that she would not be going to a club they both attended as 'someone has given me a bug and I am not well'. The deceased also left a voice message for her grandmother, 'Hi Gran, I know you are away with M just to let you know that I am feeling a lot better. I will call you later. I love you'.
>
> A friend of the accused saw the deceased that day and formed the view that Robyn looked drained and recalls the accused saying, 'she's just no well'. At around 8 or 9pm, the deceased told the accused that she needed an ambulance complaining of pain all over. The accused refused to contact an ambulance. A taxi was called by the deceased. The accused's friend Jim Duffy said he would take the deceased to the hospital. The accused intervened and refused to allow the deceased to leave in a taxi to go to the hospital saying the deceased was attention seeking. The taxi arrived and James Duffy used the taxi to return to his own home leaving the deceased with the accused. The taxi driver speaks to seeing a female, who appears to be the deceased, standing in the garden of the locus. Robert Jordan was also in the accused house during that day and evening.

He speaks to seeing the deceased and describes her as looking unwell, very pale, shivering with a blanket around her and speaking in a weak voice, which was unusual for her. Robert Jordan recalls Jim Duffy offering to go with deceased to hospital in a taxi.

On Wednesday 25th July 2018 William Uren the accused's next door neighbour speaks to the deceased being out in the garden saying, 'help me, I cannae breath. Get me an ambulance' and hearing the accused saying, 'get in', and seeing the accused take the deceased back into the house. One of the deceased friends contacted the deceased by text message. The deceased responded saying she had a bug, her period and a sore stomach.

On Thursday 26th July 2018 at about 3am the deceased soiled and wet her bed it is thought likely that this is the point the ulcer burst. The accused made up a camp bed and tried to encourage the deceased to move. The accused said the deceased told her she was still in pain and she did not move straight away. The accused said 'at some point Robyn got up and went and laid on the camp bed … I went back to sleep on the couch ' At 9:40 am a social worker attended the deceased's home address to collect her and take her to a catering class. The accused spoke to the social worker through the letterbox explaining the deceased was not well and had been unwell since the previous Thursday. Around 12pm the accused gave the deceased tea and a ham sandwich. The deceased continued to complain of being in pain and was given a pain killer. James Duffy met the accused at around 16:35 in the Melody bar. The accused said that the deceased had been playing up for most of the night and had asked for water. The accused and James Duffy attended at the locus at around 18:27 hours. The deceased was seen slumped on a sofa with her head on an armrest and her feet on the floor. James Duffy tried to shake the decease with no response. The accused and James Duffy got another drink from the fridge and both went outside to drink their drinks 'because the weather was nice'. At some point James Duffy went back inside and found the deceased's appearance to be unusual. He checked for a pulse and realised she was dead.

The accused was interviewed under caution on 25th October 2018. The accused declined the offer of a solicitor, explaining 'I don't need any tips on how to tell the truth'. The accused said she discussed the deceased's illness of 19th to 26th July with a local mother who told her there was a bug going about. The accused said she thought the bug would last a week to ten days. The accused stated she thought her daughter was improving by Tuesday 24th July. The deceased was eating pot noodles and a ham sandwich. The deceased had stopped being sick. The accused confirmed the deceased had asked for an ambulance on Tuesday 24th July. The accused said the deceased was lying on the path outside the house. The accused thought she was attention seeking and trying to wind her up. The

> accused said she told the deceased that ambulances are for people with heart attacks and helped her back to the house."

[164] None of the information within the above excerpts was made known to North Lanarkshire Council or any of its officers or employees before Robyn's death.

Further details about 26 July 2018

[165] When Ms Goldie came into the Melody Bar on 26 July 2018, she advised Mr Duffy that she had been shopping. On Mr Duffy inquiring how Robyn was, Ms Goldie advised him Robyn was getting better but had not been eating much and had Ms Goldie up most of the night asking for water. Ms Goldie advised Mr Duffy she had been out for a number of hours and needed to go back home in an hour. Ms Goldie and Mr Duffy had a few drinks and caught the bus together. They got off the bus at 6.27pm and walked to Ms Goldie's home address.

[166] Mr Duffy and Ms Goldie remained outside the house for approximately 10 to 15 minutes before Mr Duffy returned inside the property for another drink. He noted that Robyn had not moved, her feet were swollen, and her face was grey and discoloured. Mr Duffy checked for a pulse and noted there was no pulse and noticed dry blood at Robyn's nose. Mr Duffy realised Robyn was dead and telephoned 999. He was advised to put Robyn on the floor and lie her flat. Mr Duffy noted Robyn was stiff as he moved her to the floor and did not attempt CPR as he noted Robyn had been dead for a while.

[167] Stewart McCulloch, a paramedic, was first to arrive at the house, after being called at 7.07pm, and saw Ms Goldie sitting on the doorstep. On asking if someone had phoned an ambulance, Ms Goldie stated, "She's at it" and said, "He must have phoned", referring to Jim Duffy, who was within the property. Mr McCulloch could smell alcohol emanating from Ms Goldie. He entered the living room and saw "an obviously deceased child" lying on the floor on her back next to the couch. It was clear to him that rigor mortis had already set in. Mr McCulloch did not touch Robyn or attempt resuscitation as it was quite clear to him that she was dead. He explained to Ms Goldie that her daughter was dead, and Ms Goldie began to scream and wail shouting, "no she can't be".

[168] Another paramedic and a police officer took Ms Goldie into the kitchen to calm her down and obtain further information from her. Mr McCulloch and another paramedic placed four electrodes on Robyn's body to ascertain if there was any electro activity in the heart. With no activity found, Robyn was rolled onto her left side to check for any wounds. Postmortem staining was recognised and vomit was noted at Robyn's mouth. The paramedic pronounced life extinct at 1925 hours.

[169] At 7.00pm Police Constables Craig Wilson and Stewart Booth were instructed to attend at 19 Lomond Drive, Wishaw. On entering they could hear a female crying and screaming loudly. As they entered the living room they observed Robyn lying on the living room floor. She appeared to the officers to be stiff and rigor mortis appeared to be present. The police officers were made aware by the paramedics that the female kneeling next to the deceased was her mother, Sharron Goldie.

[170] Police Constable Wilson removed Ms Goldie to the kitchen and observed she was under the influence of alcohol. Ms Goldie told the officer that she had drunk three alcoholic drinks earlier. Ms Goldie advised PC Wilson that she had left the house at approximately 4.15pm and Robyn was still alive and on the sofa at that time. Ms Goldie stated she arrived home approximately 2 hours later with her friend Jim Duffy. Police officers took Ms Goldie to Wishaw Police Office where a statement was obtained. Whilst giving her statement Ms Goldie informed the officer that it was on Wednesday (25 July 2018) rather than Tuesday (24 July 2018) that Robyn had attempted to obtain an ambulance and taxi to attend hospital.

Post mortem examination

[171] A post mortem examination was conducted on 31 July 2018, at the Queen Elizabeth University Hospital, Glasgow, by Consultant Paediatric and Perinatal Pathologist, Dr A Murphy and Consultant Forensic Pathologist, Dr J Bell.

[172] The initial cause of Robyn Goldie's death was recorded as: 1a: Peritonitis; 1b: Perforated duodenal ulcer (pending further investigations). Following further investigations, the cause of death was recorded as: 1a: Peritonitis; 1b: Perforated duodenal ulcer; with contributory factor II: Acute pyelonephritis with Group B streptococcal infection.

[173] The Final Post Mortem report conclusions are summarised as follows:

> "The postmortem shows evidence of peritonitis. Postmortem radiology shows abundant air in the abdomen. In addition, there is over 2 litres of bilious/intestinal fluid in the abdominal cavity, in keeping with leakage of fluid

and air into the abdomen from an intestinal perforation. Fibrin strands are present within the effusion and there is fibrinopurulent exudate covering the abdominal organs, in keeping with peritonitis."

"A perforated ulcer is identified in the first part of the duodenum. Perforation of the ulcer would have led to spillage of intestinal contents onto the abdominal cavity and development of peritonitis. Duodenal ulceration could present with vomiting and abdominal pain. Perforation of the duodenum and development of peritonitis would be expected to cause increased severity of abdominal pain and clinical deterioration and would account for this girl's death. Intestinal perforation is a surgical emergency warranting urgent surgical intervention."

"Possible causes of duodenal ulceration include, but are not limited to, Helicobacter pylori infection, Crohn's disease and peptic duodenitis. The postmortem shows no evidence of Helicobacter pylori infection of Crohn's disease. There is no evidence of duodenal inflammation away from the area of ulceration, as might be seen in peptic duodenitis."

"Duodenal ulceration can be caused by or exacerbated by non-steroidal anti-inflammatory drugs including aspirin and ibuprofen. The clinical history indicates administration of Anadin extra (active ingredients include aspirin, paracetamol and caffeine) during the week prior to the death; however post-mortem toxicology has not identified salicylic acid (metabolite of aspirin) or paracetamol. Postmortem toxicology is positive for ibuprofen at a therapeutic or subtherapeutic level."

"There is evidence of acute inflammation in the left kidney. The pattern of inflammation is consistent with this being a urinary tract infection. This finding would be unlikely to be secondary to peritonitis and is likely to have been present prior to the development of peritonitis. This could potentially explain some of Robyn's initial symptoms. Clinical infection in the renal tract would be expected to worsen Robyn's clinical condition and her symptoms. Group B streptococcus is the likely cause of acute pyelonephritis in this case. Streptococcus anginosis, isolated from splenic aspirate, is a potential alternative cause of urinary tract infection; however, isolation of this bacterium from splenic aspirate alone would be more in keeping with it being a postmortem contaminant."

"The presence of a significant urinary tract infection may have made Robyn more susceptible to the development of duodenal ulceration and its complications."

"There is evidence of pinworm infestation in the transverse colon, with rare pinworm profiles also present on the serosal surface within areas of acute

peritonitis (likely due to spillage of bowel contents into the abdominal cavity due to duodenal perforation). This is felt likely to be an incidental finding."

"Gastric contents/vomitus were present in the mouth and in the upper airways. This may have been due to terminal aspiration or postmortem displacement of gastric contents into the mouth and upper airways. There is no evidence of a vital reaction to aspirated material and no evidence of pneumonia."

"There is a small amount of dark brown contents in the colon, which may represent altered blood. This appears low in volume, but could potentially be a consequence of duodenal ulceration and previous haemorrhage in the upper gastrointestinal tract, including the duodenum."

"In keeping with generalised organ dysfunction related to peritonitis/sepsis, there was fluid in the chest and pericardial cavity, biochemical changes in keeping with a degree of renal dysfunction and features in keeping with sepsis/shock in the liver."

[174] Blood samples obtained during the post mortem examination were analysed by Denise McKeown and Dr Hazel Torrance, both Forensic Toxicologists at the University of Glasgow. Beta-hydroxybutyrate (BHB) and Ibuprofen were identified in samples of femoral blood.

[175] Samples obtained during the same post mortem examination were referred to Consultant Neuropathologist, Professor Colin Smith for neuropathological examination. His findings are summarised as follows:

"Neuropathological examination has demonstrated no significant abnormality."

"Brain – no significant abnormality."

Expert medical opinion

[176] During the Crown's criminal investigation into the death of Robyn Goldie, Dr Richard Hansen, Consultant Paediatric Gastroenterologist was instructed to provide a report on three issues:

> The prevalence of this type of death in children.
>
> The type of symptom the deceased would be expected to experience and display.
>
> The severity of the symptoms/pain.

[177] The conclusions in Dr Hansen's report are summarised as follows:

> "i. The prevalence of this type of death in children
> ……it is clear there was a good chance of survival with supportive medical and definitive surgical therapies had Miss Goldie presented during her final illness. Mortality before perforation is rarely reported, particularly in children, presumably because rates are very low indeed. Indeed, the route to death from duodenal ulcer encompasses perforation and subsequent peritonitis or major haemorrhage, the latter of which was absent here. We can presume that presentation before perforation would have led to an even lower risk of mortality with supportive medical therapies including fluid resuscitation, antacids and antibiotics. It is difficult to speculate as to when perforation occurred during Miss Goldie's final illness, however her unusual lying position described between 25-26/07/18 ('At this point, her mother found her in the camp bed curled up on her back with her legs held up against her chest') may suggest the development of peritonitis and an attempt to both reduce pressure on the abdominal cavity and increase its volume. It is not clear at what point Miss Goldie's illness became non-recoverable. Had she presented to hospital on 24/07/18, she would have been approximately 48 hours earlier in her disease course from a sepsis, kidney injury and peritonitis perspective, whether or not each of these had yet to occur, and whilst such a presentation is likely to have reduced her risk of mortality the exact impact is hard to quantify.
>
> ii. The type of symptom the deceased would be expected to experience and display
> The most common symptom of a duodenal ulcer is abdominal pain, particularly relation to the ingestion of food or wakening the child at night, however this symptom is not specific to this diagnosis and can be found in other more common and often benign conditions. Other symptoms include loss of appetite,

> weight loss, feeling full early in a meal (early satiety), nausea, recurrent vomiting, and anaemia from blood loss.'
> With the development of peritonitis, worsening abdominal pain, reduced food tolerance and increased retching/vomiting can be seen along with dehydration/shock and signs of evolving sepsis. The overlap between peritonitis and S.agalactiae infection here mean signs of sepsis (fever, sweats, rigors in particular) may have preceded the onset of peritonitis.'
>
> iii. The severity of the symptoms/pain
> Whilst duodenal ulcer itself can be pain-free…, that was not the case here. The fact that Miss Goldie sought two distinct routes to medical attention suggests she was sufficiently symptomatic to cause her anxiety. Indeed, duodenal ulcer before and after perforation can cause severe abdominal pain, worsened by eating, and tenderness over the stomach. The development of peritonitis would have led to a progressive worsening of abdominal symptoms and the emergence of dehydration/shock and signs of sepsis over many hours before Miss Goldie's demise"

[178] During the criminal investigation into the death of Robyn Goldie, Consultant Paediatric Surgeon and Urologist, Mr Stuart John O'Toole was instructed to prepare a report.

[179] Mr O'Toole was asked by the Crown to address the following questions within his report:

> The prevalence of this type of death in children.
>
> The type of symptom the deceased would expect to experience/display.
>
> The severity of the symptoms/pain.
>
> The necessary/likely treatment for the symptoms – from the outset of the symptoms onwards and the likely indicators/how apparent this would be to a lay person/parent.

[180] Mr O'Toole's professional opinion is summarised as follows:

"It is my opinion that the likely sequence of events in this case is that the acute pyelonephritis with Group B streptococcal infection occurred first in the clinical course. The duodenal ulcer could have occurred spontaneously. However, it is likely to be linked to directly or indirectly to the pyelonephritis. This could be either as a response to the stress of the infection or could be the result of the use of non-steroidal anti-inflammatory drugs used to treat the pain of the pyelonephritis.'

The peritonitis resulted from the perforated duodenal ulcer. The presence of fibrin at the time of postmortem indicate that the perforation had occurred some hours prior to the time of death.

The symptoms of acute pyelonephritis would be abdominal pain, nausea, vomiting and a high temperature. The pain is classically felt in the back but can radiate to the groin and sides. The onset of acute pyelonephritis is often gradual with subtle symptoms and signs of a urinary tract infection (UTI), initially the patient may look reasonably well.

The symptoms of the deceased from Thursday 19th July until Monday 22nd July are consistent with this diagnosis. It is likely that if RG had been able to seek medical attention at this point, her UTI could have been diagnosed and treated with appropriate antibiotics.

At this stage in the RG's illness I would expect that most lay people would have notices that she was unwell and would have arranged an appointment with the medical services.

RGs condition appeared to worsen through Monday 22nd July and into Tuesday 23rd July. A patient with a worsening pyelonephritis would appear pale and they may suffer a rigour where they would appear to shiver and shake uncontrollably. The description of RG on Tuesday 23rd July is consistent with this. At this stage RG may have required a hospital admission and intravenous antibiotics to treat her condition.

At this point in the course of her illness RG may also have had symptoms related to her duodenal ulcer. These would include abdominal and back pain. It would be difficult for a lay person to distinguish the pain from a duodenal ulcer from the pain of pyelonephritis. However, at this stage in RG's presentation the majority of parents would have realised that their child was unwell and brought them to medical attention.

If RG had been assessed the pyelonephritis would have been diagnosed and treated and a good outcome expected. It is possible that the duodenal ulcer (prior to perforation) may not have been diagnosed at this point. All of RG's symptoms may have been attributed to the pyelonephritis.

RGs clinical condition appeared to worsen during Wednesday 25th July into Thursday 26th July. At some point during this time period RG's duodenal ulcer perforated, her intestinal content spread throughout her abdomen and she started to develop the peritonitis that eventually took her life.

The symptoms of a perforation would be a worsening of the pain which would be felt all over the abdomen, she would have found it difficult to breath as the inflammation of her abdominal cavity splinted her abdominal muscles and her diaphragm. The inflammation of her abdomen and the loss of fluids would have impaired her circulation leading to shock. She would have complained of thirst, appeared pale and listless and would have found it difficult to move.

It would appear that RG was experiencing all of these symptoms at some point from Wednesday 25th July to Thursday 26th July 2018. It is my opinion that the vast majority of lay people would have recognised that RG was extremely unwell at this time and sort emergency attention.

At this stage in RG's illness she would have required resuscitation, emergency surgery and intensive care.

In my 30-year personal experience I have only seen two children with perforated duodenal ulcers, both have survived. I have not seen a child die from a perforated duodenal ulcer in over 20 years at the Royal Hospital for Children or Yorkhill.If RG had presented to a doctor before her last few hours one would have expected her to have been saved by appropriate medical and surgical management."

Significant Case Review

[181] North Lanarkshire Child Protection Committee received a request for a review from police colleagues in September 2018. The committee agreed that Robyn's death met the criteria for a Significant Case Review. A review was carried out.

[182] The report, by the independent lead reviewer of the Significant Case Review, was published in July 2021 and detailed three findings. The findings related to the effectiveness of GIRFEC, HART, and IRD meetings in bringing the right people together to share information and make joint decisions; inconsistent use of assessment tools and frameworks; and insufficient opportunities for formal critical reflection. The council fully accepted the terms of the report and implemented improvements identified as necessary.

[183] After Robyn's death, the council developed a thematic action plan, independently of the Significant Case Review, and before its findings were made, to address issues identified by the council as arising from the circumstances surrounding Robyn's death. The plan set out improvements thought necessary to policy and procedure. Concerns subsequently raised in the Significant Case Review were addressed by the plan. Changes have been implemented at both local and national level since Robyn's death.

Changes in practice and procedure

[184] At the time of Robyn's death, the "North Lanarkshire Council: Assessing the needs of children, young people and their families – practice guide (June 2014)" was in place and that policy remains in force now. It is an exemplar of best practice when properly applied.

[185] The overarching policy document for children's services is Getting It Right For Every Child (GIRFEC). GIRFEC continues to operate a central role in child protection procedures at NLC. The GIRFEC handbook from 2012 has been updated.

[186] North Lanarkshire Council has now adopted use of a toolkit which was development by Glasgow Health and Care Partnership, "Assessment of care". They recognise this toolkit as best practice. The toolkit was developed in consultation with managers and practitioners from across children services and was tested before being rolled out. It takes account of factors which impact on a child's wellbeing. It provides a framework for assessing the impact of neglect and how this informs assessment and planning for a child, for the child to thrive.

[187] The council also introduced the "Parenting Capacity Assessment Practice Guidance" in October 2023. Guidance was already in place at the time of Robyn's death but the new guidance has been developed to better support staff to manage complexity.

[188] A document "Assessment and Planning Guidance" is in place across social work and "Guidance on planning for children and young people's Wellbeing" is GIRFEC guidance issued in August 2022 for work with children. These guidance documents address recording of assessments and planning.

[189] A standalone word document is now used to record the general assessment and child's plan as opposed to use of a facility on the electronic database (SWIS) to record the assessment, which was the practice at the time of Robyn's death and which was said to be difficult and cumbersome to use.

[190] The social work electronic database has been recommissioned. SWIS is being replaced with a more intuitive, easier and less cumbersome recording system. It should be fully implemented this year.

[191] Auditing has been introduced. Case record reading is undertaken on an annual basis. The Care Inspectorate provided training on auditing for multi-agency managers and practitioners. The Care Inspectorate's Quality Framework is used when developing templates for audits.

[192] NLC Child Protection Committee has an inspection improvement plan which includes a focus on the quality of assessment in planning for individual children and young people and a strengthening of the quality and consistent use of chronologies to ensure these are used routinely as part of an assessment. All of the Child Protection Committee partners agreed to implement the plan. It is recognised that chronologies are needed to support and reflect on events relevant to assessment and planning. There is a need for workers to be able to familiarise themselves with the history of a family when they commence work with the family. It was identified however that there is an issue in getting chronologies into a form which allows them to be used as a real tool to support practice.

[193] "Signs of Safety and Healing" is an integrated framework for child care and child protection practice implemented by East Renfrewshire Partnership and being introduced by NLC. A recent Care Inspectorate report highlighted positive results in respect of services who support children at risk of harm. It is thought that the introduction will address some of the practice deficits associated with poor quality

chronologies and will support insight and analysis of significant patterns, harms and life events in a way integral to engagement, understanding and intervention with a family.

[194] The Child Protection Committee's child protection guidance, "NL Multi-Agency Child Protection Procedures", has been updated since Robyn's death.

[195] A pan Lanarkshire protocol is now in place, "Inter-Agency Referral Discussion, Pan Lanarkshire Multi-Agency Guidance" (2022) which provides that there is no longer discretion to screen out notifications of child protection concerns from an IRD. This protocol partly addresses the changes made in the 2021 Scottish Government National Guidance on Child Protection regarding IRDs but also addresses a concern highlighted in the SCR about Robyn's case.

[196] The 2021 Scottish Government National Guidance on Child Protection (updated in 2023) provides a separate framework to address protection concerns for older children and young people. The guidance addressed "contextual safeguarding". North Lanarkshire was an early adopter of contextual safeguarding. It is an approach to understanding and responding to young people's experiences of significant harm beyond their families, including peer dynamics which may include use of substances and risk of harm from other young people. Robyn was a young person who, not uniquely, unfortunately experienced harm both in her familial and extra familial context. Learning from her case reinforced the need to understand and respond to this complexity. There is now a young persons' safeguarding panel. It compliments rather than replaces child protection processes and procedures.

[197] While there has always been a supervision policy, the current policy, "Social Work Policy for Supervision – Toolkit for Supervisors" was introduced since Robyn's death. It is currently being implemented with briefings taking place to support both supervisors and staff to use the guidance and toolkit that comes with it. The supervision policy has been revised and places more emphasis on the importance of supervision, creating space for it, and the joint responsibilities of social workers and supervisors.

[198] Improvements have been made to the accessibility of guidance and resources for staff through a local GIRFEC website populated with all the information and resources that a worker would need, including links to other resources such as the GIRFEC resources on the Scottish Government website, core assessment and planning documents, additional focussed assessment tools and e-learning module. Maintaining resources electronically means that it is easier to ensure that staff are using up-to-date versions of guidance and procedure. These electronic resources also include relevant chid protection resources.

[199] Other measures include "empowering cluster models" to afford full engagement between education and social work. This will impact on how the council respond to individual children, not only when a child is being considered at school level, but it also updates the mechanics for multi-agency consideration particularly for children who may be at the threshold for moving from single agency to multi agency support.

[200] All school records for children are now held electronically, allowing for transmission of information between schools as and when it is needed.

Care Inspectorate

[201] The Scottish Commission for the Inspectorate of Care carried out an inspection of relevant North Lanarkshire Council services. It published a report on 17 October 2023. That report is "Care Inspectorate Report of a Joint Inspection of services for children and young people at risk of harm in North Lanarkshire." It recorded four general statements as to relevant practice in North Lanarkshire Council. The Inspectorate evaluated the impact of relevant services as "very good."

Evidence

[202] While it is not possible to set out all the evidence which was helpfully before the Inquiry, key chapters are set out below. First is the evidence of Sharron Goldie and comment on it. I then set out evidence of some of the key workers. It was clear that Robyn's death has been a very difficult experience for the workers who were involved with Robyn. When involved with Robyn, they provided a high input of care to her and cared about the outcome for her. They gave evidence at length and made every effort to assist the Inquiry. They did their best to give the Inquiry an accurate account. I then go on to the evidence of the Children's Reporter, Martin Jess and the expert witnesses, Maggie Mellon and Colin Anderson.

Sharron Goldie

[203] Ms Goldie is 49 years old and unemployed. She said social work's first involvement with Robyn in 2007 came about largely as a result of Ms Goldie's partner of

the time being under the influence of alcohol and falling over when she was with him and Robyn at Strathclyde Park. She herself had consumed only 3 pints over the course of the day. In 2009, Robyn called the gas engineer from her phone and he attended at her house. Whilst he was in the house, she shouted at Robyn as she refused to eat her dinner. The engineer called the police as he said that he did not like the way in which she was speaking to Robyn. When Ms Goldie met with social work she agreed with them that she was unable to care for Robyn at that time because she had a broken wrist and a dislocated shoulder and it was difficult to care for her. Robyn was placed in the care of Ms Goldie's mother, JD. After Ms Goldie had a few months to recover, Robyn came home to stay at her house at the weekends.

[204] Robyn came back to live with her on 12 July 2017. Her gran agreed that it was a good time for Robyn to return and to start Clyde Valley High School in Wishaw. She claimed that she phoned social work who had no objections to Robyn returning to her care. After Robyn was returned to her care, Robyn refused to attend school. Robyn's behaviour became increasingly difficult to manage. Robyn used to kick, punch and spit at Ms Goldie. The social work department decided to place Robyn in her gran's care again. Her gran also had trouble with Robyn. Robyn's first few months at high school were difficult as she did not know anyone in her year.

[205] Robyn told Ms Goldie that she had been sexually assaulted by a boy her age. Ms Logan was present when Robyn told her. Ms Goldie described Robyn as boasting about it. Ms Goldie advised her not to report it to the police as the court and press would be involved. She advised her that she was better to forget about it. Robyn

eventually decided not to report it. Ms Goldie was not happy that Ms Logan made arrangements for Robyn to have a contraceptive implant as Robyn was too young to be having sexual intercourse. Giving her contraceptive would be giving her the green light to have sex. If Robyn had got pregnant then she, Ms Goldie, would have looked after the baby.

[206] Robyn told her that there was blood in her urine. She made an appointment to see the doctor. She did not think that the doctor provided much help to them.

[207] On 19 July 2018, Robyn returned from a social work youth group. She was complaining of having sore legs, sore stomach and felt sick. Ms Goldie gave her ibuprofen for her muscles, and paracetamol for her sore stomach. She assumed that Robyn had picked up a bug which a friend had told her was on the go. Robyn had not been eating much and had lost some weight. She thought that Robyn had the stomach bug and it would pass.

[208] This was still the case on 24 July when Robyn asked for an ambulance. Robyn was so keen to go to hospital but Ms Goldie thought that she did not need to. She had been a lot worse on the previous Friday (20 July) and if she had been going to phone an ambulance it would have been then. When it was put to her that Robyn had been unwell for a number of days she said she thought Robyn was exaggerating. Ms Goldie's friend Jim Duffy wanted to take Robyn to hospital in a taxi but Ms Goldie told him to go home in the taxi. She agreed that she could influence what Robyn did in a number of matters, including in whether she went to hospital.

[209] On 25 July 2018, when Robyn was out in the garden saying that she could not breathe and wanted an ambulance, Ms Goldie again thought she was exaggerating. She felt that at times Robyn was "at it". Ambulances were only for people having heart attacks. Ms Goldie claimed that Robyn asked to go shopping for school things that day. Since her appetite had been poor and she was thinner than usual, Ms Goldie phoned the doctor's surgery to ask what food she should give her to help build her weight back up. The receptionist told her that she could not give advice and could only make appointments. Robyn told her that she was feeling better so Ms Goldie did not make an appointment for her.

[210] On 26 July 2018, Ms Goldie left the house to go to the shops. Robyn told her that she wanted food from Greggs. She went to get more paracetamol and ibuprofen. She left Robyn watching the TV. On her way back to the bus stop, Ms Goldie stopped off at the pub for a rest. She had forgotten to get the food Robyn wanted. Her friend, Jim Duffy, told her that he would go to Iceland to get Robyn her sausage rolls. She was in the pub for around an hour. She returned home around 6.00pm. When she returned home, she thought that Robyn was asleep on the couch and she sat in the garden and had a beer with her friend Jim. When she went inside, Robyn was lying on the floor and she thought that Robyn and Jim were playing a prank on her. Jim phoned the ambulance. Ms Goldie could not believe it. Robyn died that day.

[211] When asked to reflect on observations that she and Robyn had more of a sibling relationship than a parent and child relationship, Ms Goldie made the incongruous comment that she had never had a sister. She then said that there had been 8 years

when she could only visit Robyn and that she had little influence over Robyn's behaviour. She locked Robyn out of the house on one occasion because Robyn was violent to her.

[212] I found Ms Goldie's evidence to lack credibility and reliability. She minimised her responsibility for social work requiring to intervene in Robyn's earlier childhood. She did not acknowledge her misuse of alcohol and violent behaviour during 2017 and 2018 which caused such anxiety and upset to Robyn and clearly contributed to Robyn's own behavioural difficulties. Her evidence that Robyn boasted about the sexual assault contradicted what was observed by workers at the time and lacked the insight and empathy which might be expected of a mother of a child in that situation. There was no basis for her claim that the GP did not help when she took Robyn to see Dr Crofts on 30 May 2018. This also deflected from her own failure to disclose the sexual assault to the GP. There was inconsistency in her evidence and between it and other evidence. She acknowledged in evidence that Robyn was unwell in the week leading to her death and indeed she called the GP surgery about this but did not take the appointment offered. However, her evidence was also, effectively, that it could be concluded that Robyn was fabricating the extent of her illness. She had no explanation as to why she should think Robyn would be fabricating when she knew she was genuinely unwell, despite repeated attempts at exploring this in questioning. Her friend, Jim Duffy, was sufficiently concerned by what he observed to offer to take Robyn to hospital, Robert Jordan described her as looking unwell, very pale, and shivering. A neighbour also observed Robyn struggling to breathe. I inferred from this that they

considered that Robyn was genuinely and seriously unwell. Their observations do not fit with Ms Goldie's evidence

[213] She excused her failure to call an ambulance on her being of the view that ambulances were only for people with heart attacks, however she would not let Robyn be taken to hospital by taxi or even for Robyn to be seen at a GP appointment. Her claim that Robyn wished to go shopping on 25 July 2018, the same day that she was also observed to be out in the garden struggling to breath and asking for an ambulance to be called, and given the opinion of Mr O'Toole as to Robyn's symptoms by then, was implausible.

[214] I did not believe her evidence that she did not make the GP appointment offered that day because Robyn told her she was feeling better. I was also skeptical about her account of the timing of her movements on 26 July 2018 and her motivation for leaving the house that day and I did not accept the account.

[215] It has been difficult to contemplate the desperate predicament Robyn was in at that time. Her mother not only failed to get her medical attention but blocked Robyn's own attempts to access medical attention. In reflecting in evidence on the last days of Robyn's life, Ms Goldie demonstrated little empathy for Robyn, or acknowledgement that she could have acted differently. These difficulties in Ms Goldie's account are consistent with the observations of Dr Raja that Ms Goldie had limited empathy and that she could not comprehend how her parental care could have been different. It is striking that not even the impact of the utterly tragic death of Robyn has resulted in Ms Goldie being able to reflect that her parenting skills fell far short and in what way

they could have been better. This is consistent with the pattern shown throughout social workers' repeated attempts in 2017 and 2018 to have Ms Goldie acknowledge the deficits in her parenting and adequately address them.

Christian Anderson, senior social worker

[216] Ms Anderson spoke about the assessment process at the time of Robyn's case. There was a lack of a parenting capacity assessment format or document in the in 2017. She said however that the thought process of a parenting capacity assessment would have been threaded through the general assessments by children and families social work.

[217] At the time, there was a facility on the social work electronic database, which allowed the general assessment to be compiled, taking the writer through each of the areas the assessment had to cover. However it was not easy to use. The general assessment and plan are now contained in a standalone word document. They now think more and better about how they assess, record, and plan.

[218] Ms Anderson said that a general assessment was though carried out in Robyn's case. The assessment evolved over time and an assessment and plan was in workers' minds. She said that it is now better recognized that the plan, which comes from an assessment, was important. The plan now forms the minutes of the meeting and is much more of a working tool.

[219] The plan in September 2017 was for Stephanie O'Hara to gain an understanding of the situation for Robyn and her mother. Support would be needed for Ms Goldie and

Robyn adapting to living together again, for Ms Goldie's parenting of Robyn, including getting her back to school, and work would need to be done on how the family would support that. That work would give social work a flavour of any additional needs of Robyn or her mother. It would also monitor how Ms Goldie and Robyn were getting on. Work would be done with Ms Goldie to look at her alcohol use and how her caring responsibilities would impact on her social life. She said the team regularly revisited the plan during the time they worked with Robyn.

[220] Ms Anderson said that, although workers often had to reinforce with Ms Goldie what was expected of her as a parent, that was no different from many other parents who don't have a brain injury. Social work would work with parents as they found them. Social work made adaptions to the support they offered Ms Goldie, eg, offering individual sessions on managing teenage behaviour when Ms Goldie would not attend group work. They repeated information to Ms Goldie as many times as was needed. She did not have high level concerns about Ms Goldie's cognitive abilities.

[221] In Ms Anderson's opinion, if there had been an IRD held in October 2017 in respect of the school's Notification of Child Protection Concern, the decision would have been not to proceed with a child protection investigation. Ms Anderson's assessment, in October 2017, was that there was not a risk of significant harm to Robyn from Ms Goldie's ongoing violence to Robyn.

[222] On reflection, she thought that consideration should have been given to an IRD being held after incidents in November 2017, one when Ms Goldie was heavily intoxicated and grabbed Robyn by the hair and dragged her into the living room as

Robyn tried to call social work and one when Robyn reported being hit with a walking stick by Ms Goldie. However, this was not behaviour that was any riskier than occurred in many other families and it was thought that social work could manage this with the involvement of Community Alternatives.

[223] She thought that there were good times, when Robyn and Ms Goldie worked well together and life for them both was very settled for periods of time. If there was a period of time when things were going well and Robyn was going to school, then there did not need to be such intense involvement.

[224] She accepted that Ms Goldie did not behave as the adult in these conflict situations, as they expected of her. She did not feel that there was malice involved when Ms Goldie assaulted Robyn and that there was not a risk of significant harm. When reports of incidents were received, social work input intensified. The fact that Robyn did not go to school made the situation worse, as Robyn and her mother were together for many hours each day and there was no respite for Ms Goldie. Workers were proactive in trying to get Robyn to school by visiting in the morning and encouraging her to go.

[225] Unusually, the police attended the GIRFEC meeting on 26 February 2018. Ms Anderson said that there was a clear plan after that meeting and that all attending knew what it was. Robyn was to live with her gran under a kinship placement. When, in April 2018, Robyn returned from her grandmother's to stay with her mother, it was apparent to Ms Anderson that Robyn had a key role in the decision. Robyn was clear she wanted to live with her mother and this was exactly what the intensive service of

Community Alternatives did, ie, supported families to be together. She said that, in hindsight, another GIRFEC meeting should have been called after Robyn returned from living with her grandmother in April 2018. However, Ms Anderson did not think that the plan would have changed should such a meeting have been held. Ms Anderson did not agree with Brian McNott's view that there was "disguised compliance" from Ms Goldie at that time. Things may have simply been more settled for times and there was not a push to get Robyn to school as there had been before. However, she did consider that the situation had got to the point where the formality of a compulsory supervision order was needed.

[226] Ms Anderson said she was aware from Brian McNott and Vicki Logan talking from around May 2018 about a pattern forming of Ms Goldie not being able to cope with Robyn's behaviour.

[227] The failure of Ms Goldie to tell the GP that Robyn had been sexually assaulted tipped the balance for Ms Anderson as it took social work into a different realm in terms of risk. It resulted in an IRD being held on 8 June 2018. The decision was to proceed with a child protection investigation. Ms Anderson acknowledged that a child protection case conference was not subsequently convened within the appropriate time scale. That can happen because of pressure of business. Had one taken place before Robyn's death, Ms Anderson would have recommended that her name be placed on the Child Protection Register. This would have been due to the incident of the alleged rape and Ms Goldie's subsequent decisions in respect of medical treatment.

[228] Ms Anderson did not believe that a decision of a Child Protection Case Conference would have been that Robyn be accommodated out-with her mother's care. That had never been a consideration. The situation was not particularly different from any other which Community Alternatives dealt with.

[229] Robyn's extended family declined to be involved in further decision making. If Robyn was accommodated, she would have been moved into one of the local authority's Children's Houses. That would not have been in her interests because of the other young people who she would live with in a Children's House. Because of their own difficulties, she would have been exposed to significant risk within the community and in the Children's House. In addition, it was likely that she would have run away from the House as she did not want to be removed from her mother's care. This would have exposed her to risk and not provided the solution intended in moving her into a Children's House.

[230] The likely plan that would have been put in place, should there have been Child Protection Registration, was already in place in effect. It would have included the involvement of the school nurse and the sexual health nurse. If the child protection case conference had gone ahead, they would have looked again at parenting capacity. They would have continued to work on changing Ms Goldie's attitudes. The plan would still be for Robyn to live at home with Ms Goldie.

[231] Having considered the charge in the prosecution of Ms Goldie on Robyn's death, Ms Anderson said that there had not been evidence known to social work that Ms Goldie gave cannabis or alcohol to Robyn. There was evidence that Robyn had,

unbeknown to Ms Goldie, used money she had been given by Ms Goldie to buy alcohol and cannabis. Robyn had not presented to workers as having used alcohol or cannabis. Robyn caught fleas from the cat. This was dealt with timeously and appropriately by Ms Goldie and was not an unknown occurrence in other families (from other witnesses and the records it appears that it was Robyn's grandmother who dealt with this problem). There were some things which Ms Goldie could do, such as buying food, heating the home and maintaining the home, although the condition of the latter fluctuated. While the home could be untidy, she did not know it to be unhygienic. When police visited, the reports were that there was sufficient food for Robyn, albeit that it was sometimes food which was not to Robyn's taste.

Brian McNott, allocated social worker

[232] Mr McNott, along with Ms Logan and other workers, had a high level of involvement with Robyn. At times they were in daily contact either through visiting and/or taking Robyn to school, or in telephone contact, or both. He spoke informally to Christian Anderson on an almost daily basis. He said formal supervision happened approximately every 6 weeks. He spoke with Victoria Logan on a regular basis about incidents or intervention, and they carried out joint visits and then debriefed with each other afterwards.

[233] Mr McNott said he assessed parenting capacity using the Scottish Government's My World Triangle "what I need from people looking after me". Ms Goldie was articulate and could engage in conversation but over time it became apparent that she

struggled to move from discussion to implementation of strategies. He believed that if Ms Goldie gained a greater understanding of handling teenage behaviour, then things would improve over time.

[234] After a while he tailored advice or guidance to one or two small, achievable points to help her absorb it more easily. There were pieces of advice that she would take on board such as, if there were concerns about the conditions of the home, she would ensure it was tidied. If he asked her to phone if Robyn did not got up for school, she would call either him or Ms Logan. However, she did not follow through on all pieces of advice. With the benefit of hindsight, he assumed Ms Goldie's brain injury did impact on her ability to follow through on tasks. It did not impact every facet of her life but she struggled to provide the consistent level of parenting that Robyn required. Boundaries only went so far, and she would give in after a while. She would frequently put her own needs first. She often displayed a level of immature response and struggled to intervene as a parent appropriately.

[235] Mr McNott believed Robyn shared information with him, in terms of what she was experiencing at home. She was concerned about her mother's alcohol use and that this could result in her being removed from her mother's care again. Both Robyn and her mother wished her to remain living together, even after incidents of violence. Ms Goldie would, at times, say that she could not cope with Robyn. She was supported at those times.

[236] Robyn had a desire for friends and her friend R was able to provide friendship which was positive. Also, she gave Robyn advice which on occasion was helpful, but

sometimes not. Mr McNott had concerns regarding the respite the friendship gave in that it meant Ms Goldie and Robyn were not working through their issues together and instead Robyn would go to see R. He was asked if R's family were known to social work and he confirmed that they were, at one point. He did not know the reasons. My impression was that the reason Mr McNott had discouraged Robyn seeking respite with the mother of R was that he thought it hampered efforts to have Ms Goldie exert firm boundaries for Robyn and not concerns arising from any previous social work involvement with R's family.

[237] Robyn's grandmother clearly had a more settled lifestyle than Ms Goldie and could provide Robyn with the stability that she needed and craved. Gran was also willing to support Robyn and took on the responsibility willingly.

[238] After Robyn returned to Ms Goldie's care in April 2018, there was evident risk however at levels that social work often worked with. They were also balancing the risk of Robyn remaining at home against potentially being accommodated into a Children's House. Robyn was immature and vulnerable and he would have been concerned about her being exploited or involved in criminality alongside other young people in that environment. There was also the risk that she would run away from a Children's House. Robyn's uncle was the only other potential kinship option. Mr McNott could not recall whether this was progressed and, if not, why it was not. There was the potential over time for gran to change her mind about Robyn being placed with her again as she loved Robyn.

[239] He decided to make a referral to SCRA because in the 6 months that he had worked with the family there had been little progress made in respect of Robyn's experiences at home, and Ms Goldie had not shown herself to be motivated to implement the advice and guidance given to her by services. Additionally, there were no signs of improvement in relation to school attendance. He could not recall why he focused on grounds based on Robyn being beyond the control of her parent and failure to attend school without a ground based on abuse and neglect of Robyn by her parent. He suggested that the ground of being beyond parental control encompassed the violence and lack of positive parenting strategies within the family home. He did make reference to violence in the report but, on reflection, he thought it could have been more clear.

[240] He was not looking for an order which would have accommodated Robyn. His primary objective was for Robyn to stay in a safe environment. However, having grounds established at the children's hearing would help in the event Robyn did require to be accommodated.

[241] He felt disguised compliance was an issue. Disguised compliance, in his view, is a caregiver providing workers with access to the home however not absorbing the advice or guidance given to them. They may also be economical with the truth in respect of only sharing what they want you to hear rather than painting a fair picture.

[242] The child protection investigation, started after the IRD on 8 June, followed a structured process of investigation. This included engaging with Robyn, Ms Goldie, and teacher Pamela Ferry, accessing records from social work and any information provided

to the IRD from the multi-agency team. He recommended proceeding to a Child Protection Case Conference on the basis of accumulating concerns, additional impetus being added because of Ms Goldie's failure to support Robyn after the allegation of rape.

[243] Mr McNott spoke to social work's family group decision making coordinator Janice Griffiths about becoming involved with the family to help them explore natural family supports – either to support Robyn to stay at home more successfully or to find alternative accommodation in the event of it being required. As family group decision making is a voluntary process, Ms Goldie did not engage with it.

[244] It was not unusual for there to be no answer from Ms Goldie or Robyn when an unannounced visit was made, as had been the case when Ms Logan visited on 25 July. They had always managed to see the family on following this up

Victoria Logan, child and family support worker, Community Alternatives

[245] Ms Logan's role was about creating more structure in the home, supporting Ms Goldie with managing teenage behaviour and setting boundaries etc. She is not trained to undertake a parent capacity assessment. She took her time to explain things to Ms Goldie. As her involvement went on she started to get concerned about Ms Goldie's ability to understand things. Ms Goldie was sometimes not taking on the seriousness of the issues being raised and following advice.

[246] Robyn presented as confident, chatty and pretty open. Ms Logan felt she had a good relationship with Robyn who was able to talk to her. Robyn made a lot of disclosures to her about things at home or the community. After Robyn went to gran's

care in February 2018 and returned to her mother's care in April 2018, both Ms Goldie and Robyn were not as open. The level of contact from both, and disclosures, were less. This could have suggested that things were improving but looking back she is not sure that was the case. Community Alternatives saw Robyn more than once a week from April 2018.

[247] She did not recall the house being cold. When Robyn complained that there was nothing to eat, Ms Logan checked the kitchen and found sufficient food. Although the house was messy at times, it was not overly concerning. She recalled Robyn and gran spoke to her about the possibility of scabies. The problem turned out to be cat fleas and gran attended the pharmacy for medication.

[248] Ms Logan spoke to Robyn about devising a safety plan. It was more about Robyn identifying what made her feel calm and probably not best described as a safety plan. It was about managing her emotions, supporting her in finding strategies in keeping her calm and finding a safe way to do it. It was not about keeping her safe from Ms Goldie but about preventing situations escalating. Similar work attempted with Ms Goldie was unsuccessful. It was difficult to undertake direct work with Ms Goldie at times, especially if Robyn was about.

[249] She viewed R, Robyn's friend, as a positive factor. Robyn would stay with R if there was any crisis and R's mother was a positive support as well. There was times Robyn wanted to go to R's home but Ms Goldie did not allow her. She believed there were times where Robyn would try to orchestrate the situation in an attempt to stay with her friend.

[250] Ms Logan was worried about Robyn's vulnerability in relationships with boys and that Ms Goldie was not effectively safeguarding Robyn in this regard. The disclosures they both made about incidents of violence in the home were quite concerning to Ms Logan. She would have raised these as explicit risks in GIRFEC meetings and informal discussions as well as in supervision with her line manager, Tony Scott.

Pamela Ferry, teacher

[251] Ms Ferry is the acting deputy head of Clyde Valley High School. At the time of Robyn's attendance at the school, Ms Ferry was Robyn's pupil support teacher. She receives yearly training on child protection procedures.

[252] She was the first line of contact with Robyn's home and attended multiagency meetings. Robyn had not undergone the transition process to the secondary school as she was not from one of the associated primary schools. The school arranged with Ms Goldie that Robyn would not start on the first day of school as they thought it would make transitioning easier for her. Despite this, Ms Goldie brought Robyn on the first day of school.

[253] Robyn stood out from the first day. The school concerns are set out in the note of the HART meeting on 29 September 2017. As time went on, Robyn did not establish friendships. She would boss other pupils about and shout at them if she did not get her own way.

[254] At the time, pupils' records from primary school were kept in paper form and followed the child from school to school. There would be additional files for children needing extra support. These would include information about previous social work involvement and Child Protection Registration. Robyn's primary school were unaware that she was moving to Clyde Valley High School and so no file was sent to Clyde Valley High School. The school made efforts to retrieve Robyn's files from the primary school and its associated secondary school, Caldervale High School, but to no avail and the records have not been found. Despite Ms Ferry contacting Robyn's primary school and social work, the school were not made aware of the earlier child protection concerns in respect of Robyn. Ms Ferry only became aware of the history at the IRD on 8 June 2018.

[255] Social work asked the school to retract the notification of child protection concern it made in October 2017. Although there had been other cases in which a notification resulted in social work concluding that there was not a child protection concern and the school accepted that in those other cases, both Ms Ferry and Ms Neilson were clear that they would not retract the notification in Robyn's case. Later, when she attended the IRD in June 2018, she reflected and wondered why they had not just held an IRD after the notification in October 2017. She felt it would have been more beneficial to have had four different agencies, police, social work, health, and education, discussing things. This was the first IRD she had taken part in. There was information given at the IRD in June 2018 which she was not aware of.

[256] A referral could have been made to SCRA by the school. However, Ms Ferry's view was that, given the high level of support being provided to Robyn, there was no requirement for education to make a referral. Robyn was already being dealt with by social work.

[257] Over the course of the school year, Robyn's non-attendance at school continued to be a problem. Robyn got into conflict with other pupils. She was isolated in school. There is limited input from educational psychology for pupils. The educational psychologist would only give advice to staff on how to try to deal with a child's issues. Robyn's attendance rate for the school year 2017 to 2018 was 54%. Robyn refused to attend school. She gave different reasons. One reason was that she was fearful of other children however Ms Ferry investigated and found no evidence to support that but it appeared that Robyn was antagonising other pupils.

[258] Since Robyn's death, the HART model has been replaced by the Cluster model. That links the high school with its associated primary schools. Children will be raised at Cluster meetings if there are serious concerns about them. The Cluster model brings different agencies together and planning meetings decide what support is offered to a child. In Robyn's case, she would be raised at Cluster meetings and the meeting would be looking at what external supports might be used to address her attendance. There is a well-being officer and children can attend a learning hub to work on numeracy and literacy. The school cannot refer a child to social work any longer unless they have raised the child at Cluster meetings however this is superseded by any child protection concern arising.

[259] Other changes are that the electronic system for recording pastoral notes has a facility which generates a chronology of significant events, which previously would have to be compiled manually. The Home School Partnership Officer now carries out home visits to families where there is an issue with attendance. There is a campus police officer who also attends on these visits.

Karen Murray, sexual health nurse, NHS Lanarkshire

[260] On 20 July 2018, Robyn was brought to an appointment with Ms Murray at a local health centre to discuss contraception. While waiting in the health centre she would have been in view of any medical staff passing through the waiting area. She met with Ms Murray alone. Her presentation did not prompt any concerns about her health, either in Ms Murray or in any other medical staff. She did not complain of being unwell. Ms Murray explained what contraception was and when it would be used. Robyn declined contraception, saying she had no plan to be sexually active. The appointment lasted around 5 minutes. Ms Murray has previously worked in an accident and emergency department and is confident she would pick up on any symptom of a deteriorating child.

Martin Jess, Children's Reporter, SCRA

[261] The main piece of relevant legislation providing the framework for the reporter's role is the Children's Hearings (Scotland) Act 2011. Individuals and organisations may refer a child for whom they have concerns to the reporter. Section 66(2) of the 2011 Act

requires the reporter to consider two key questions on receiving a referral. They are whether a ground under section 67 of the 2011 Act applies in relation to the child and, if so, whether it is necessary for a compulsory supervision order to be made in respect of the child.

[262] The first question involves assessing whether there is sufficient evidence to prove one of the grounds set out in section 67 exists. The grounds under section 67(2) include the following:

> "(a) the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care,
> (b) a schedule 1 offence has been committed in respect of the child,
> …
> (n) the child is beyond the control of a relevant person,
> (o) the child has failed without reasonable excuse to attend regularly at school,"

[263] In considering the second question, the reporter must take into account practice directions from the Principal Reporter of SCRA. Practice direction 6 was in force at the time a referral was made in 2018 in respect of Robyn. It provides that the key factors to be recorded are:

> (i) the extent of concern for the child's welfare taking into account what is known about the child in relation to three key issues – the child's development, parenting, and the child's family and environment;
> (ii) the history of co-operation with any previous intervention and the impact of that intervention; and
> (iii) the current motivation to change and willingness to co-operate with any intervention.

[264] On receipt of a referral, reporters routinely request reports from social work services and other agencies in order to ingather sufficient information about a child to

make a decision. In the event that the reporter considers that there is sufficient evidence to establish a ground or grounds under section 67 and that it is necessary for a compulsory supervision order to be made, the reporter must arrange a children's hearing.

[265] Mr Jess received a letter of referral of Robyn from BM around 1 May 2018. The letter indicated that the key concerns were Robyn's school attendance and her behaviour. Brian McNott described Robyn as being beyond parental control. Reference was made to Robyn's mother's "disguised compliance" and a failure to adhere to strategies to keep Robyn safe but otherwise there were no further details regarding the mother's conduct. On around 8 May 2018, Mr Jess requested a report from the social work department for further information. He received a report on 30 May 2018.

[266] The report gave information about non-attendance at school, Robyn's behaviour, failure of mother to support strategies to keep Robyn safe but also the effects of mother's alcohol use. Mr Jess was not satisfied that the report had presented unequivocal reasons to conclude a compulsory supervision order was necessary, ie, would make a difference, given the extent of the involvement of services that were already working with the family. He decided that he needed further information, especially about school-related concerns as the report had not touched on these to any degree. On 30 May 2018 he requested a school report, to be submitted within the usual time frame of 2 weeks. The information which Mr Jess had at that time did not suggest that the concerns for Robyn's welfare were at the more serious end of the scale of concerns SCRA regularly deal with, or that her situation was one that required the most urgent attention. In Robyn's case,

while the concerns he had been made aware of were material, there was nothing in the information he had that suggested there was an acute risk of physical harm. Alongside this he was aware of the involvement of services who were, according to the social work report, seeing her at least three times per week.

[267] The school report highlighted a range of concerns not described in the social work report. However, given the significant intervention already in place, Mr Jess wished to discuss Robyn's case with Mr McNott before answering the question of whether a compulsory supervision order was necessary. He had a conversation with Mr McNott on 6 July 2018. The focus was very much on Robyn's behaviour and the mother's ability to implement strategies to keep her safe. There was also a discussion about the allegation of rape made by Robyn and her mother's response to this.

[268] The discussion on 6 July 2018 caused his assessment of the level of concern for Robyn to be such that he considered a compulsory supervision order necessary. He therefore decided to arrange a hearing. Given the significance of the new information, Mr Jess asked Mr McNott to submit a supplementary report, setting out the information so that there was written confirmation of it.

[269] Mr Jess considered that a hearing should be convened to take place at the start of the new school term, in order that school staff could attend to give useful insights to the hearing as well as take part in discussion about how to support Robyn to get back to school, an important factor in addressing wider concerns about Robyn's behaviour.

[270] The section 67 ground would have been that Robyn failed without reasonable excuse to attend regularly at school, in terms of section 67(2)(o). The practice direction in force at the time provided that:

> "the reporter is to specify the ground or grounds which relevantly reflects the principal concerns regarding the child's welfare and which, were a children's hearing to be arranged, would support constructive and appropriate consideration and decision making by the children's hearing".

Although Mr Jess could not now recall his precise decision on the matter, he thought he would also have been intending a ground that Robyn was beyond the control of her mother, under section 67(2)(n). He did not consider, on the basis of the evidence which he had at the time, that there was sufficient evidence for the ground in section 67(2)(a), ie, that the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care. He said that for there to be sufficient evidence of this ground there requires to be a lack of parental care (judged by the standard of the reasonable parent) and an actual or likely link between that lack of care and the child suffering unnecessarily or her health or development being seriously impaired. Concerns had been made known to him regarding her mother's failure to implement certain strategies to respond to Robyn's behaviour and her not encouraging Robyn to formally report that she had been raped. However, he considered that the information he had at that time indicated a lack of the evidence needed to prove a ground in terms of section 67(2)(a). Subsequently, Mr Jess has learned that there was additional information ingathered by the police in the course of their

enquiries into Robyn's death. He understands that this information had not been obtained by other agencies. It was not known to him at the time of his decision.

[271] Even though the grounds for any hearing arranged might have been with reference to Robyn's school attendance and behaviour, the hearing would still have to consider all aspects of Robyn's life. The grounds do not restrict the hearing's consideration of issues. If a grounds hearing had taken place for Robyn, the options available to the children's hearing would depend on what happened at that hearing.

[272] If the grounds were not accepted by Robyn or her mother, then the hearing could have (i) discharged the referral or (ii) directed the reporter to make an application to the sheriff concerning the grounds not accepted. If directing such an application, the hearing could have made an interim compulsory supervision order if they were satisfied that such an order was necessary as a matter of urgency for Robyn's protection, guidance, treatment or control. Any interim order would have included one or more specific measures listed in section 83(2) of the 2011 Act. However, the hearing need not have made any order. If the hearing made such an interim order, it is possible that it could have included a measure requiring Robyn to live somewhere other than at home.

[273] If the grounds were accepted by both Robyn and her mother, but the hearing wished further information before deciding whether or not a compulsory supervision order was necessary, they would defer the hearing until a later date. If they did so they could make an interim order of the same type referred to above and by applying the same test.

[274] If the grounds were accepted and the hearing had enough information to make a decision, they could have (i) discharged the referral, or (ii) made a compulsory supervision order. If they made an order this would have included one or more specific measures listed in section 83(2) of the 2011 Act. It is possible that one of those measures might have required Robyn to live somewhere other than at home where they considered that to be necessary in Robyn's best interests and where a specific alternative place had been identified. It is also possible that no such measure would have been included and she would continue to reside at home.

[275] In considering whether to make a compulsory supervision order or interim compulsory supervision order the children's hearing would only have been able to make the order if it had considered that it would be better for Robyn that the order was in force than not.

[276] Although these were the options that would have been available to the children's hearing, Mr Jess considered it too speculative to say what the actual outcome might have been. The decisions made by any children's hearing depend on the information available to the panel members, both in the form of the written reports and other documentation available, and what is said by participants at the hearing. In reaching its decision, the children's hearing must take accounts of any views a child wishes to express.

[277] All of the options depend on the parent and child attending the grounds hearing. It is not uncommon for them to fail to attend and for the grounds hearing to have to be rearranged for their attendance. There can therefore be delay caused by this. If there

had been a referral to SCRA in late 2017 or earlier in 2018, it is possible that the procedure arising from the various options would not have concluded by the time of Robyn's death.

[278] The reporter does not make any recommendation to the hearing or advocate for a particular decision or outcome. The recommendation of the social worker as to such matters as to whether Robyn should be accommodated, as well as the views of Robyn on the issue, would hold considerable sway with the hearing.

[279] A hearing can be expedited however there would usually be an element of urgency for that to happen and there are still notification requirements meaning that there has to be a minimum of 7 days, but usually 2 to 3 weeks' notice, given to parties of a hearing. A hearing can take place more quickly than that but that involves a Child Protection Order being granted by the sheriff first, usually on application by the local authority. That would happen if there was a matter of acute urgency, but that was not Mr Jess' recollection of the position in Robyn's case. His plan to hold a hearing at the start of the new term was not out-with the normal range of timing for a hearing.

[280] There was already significant intervention for Robyn. Community Alternatives is an intensive 7-day per week resource. A compulsory supervision order would have provided an overlay of statutory authority. It is a significant intervention for any child. It puts a responsibility on a local authority. It brings about more structure. The impact of an order can range from it being a very effective measure with significant impact, to sadly also there being very little difference made. However the hearing is designed so that where an order has not had a positive impact can be the subject of a review. A

review can be arranged fairly quickly and other measures under the order can be asked for at the review hearing. It is quite common for there to be a series of reviews of a compulsory supervision order to make the order more effective.

[281] Mr Jess has considerable experience both of social work and the children's hearing system. He spent 12 years as a social worker before becoming a Children's Reporter over 20 years ago. His evidence about the children's hearing system in general and the processing and progress of Robyn's referral was clear, comprehensive and illuminating. It is notable that the information contained within the first social work report received in May 2018 did not contain information sufficient to persuade that a ground involving a lack of parental care was made out or that a compulsory supervision order was necessary.

Maggie Mellon

[282] Ms Mellon is a qualified social worker. She now works independently and has amassed considerable experience and expertise in the area, recognised at governmental level. She is published in the areas of child protection and children's care.

[283] The events in Robyn's case took place within the context of current legislation, policy and practice. The Getting It Right For Every Child (GIRFEC National Practice Model) and the National Risk Framework for Risk Assessment were in place during the relevant time frame. These provide the basis for assessment of need and risk for children and young people. Multi-agency child protection committees chaired and led

by the social work service are responsible for implementing national child protection regulations and guidance.

[284] The GIRFEC National Protection Model provides a model for assessment, planning, and action in a single or multiagency context. It provides a framework for practitioners and agencies to structure and analyse information consistently to understand the child or young person's needs, the strengths and pressures on them, and to consider what support they might need. It defines needs and risks as two sides of the same coin. It promotes the participation of children, young people, and their families in gathering information and making decisions as central to assessing, planning, and acting and provides a shared understanding of the child or young person's needs by identifying concerns that may need to be addressed. The National Framework for Risk Assessment from 2014 onwards provides that social work intervention with children and young people, and their families, should operate to evidence based principles. This is referring to the process by which practitioners gather relevant information about what is happening to a child and use their knowledge from research theory and practice experience to arrive at a better understanding of the child and family's experience.

[285] In Robyn's case there is no record of any single or multiagency assessment taking place. The decision made in October 2017 by the social worker and police that there was no need for a child protection investigation was a missed opportunity to start the process of gathering and considering information about the history and current circumstances.

[286] This decision was made without the input of other agencies. The lack of contact with health services at this stage may have been particularly significant as it seems the mother's disability was a significant factor in this case. The mother's disability was her acquired brain injury, psychotic mental illness in the past, and excessive use of alcohol. The assumption that the case was amenable to advice and guidance and support might have been challenged if health professionals had been consulted at that stage.

[287] Ms Mellon pointed to guidance issued by the British Association of Social Workers on acquired brain injury where various effects of acquired brain injury are listed. She also referred to an article regarding traumatic brain injury in mothers identified as high risk for child abuse/maltreatment and a recent study by the University of Glasgow on brain injury in women and a significant prevalence of associated violent offending.

[288] Ms Goldie's disability should have been considered and appropriate medical opinion and assessments sought as to its impact on her use of alcohol, mental illness, poor capacity to understand and process information, aggressive and unpredictable behaviour, and apparent absence of understanding or ability to meet Robyn's needs. Ms Mellon considered that assurances from Ms Goldie that she was not addicted to alcohol were accepted or at least not seriously challenged.

[289] Ms Mellon was of the view that, in the absence of a single or multiagency assessment to inform the best response to the needs and risks, there seemed to be an assumption that this was a case of a difficult mother/daughter relationship which would be amenable to mentoring/coaching and some monitoring. However despite advice and

guidance being repeated to both mother and daughter, the mentoring and advice approach did not have any impact on the level or seriousness of incidents. Robyn's welfare deteriorated over time. Ms Mellon's view was that when advice and guidance to the mother was not effective there was an increased emphasis on advising Robyn about keeping herself safe. Ms Mellon referred to Robyn being advised to make a safety plan for herself. This involved using the social work emergency service for help out of hours and reporting assaults by her mother to the police. Robyn had said that she did not want to report to the police as she did not want to have her mother arrested.

[290] Ms Mellon questioned whether Community Alternatives was the right service for Robyn. Her understanding was that Community Alternatives provided support to prevent young people, from entering secure accommodation and prison. They provided advice which is standard to parents of teenagers who are pushing boundaries and challenging parental authorities. Ms Mellon questioned whether it was appropriate in Robyn's case, where her mother may have lacked understanding. She was advised to be firm with Robyn. However it appeared that Ms Goldie was firm in denying Robyn attention or medical assistance in her last few days alive. Ms Mellon queried whether Ms Goldie's assessment of the situation at that time that Robyn was simply attention seeking was as a consequence of a failure to process information that might seem obvious to others.

[291] Ms Mellon emphasised that considerable time and effort was put in to help Robyn and that Robyn confided a lot in workers, particularly Vicky Logan, and that there was considerable care and concern shown.

[292] The allocation of a social worker and the high level of support offered 7 days per week by the Community Alternatives service was clear evidence that an assessment was needed. Without an evidence based assessment and multidisciplinary framework for action, reaction to the daily events dominated efforts to offer help. There was often prompt and caring reaction to events but no evidence of proactive planning. Any plan, although not explicit, seemed to be to maintain the situation rather than question the viability of care by Robyn's mother. An assessment would have provided an opportunity to step back and consider the information from all agencies as well as Robyn and her family, the current concerns, and Robyn's current circumstances and views.

[293] Ms Mellon was critical of the decision to discourage the mother of Robyn's friend to allow Robyn to shelter with them cut off an important safety factor. It also coincided with Robyn increasingly being reported to be in bad company at drinking parties in other areas and generally being out and about at night. Ms Mellon was of the view that, because Robyn was aged 12 and 13 during this period, she was given responsibility for keeping herself safe but was ultimately unable to do so at the time of her death.

[294] Her death could not have been foretold however significant harm and risk of further harm was being recorded on a weekly basis. While the GIRFEC approach encourages voluntary engagement and support, in cases where risk of significant harm has been notified the formal processes must be followed. Where anyone has a child protection concern then local child protection procedures must be followed without delay.

[295] Whilst child protection procedures are not guaranteed to offer protection to a child at risk, where procedures and guidance are not used when it is acknowledged that a child is not safe then the opportunity to protect is lost. Ms Mellon acknowledged the preference to keeping a child at home to avoid greater risks to a child in care. However reliance on this general preference should not take the place of informed decision making.

[296] Ms Mellon disagreed with the evidence of Colin Anderson, another expert witness, on his conclusion that it was highly doubtful if the outcome for Robyn would have been different even if a full assessment had been carried out and/or a compulsory supervision order had been in place or there had been Child Protection Registration.

[297] Ms Mellon took from the joint minute that there was evidence of a significant history of neglect and abuse of Robyn by her mother in her earlier life. Social work records revealed that severe and persistent neglect and abuse were evident immediately upon Robyn's return to her mother's care in August 2017. This included being hit, being locked out of the house, not being provided with basic care, food, and shelter and being exposed to sexual harm. Ms Mellon's view was that the joint minute set out that Robyn's illness took place over a period of 10 days up to her death on 26 July. Her understanding was that Robyn did not die from a sudden onset of an illness which overwhelmed her within a matter of a few days as Mr Anderson said. The evidence was that her illness was entirely treatable if medical help had been sought. Up until the last hours of her life Robyn could have potentially been saved if she had had treatment.

[298] While the cause of her death was infection, her death occurred as a consequence of neglect. This or some similar preventable harm could reasonably have been foreseen. If assessment procedures had been followed, multiagency child protection procedures would have been initiated and followed from the point of first referral by the school. Child protection measures were clearly required and would have been properly identified. Ms Mellon considered that Robyn would then have been subject to Child Protection Registration. She would have been seen at least once a week. There would have been a plan which would have included safe and protective adults in her family and community, eg the friend and her mother who had offered refuge but instructed to no longer do so. At the very least Robyn would have been physically seen by workers in the week before she died at which point the need for urgent medical care would presumably have been recognised and acted upon. She accepted though that while Robyn's death was avoidable and preventable, it was Ms Goldie's actions which caused the neglect of Robyn which led to her death.

[299] Ms Mellon was of the opinion that there was a systemic failure to protect Robyn from known physical and emotional abuse and neglect in her mother's care. Robyn's death was avoidable and preventable. Legislation and guidance specifically developed and provided to help keep children safe was not used. The failure was systemic in the sense that it involved not just one person. A number of people were involved, including senior social workers, and the failings were not picked up on by anyone.

[300] She considered that there were defects in the system of working in relation to Robyn's social work interactions which contributed to her death. Although the actual

cause of death was unpredictable, the likelihood of significant harm to Robyn by neglect as a direct consequence of her mother's disabilities and lifestyle was foreseeable.

[301] Although there were aspects of Ms Mellon's interpretation of the facts which I did not ultimately concur with (and I deal with them in my analysis and decision), her explanation of various practices and procedures in place at the time, and her review of the background facts in Robyn's case in that context, were of great assistance in my determination. I am grateful to her and to Colin Anderson for their time and for the care taken in addressing the issues for this Inquiry.

Colin Anderson

[302] Mr Anderson is a qualified social worker, a former Director of Social Work, a former Chief Social Work Officer, and an independent social work consultant. He is recognised for his expertise in the area. He has undertaken a number of Significant Case Reviews. His main area of interest over his career has been child protection.

[303] He said that there was an absence of a GIRFEC comprehensive single or multi-agency assessment and care plan relative to Robyn's needs and risks. There was a need for, and there should have been, a structured assessment with clear planning and clear outcomes. That would have set out what had to change for the situation to improve for Robyn and how agencies should be coordinated to deliver a joined up approach. He did not see that structure begin to appear until the social background report was prepared for the Children's Reporter on 30 May 2018. The social background report contrasted

with the minutes of the GIRFEC meeting in October 2017 and February 2018 in that regard.

[304] If there had been such an assessment and care plan, even if not written down, then he would have expected that to have been revealed in the workshop exercise done with front line workers involved with Robyn in the Significant Case Review. However, he had not been able to find such evidence either in the Significant Case Review, the affidavits for this inquiry, or social work records.

[305] Mr Anderson commended NLC's policy document "Assessing the needs of children, young people and their families". This had been in place since June 2014. It embodies the principles of GIRFEC. It is supplemented by additional guidance. If these policy and practice documents had been followed and applied, they would have offered a structured and effective approach to assessment, care planning, and decision-making in Robyn's case.

[306] He accepted that the frontline workers had spoken of an ongoing assessment and a plan in place. He accepted that workers may have known of, and been informed by, NLC's policy document on assessment. However, its effectiveness would be significantly diluted by the lack of shared documentation to support their approach and he could see no evidence from the case files and reports to support an assertion that practice was expressly informed by the policy document. Committing a plan to writing is not simply a matter of form but crucial to there being clarity in what the plan is, timescales for successful implementation, and review of its success or otherwise.

[307] An example is in the minute of the first GIRFEC meeting in October 2017. The minute follows a pro forma in line with the policy document. However specific sections entitled "Intended Outcomes", "Contingency Plan" and "Monitor and Review Arrangements" have been left blank. The minute of the GIRFEC meeting of 26 February 2018 was narrative in form rather than having the structure that it should have.

[308] If there had been such an assessment, it would have resulted in much better informed decision-making. It would have resulted in a written plan which would then be reviewed at agreed intervals, perhaps 3 monthly, in order to see whether the approach by social was working. If a plan is not being met then social work need to consider whether changes to the approach are needed, including seeking statutory measures. Social work's involvement had been reactive because of the lack of a comprehensive written assessment and plan. If there had been such an assessment and plan social work's involvement could have been proactive.

[309] However, Mr Anderson could not give an opinion on whether such an assessment and plan might have prevented Robyn's death. He considered that there were too many variables for him to do so.

[310] The absence of this assessment also meant that decision-making processes were not informed by the impact of Ms Goldie's disability. Ms Goldie has an acquired brain injury. Historically, she also had mental health issues. He was unable to say whether the disability had any relevant role to play in the events leading to the death of Robyn. A 2009 social work record entry states "possibly due to her brain injury, deflecting from issues and apparently being unable to process what both workers were saying to her".

Mr Anderson referred to findings in the report prepared in October 2020 by Dr Raja, regarding the effect of traumatic brain injury on emotional intelligence, that Ms Goldie was not equipped with sufficient parental skills and abilities and that these difficulties were compounded by alcohol misuse problems. However, from the report and from the sentencing statement of Lord Beckett, it was clear that Ms Goldie had capacity to make decisions relating to the medical welfare of Robyn.

[311] Mr Anderson agreed with Ms Mellon that a psychiatric report prepared for the purposes of examining culpability would differ from a report prepared to inform a comprehensive assessment and care plan by social work. Dr Raja's report revealed though potential implications for Ms Goldie's ability to engage with social workers in voluntary plans to support Robyn at home.

[312] From Mr Anderson's review of relevant case records, Ms Goldie's disability was pronounced and there should have been a full and evidence based assessment of her ability to engage with a care and safety plan. This would be a parenting capacity assessment. He made no assumptions about what such an assessment would have shown, if it had been carried out. However, it should not have been expected that Ms Goldie had the capacity to fully understand and engage with voluntary intervention. Brain injuries are very complex things and, while a person may retain a high IQ, emotional intelligence may be impacted. External factors such as alcohol or drug consumption, or anxiety, can exacerbate any impact. This means that the parent's capacity to function can fluctuate. An assessment would have flagged any such fluctuation as a key factor.

[313] The new Scottish Government National Guidance for Child Protection Committees Undertaking Learning Reviews (2021, updated 2024) has specific sections on protection of disabled children and parents with learning disabilities.

[314] The decisions in October and December 2017 by social work and police not to proceed with an IRD were flawed. In October 2017 concerns were noted to be the mother's alcohol misuse, inappropriate male visitors being allowed in the family home late into the evening, the parent child relationship being turbulent and more akin to a sibling one, and the mother's view that Robyn was out with her control. By December 2017 the position had not improved and had in fact deteriorated.

[315] Although child protection procedures were underway at the time of Robyn's death, Mr Anderson's view was that identifiable risk factors should have prompted not only an IRD but a formal child protection investigation and case conference at an earlier stage. Such an investigation would produce the comprehensive assessment which was absent in Robyn's case. Multiagency assessments should have flagged concerns about Ms Goldie's brain injury and cognitive impairment.

[316] Failure to hold an IRD meant that the relevant agencies were not brought together. The HART and GIRFEC meetings had less urgency than those under child protection would have had. The GIRFEC meeting minutes were in narrative form and lacked concise focus.

[317] If an investigation led to a decision of Child Protection Registration then this would have resulted in increased vigilance. That would have taken the form of ongoing review by a multi-agency core group and a requirement to notify the lead worker of any

incidents or concerns. However, Mr Anderson concluded that it would be speculative of him to say that Robyn would be alive "but for" an IRD not having be held earlier. This was because of the variables involved.

[318] A consequence of Child Protection Registration would be a requirement for workers to "lay eyes on the child" at a minimum frequency of weekly. In the event that a worker attended at the door for a pre-planned activity and received no answer or were told through a letterbox that the child was ill, he would expect there would be an insistence on the part of the worker to see the child.

[319] He observed, from facts set out in the joint minute in particular, the sudden nature of the death and the lack of any indication of an emerging situation of such severity that warranted a more immediate follow up by social work. An example of a variable was whether, on seeing Robyn, a worker would recognise that she needed medical attention. That would depend on how she presented and whether symptoms were obvious. Where Robyn was seen by Victoria Logan and Karen Murray on 20 July 2018, and the visit by Ms Logan on 25 July was not pre-planned, a reasonable time to see Robyn again was on or by 27 July, the day after her death. The support worker who had been unsuccessful in gaining entry on 26 July and who was transporting another child, acted appropriately.

[320] Robyn was engaged as an older child and her views were given weight in the process of intervention. It could be said that she was allowed too much latitude in deciding where she should live. A child's views would be a significant factor in decision making in respect of where they should live. However, a local authority has a

responsibility to override those views where it considers that a placement with a carer cannot be sustained. Mr Anderson would expect that, as part of a contingency plan, work would be carried out with a child to try to have them on board with any move deemed necessary.

[321] Robyn did not turn 13 until 5 months after social work intervention began. She would have transitioned from "child" to "older child" over the course of the intervention. An assessment is an evolving process. The lack of a comprehensive and contextual assessment of Robyn's needs and risks was a key factor in the case. Her needs and risks over the period of intervention should have been set in context and been subject to regular reviews and updates.

[322] Mr Anderson acknowledged the lack of national assessment tools specific to older children at the time of Robyn's death and that, since then, North Lanarkshire Council has successfully implemented a contextual and age appropriate safeguarding approach.

[323] Mr Anderson's opinion was that there were sufficient grounds for a referral to the Children's Reporter earlier in the period of intervention in 2017/2018. He deduced that a referral was not made earlier because it was thought at the time that Ms Goldie was engaging on a voluntary basis. Mr Anderson acknowledged that a principle of minimum intervention applied to this decision however, in his opinion, a referral was warranted because of the grounds for concern.

[324] There were a variety of possible outcomes of such a referral but it would have prompted a comprehensive assessment at an earlier stage. Mr Anderson noted that the

focus when preparing grounds for the reporter was on a ground of "beyond parental control" and not on "lack of parental care".

[325] Since Robyn's death, multi-agency training has been put in place to allow all agencies to better understand the process of referral to the Reporter and the information required to help inform decisions on the need for compulsory supervision orders.

[326] Social workers were influenced by the impression that the only available alternative to living with her mother was for Robyn to be accommodated in a Children's House and this was seen as a more negative and damaging option for Robyn.

Mr Anderson observed that Children's Houses in the present time were certainly an improvement on what had been the provision earlier in his career. In recent times they are units limited to four or five children and the experience and outcomes for children living there can be positive. Where assessment reveals that accommodation out with the parent's care is necessary and that other options are not available or suitable, then it is the duty of the local authority to place the child there and manage the placement. Having said that, it was unlikely that a decision of a children's hearing during the period of intervention would, at least in the first instance, have been to place Robyn in a Children's House, given social work's likely recommendation and Robyn's views.

[327] Mr Anderson's opinion was that it was overly optimistic of to have endorsed a kinship placement with Robyn's grandmother at the GIRFEC meeting in February 2018. He could understand why the decision was made. Nevertheless when Robyn had been in the grandmother's care previously, her behaviour had deteriorated to the point where

her grandmother decided she could no longer look after her. Work could have been done with the grandmother in an effort to help sustain a placement with her.

[328] Since Robyn's death North Lanarkshire has established a Kinship Care Team which offers a more proactive and time sensitive approach to supporting kinship carers. This includes providing an allocated worker for the kinship carer, mirroring the provision which has been in place for foster carers for some time. This can help support the carers but also the placement. Many kinship carers are grandparents and the new service includes the opportunity for carers to meet in support groups and discuss their experiences and challenges in caring for the children in their care.

[329] Mr Anderson found no evidence of formal supervision of the allocated workers having taken place. It was reported in the Significant Case Review that informal supervision was highly valued. However, reflective supervision requires to be structured and protected time set aside for that. The supervising manager needs to structure critically reflective reviews of all cases in a worker's case load rather than have the worker determine the supervision agenda. He acknowledged that Tony Scott said that Vicki Logan received structured and regular supervision however Mr Anderson did not see formal recording of such.

[330] Since Robyn's death, provision has been put in place which should ensure and facilitate such supervision in a "safe space" for workers. This allows for workers to reflect, in an environment which is not fault finding, on complex cases and to receive the input of colleagues and other professionals.

[331] Robyn's case was undoubtedly complex due to the concerns and issues arising in it and in comparison to the range of cases which workers in the team in North Lanarkshire could expect to come across.

[332] Mr Anderson had considered the terms of the Care Inspectorate report on NLC. He had considered the thematic action plan developed by NLC and had spoken to the chair and lead officer of NLC's child protection committee regarding its implementation. He considered that they had fully implemented improvements recommended by the Significant Case Review and which had already been identified in the thematic action plan. He had spoken to the chair and lead reviewer of the Child Protection Committee. From that he ascertained that not only had they implemented the recommendations, there are measures for continuous improvement. Case file audits are made so that the committee can be satisfied that improvement is not a one off.

[333] In conclusion, Mr Anderson observed that the absence of a GIRFEC comprehensive single or multi-agency assessment and care plan relative to Robyn's needs and risks and her mother's parenting capacity had a direct and negative impact on understanding of Robyn's needs as an older child, engagement of child protection measures, referral to SCRA, consideration of Robyn being accommodated out-with her mother's care, and supervision and scrutiny of worker's decisions. A comprehensive assessment and care plan might have resulted in more focused direct work to shift and improve the dynamic of the relationship between Robyn and Ms Goldie.

[334] Nevertheless, he could not say that the existence of such assessments, or earlier child protection measures and/or earlier referral to SCRA, would have resulted in Robyn

being accommodated away from her mother or would otherwise have prevented her death. He considered that attempts to maintain Robyn at home would not have been exhausted by the time of her death. There were too many variables for him to accurately predict, however, he was highly doubtful that the outcome for Robyn would have been different.

[335] The reasoning behind Mr Anderson's opinions was evidence-based and persuasive, and I accepted his conclusions.

Submissions

[336] All parties to the Inquiry were in agreement as to when and where the death occurred, the causes of the death and that there was no accident involved.

[337] It was also agreed that a precaution which could reasonably have been taken and might realistically have resulted in the death of Robyn Goldie being avoided would have been for her mother Sharron Goldie to seek medical assistance for her daughter Robyn.

Crown Submissions

[338] The Crown submitted that there were two issues which required to be explored further, namely whether earlier child protection measures or an earlier referral to the Children's Reporter would have made a difference to the outcome in Robyn's case.

[339] Given the evidence before the Inquiry, an earlier referral should have been made to the Children's Reporter. A referral at an earlier stage to the Children's Reporter was a

precaution which could reasonably have been made however there had not been evidence which could lead to a conclusion that such an earlier referral might realistically have avoided Robyn's death.

[340] Turning to child protection measures, the evidence of both expert witnesses was to the effect that there was risk of harm to Robyn such that a formal child protection approach should have been taken as early as October 2017. The Crown referred to Mr Anderson's evidence and his view which was that under Child Protection Registration, Robyn would have continued to reside at home but with more formal supervision and regular child protection meetings. He had said that, given Robyn was seen on 20 July and did not appear unwell or report any illness, it would have been reasonable to expect that workers should have "laid eyes on" Robyn by Friday 27 July, the day after her death. This would have been the minimum requirement should Robyn have been on the Child Protection Register. The actions of workers from social work locality and Community Alternatives were reasonable. Although in Ms Mellon's opinion the harm to Robyn was foreseeable, her death was not.

[341] The court could determine that precautions which could reasonably have been taken by social work services were to hold an earlier IRD and to invoke child protection measures in October 2017 or at the latest November 2017, and to make an earlier referral to the Children's Reporter, in October 2017. However, the Crown did not seek a determination that, if these steps had been taken, Robyn's death might realistically have been avoided.

[342] On the question of whether there were any defects in any system of working which contributed to the death of Robyn, the Crown referred to Ms Mellon's opinion that the threshold for significant harm had been reached and guidance and processes in respect of child protection should have been followed from November 2017 but were not. Ms Mellon's evidence was that this was a systemic failing.

[343] The Crown's position was that the systemic failing had not, however, contributed to Robyn's death.

[344] The Crown suggested a further findings under section 26(2)(g) in respect of screening out of NCPC's from IRD's, recording of general assessments and parental capacity assessments, and the child's plan and supervision of workers.

North Lanarkshire Council submissions

[345] The council were in broad agreement with the Crown's position in respect of section 26(2)(e) of the Act.

[346] It submitted that there was not an evidential basis for it being established to the civil standard that an earlier referral to SCRA would have been accepted by the reporter, would have led to a compulsory supervision order and that the conditions of a compulsory supervision order would have realistically resulted in Robyn's death being avoided.

[347] The council accepted that a precaution which could reasonably have been taken was to have an earlier IRD in October 2017 to enable a child protection investigation to begin. Even if that had taken place, however, there remained uncertainty over whether

there would have been Child Protection Registration. A decision might have been made that the level of intervention was such that it was not necessary.

[348] The Council agreed with the tenor of the Crown submission that there had been a systemic failing in terms of a relevant system of working and that the North Lanarkshire Council guidance was not followed in terms of a lack of assessment, a lack of a structured care plan and a lack of recording of assessment in care plan and outcomes on the part of social work. However there was no evidence to show or infer that any systemic failure extended beyond the circumstances of this case. Any defects in the system did not contribute to Robin's death. It was more appropriate to seek a determination under section 26(2)(g).

[349] The council submitted that recommendations need not be made. Work done since Robin's death, at national and local level, can be viewed as addressing the issues in this case.

[350] The council could not support the submission of behalf of Ms Goldie that a recommendation might be made relating to parents with a known acquired brain injury being the subject of medical assessment. Nowhere in the evidence was it suggested that a medical assessment of cognitive capacity is common practice or should be viewed as being at the forefront of the minds of social workers. The evidence of Fiona Smith was that capacity should be assessed based on observation over a reasonable timeframe. This did not exclude the need for medical input or create a presumption against it. However, the existence of an acquired brain injury should not, in itself, save in cases of immediate concern, prompt the need for a referral to formal assessment. Social work

carry out an holistic assessment of parenting capacities from a range of perspectives, using a range of tools and methods. The introduction of the default need of assessment in cases where there has been an acquired brain injury would risk medicalising holistic process and impairing the relationship between parents and workers. The more formal process which now exists of assessment of capacity should highlight the need to consider medical input where that arose. The recommendation would require considerable deployment of resources from the NHS and the Inquiry had not heard evidence from the NHS as to the utility and practicality of implementing such a recommendation. There was not the evidence before the Inquiry for the court to make a meaningful assessment of what a "similar case" may look like or whether an assessment might prevent a death in the future.

Submissions on behalf of Christian Anderson, Brian McNott and Victoria Logan

[351] It was accepted that earlier child protection measures or an earlier referral to SCRA would constitute reasonable precautions in terms of section 26(2)(e). However there was no evidence which would suggest that either measure implemented at an earlier juncture would have altered the pathway and outcome for Robyn.

[352] While an earlier referral to SCRA would have been a reasonable precaution, the course chosen by the social workers was reasonable. Reference was made to *Sutherland* v *The Lord Advocate* [2017] CSOH 32. At issue there was the exercise of clinical judgement. Lord Armstrong said:

> "It was submitted that it would be possible to envisage a situation, involving the exercise of clinical judgement, whereby a doctor was presented with two or more options and could not know which was in the patient's best interests. I accept that in such a situation where the optimal course was not taken, it would not be appropriate to determine that the selection of another of the available options would have been a reasonable precaution."

[353] It was submitted that the rationale in respect of clinical practice could also be applied to social work practice. In this case social workers were exercising professional judgement as to how best to handle an ever evolving situation. It was submitted that the court should step back from finding an earlier referral ought to have been made, but rather that it could have been made. In the same vein, it was submitted that whilst earlier child protection measures could have taken place, it was reasonable that they were not.

[354] The court ought not to infer from the absence of the written assessment and plan that there was no assessment and plan. The suboptimal record keeping did not realistically impact how Robyn was managed.

Lanarkshire Health Board

[355] It was the Board's position that no finding under section 26(2)(e) of the Act should be made insofar as it related to the healthcare provided to Robyn by Lanarkshire Health Board. Similarly no finding ought to be made under section 26(2)(f) of the Act so far as it related to the healthcare provided to Robyn by Lanarkshire Health Board. The board submitted that there were no other facts regarding healthcare that were relevant

to the circumstances of the death and no recommendations were required in respect of matters relating to healthcare.

Sharron Goldie

[356] It was accepted that the most immediate precaution which could have been taken, namely securing medical treatment for Robyn, was not taken by Sharron Goldie. It was the position of Sharron Goldie that had that precaution been taken at some time between 19 and 25 July 2018 it was more likely than not that she would have survived. It was less clear if the medical treatment had been secured following perforation of the duodenal ulcer, believed to have occurred on 26 July 2018. However the report of Mr O'Toole spoke of him only having seen two children with this condition in 30 years of experience and both had survived. Therefore it was accepted that Robyn may also have survived had her treatment been secured after perforation of the ulcer.

[357] While there were defects in the system of working by social work, they did not contribute in any material way to the death.

[358] In terms of section 26(2)(g) of the 2016 Act, it was submitted that social workers ought to have initiated some formal assessment of Sharron Goldie given their awareness that she had an acquired brain injury. It was insufficient for a social worker to point to the fact that Ms Goldie was able to follow instructions at certain points in her parenting of Robyn. That was no substitute for a formal psychiatric/psychological assessment to determine her parenting capacity in light of her acquired brain injury.

[359] Following on from that, in terms of sections 26(1)(b) and 26(4) of the Act (the making of improvements to any system of working), it was submitted that, where there are similar circumstances and there is a known acquired brain injury in a parent a situation in which the social work department have known child concerns, formal assessment of such a parent ought to be instructed by the social work department.

Analysis

[360] The actions and decisions taken by social work in 2007 and 2009 to 2011 were appropriate and reasonable, given the circumstances at play at the time. They were proportionate, in terms of being the minimum intervention required, and resulted in Robyn's welfare being safeguarded. Similarly the decisions by SCRA not to arrange children's hearings at that time were appropriate in the circumstances.

[361] Turning to 2017 to 2018, although there may have been occasions when Ms Goldie and Robyn appeared to get on well, given the frequency of incidents noted in the records and the high rate of school absences I cannot agree that Robyn's life could be characterized, as it was, as being very settled at times.

[362] Ms Anderson said that, if there was a period of time when things were going well and Robyn was going to school, then there did not need to be such intense involvement. That seemed to me to be consistent with the reactive approach which Colin Anderson identified. It would also be consistent with a lack of an evolving comprehensive assessment. I did not consider that a period of quiet, in what has been

described as a complex case, could provide reassurance that the situation was improved and did not need the same level of intervention.

[363] It was thought that a pattern had formed around May 2018 of Ms Goldie not being able to cope with Robyn's behaviour. However, I observe that such pattern had formed long before then, and at least from November 2017.

[364] Although it was said an assessment and plan was in workers' minds, I have to doubt the soundness of any such assessment and plan. Both experts spoke of a lack of a single or multi agency assessment and plan. The evidence of Colin Anderson was that not only was there no *written* comprehensive assessment and child's plan, there was no evidence otherwise of an assessment and plan. I prefer that evidence on the matter.

[365] Ms Anderson did not have high level concerns over Ms Goldie's cognitive ability, however it is clear that, over a number of months, there was no real improvement in Ms Goldie's adoption of guidance given by workers, even though it was adapted to try to help her absorb it. That was the position well before May 2018, when a referral to SCRA was made and it was decided to hold and IRD. Meanwhile, there were repeated episodes of violence towards Robyn and a number of other concerns arising. That also undermines the assertion that there was an effective evolving assessment and a plan which was being reviewed and changed.

[366] That Robyn was not assessed as being at risk of significant harm from Ms Goldie's violence alone is hard to understand, considering the pattern of violence seen in 2017 to 2018. The fact that the incidents of physical abuse, emotional abuse and neglect and physical neglect did not lead her to being assessed as at risk of significant

harm before she was, supports that a comprehensive assessment and child's plan was not developed.

[367] The safety plan which Victoria Logan devised with Robyn was about techniques to help her stay calm. NLC dispute the evidence of Ms Mellon on the issue of the safety plan. They deny that the safety plan was about Robyn having responsibility for keeping herself safe. I accept the evidence of Ms Logan on the purpose of the plan. However, workers were nevertheless advising Robyn to call the police if incidents of violence arose. For example, after the incidents around 8 to 10 December 2017, when Robyn was hit to the eye, dragged by the hair to the floor, and punched in the face, workers attending tried unsuccessfully to have them report matters to the police.

[368] Despite this and at the same time, the view was formed that it was not a situation where the threshold of significant harm had been reached. This was also shortly after Robyn reported feeling afraid when her mother said to Robyn that she had "stabbed people like you". The evidence of the two expert witnesses is that the threshold had been reached before that, in October 2017, and it seems hard to understand why the threshold would not be met by the various incidents of violence, emotional abuse and neglect.

[369] It has to be acknowledged that Robyn would also be violent to her mother. It is not possible to say with any kind of certainty what caused her to behave in that way as there may have been a number of factors at play. However, it would be in no way surprising for a child to act out in that way when coping with the repeated parental abuse and neglect which undoubtedly caused Robyn so much anxiety and distress.

[370] The danger in describing the violence between mother and daughter as "sibling fighting" was that it might diminish the seriousness of the violence towards Robyn. In the long list of concerns noted at the IRD on 8 June 2018 the only mention of violence toward Robyn is what is listed as pushing and shoving each other during "sibling fighting" in a "difficult relationship" between Robyn and her mother. Although it may not have been intended, such language might inadvertently tend to suggest to the reader that an equal responsibility for the violence lay with Robyn. It is also in line with the ground suggested in the referral to SCRA being that Robyn was beyond parental control. While that may well have been the case, the grounds which might come to mind first, considering the chronology, would be under section 67(2)(a) and/or (b) of the Children's Hearings (Scotland) Act 2011. Those grounds are (a) that the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care, and (b) a schedule 1 offence has been committed in respect of the child.

[371] That in turn seems to be a consequence of those issues not being clearly identified in a written comprehensive assessment from an early stage. It is certainly the case that the hearing can take account of concerns beyond the ambit of the grounds before them. However, the grounds chosen for the children's hearing to consider, ie Robyn's non-attendance at school and Robyn being beyond parental control, would tend to suggest that particular focus would be on these issues at any hearing.

[372] The progress of the referral which was made to SCRA in May 2018 was reasonable and appropriate in the circumstances of the case. There was no evidence

which would suggest that circumstances arose meriting an application to the sheriff for a Child Protection Order which would have resulted in an earlier children's hearing, should an order have been granted. The Children's Reporter sought and obtained the information necessary for a decision to be made in a timely manner. The plan to hold a children's hearing at the start of the new school term was sensible and appropriate. There was not information before the reporter to suggest that an urgent hearing was required or that the principal concerns were other than those reflected in the grounds chosen.

[373] I observe that in the social background report provided to SCRA, Robyn's school attendance and her behaviour were the two main issues flagged. There was less emphasis on, and detail about, issues of ill treatment, emotional abuse and neglect, and physical neglect and the resulting level of existing and prospective harm. The Children's Hearing can and do consider matters beyond those narrated in the grounds and the social background report before them, however the existing concerns and harms would not have been as apparent unless a full description of them was subsequently brought to their attention in Robyn's case.

[374] I accept the evidence of Ms Mellon and Mr Anderson that there was an absence of a comprehensive written assessment and child's plan and that, if the policy and practice documents in place at the time had been followed and applied, they would have offered a structured and effective approach to assessment, care planning and decision-making.

[375] Both experts were clear that they did not criticise individual workers who undoubtedly cared about the outcome for Robyn. I accepted evidence that Community Alternatives went beyond providing a service confined to keeping the family together and that it was an appropriate service to deploy along with other input.

[376] There had been no medical assessment of Ms Goldie in respect of parenting capacity. The evidence of Ms Swift was that a medical examination of Ms Goldie could have been undertaken in 2017/2018 on the question of a cognitive assessment. She said, however, that workers would have required to assess capacity first before reaching the stage of asking for a medical examination. While it was not suggested that it was common practice to seek a medical assessment of cognitive capacity, it was a tool which could have been deployed if a parenting capacity assessment had identified that a psychiatric examination was necessary. Given the circumstances of Robyn's death, whether a psychiatric or psychological examination was a necessary investigation is a pertinent question. The absence of a parenting capacity assessment as part of a comprehensive assessment means that there cannot be assurance that it was reasonable for social work to proceed without a medical examination.

[377] NLC also disagree with Ms Mellon's evidence about the decision to discourage respite being sought from Robyn's friend and her mother. They make the point that Ms Mellon came to this view without the benefit of the background information about the friend and her mother which Mr McNott had. That is true and Ms Mellon conceded this. However, I formed the view that the reason behind discouraging respite about attempting to have Ms Goldie set firm boundaries for Robyn rather than concerns about

any background information. It must also be said the lack of a statutory footing meant that the process of identifying family support and respite, in April 2018, did not progress. This was a voluntary process and Ms Goldie did not cooperate in it. It can be inferred that, had earlier child protection measures been put in place or an earlier referral to SCRA been made, then a more formal or even statutory basis for involvement with Robyn might have ensured that the process of identifying suitable respite took place.

[378] Ms Mellon's understanding from her reading of the joint minute was that Robyn's illness took place over a period of about 10 days and that had Child Protection Registration or a compulsory supervision order been in place the outcome for Robyn would have been different. If a child is subject to Child Protection Registration there is usually a requirement that workers "lay eyes" on them at least once a week.

[379] From the opinions of Dr Hansen and Mr O'Toole, and from the observations of a neighbour and Ms Goldie's friend, it is clear that in the days leading up to her death Robyn began to exhibit symptoms. They were symptoms which it would be expected a worker would have noticed and acted upon if they had seen them. However, it is equally clear that when Robyn was seen by Miss Logan and Ms Murray, 6 days before her death on 20 July 2018, she was not exhibiting any symptoms and did not complain of any. There was no cause at that time for workers to, nevertheless, be alert to a developing illness. Miss Logan visit on 25 July was not pre-planned. It was not unusual for there to be no answer on an unannounced visit. There was no reason for social work to think that something so untoward was going on that there would need to be

immediate access to Robyn insisted upon. A Community Alternatives worker attended on the day of Robyn's death to collect Robyn to take her to the café group. Ms Goldie spoke to the worker through the letterbox and told her that Robyn would not be attending as she had not been well since the previous Thursday, 19 July. The worker who attended at the house on 26 July acted appropriately. She had another child in her car when she attended at the door of Robyn's home. She updated the case notes when she returned to the office and the expert opinion was that she acted in a reasonable and professional manner. No criticism could be attached to her actions.

[380] There is some doubt, given the opinions of the medical experts, whether by that late stage Robyn's death might have been prevented if it had been discovered by workers. I accept the evidence of Mr Anderson that, if Robyn was subject to Child Protection Registration, given she had been seen on 20 July, a reasonable time frame for her to have been seen again by social work would have been by 27 July, the day after her death.

[381] The decision not implement earlier child protection procedures was flawed and, for this reason, I cannot agree with the submission that the alternative course was also reasonable. Having concluded that there was a failure to create a written comprehensive assessment and child's plan, I cannot agree that the practice adopted was reasonable. That applies also to the decision not to refer to SCRA at an earlier stage.

[382] In terms of the submission for the mother in respect of a recommendation a medical assessment when there is a known acquired brain injury in a parent, the evidence supports that a medical examination should take place, where an ongoing

parenting capacity assessment reveals that is needed. There is therefore an element of discretion in the process in that such a decision is made on a properly informed, case by case, basis. In this case, the decision making on that matter was not informed by an adequate assessment. However, I am not persuaded on the evidence that a requirement in all cases is merited. The crucial issue is that an effective assessment commences and is ongoing so that, where there is a need for a medical examination, that is revealed.

[383] From the reports of Dr Hansen and Mr O'Toole, I am satisfied that Robyn would have displayed symptoms and signs, which Ms Goldie would have seen, that indicated that she was becoming increasingly unwell in the days leading up to her death and it would be expected that a competent parent or carer would have recognised and acted upon this. Jim Duffy, James Provan, and Ms Goldie's neighbour observed this as did, I conclude, Ms Goldie.

[384] Ms Goldie had made GP appointments before. She recognised that Robyn was unwell and had contacted the GP reception that week. She could have made an urgent GP appointment and she could have telephoned for an ambulance or, at the very least, allowed Robyn to go with Mr Duffy by taxi to the hospital.

Conclusion

[385] In considering those matters set out at section 26 of the Act, the Inquiry has had the benefit of persuasive and uncontroversial evidence about the time, place and cause of Robyn's death. Similarly, it is clear that there was no accident related to the death. Therefore the questions at section 26(2)(a),(b),(c) and (d) can be easily answered.

[386] Turning to the question posed at section 26(2)(e) of the Act, namely whether any precautions could reasonably have been taken which, had they been taken, might realistically have resulted in the death being avoided, the most obvious precaution would have been for Robyn's mother to secure, or allow her to access, medical attention and treatment when she complained of being unwell and showed symptoms in the week leading up to her death. There was no good reason for this precaution not to be taken by Ms Goldie. She was capable of taking the precaution. It was a precaution which could reasonably have been taken. Such a precaution being taken up to 25 July would almost certainly have resulted in Robyn's death being avoided and might realistically have resulted in her death being avoided if taken on 26 July. Both Dr Hansen and Mr O'Toole agreed that Robyn's death was avoidable.

[387] Aside from that precaution, there is a question as to whether precautions could reasonably have been taken by social work or other agencies, and whether any such precautions might realistically have resulted in Robyn's death being avoided. I was satisfied from the evidence, particularly the expert evidence of Ms Mellon and Mr Anderson, that precautions could reasonably have been taken by social work, but were not.

[388] In July 2018, Robyn came to the greatest of harms due to neglect and ill treatment by her parent. In her earlier childhood she had been exposed to the risk of significant harm by her mother. On returning to her mother's care in 2017 she was exposed to the risk of significant harm. Indeed she did, in fact, come to harm in suffering physical assaults, emotional abuse, physical neglect and impaired academic progress. While I

have concluded that Robyn's death could not have been foreseen, there were steps which could have been taken, from soon after her return to her mother in 2017, which might have avoided the harm which could be foreseen.

[389] There could have been a comprehensive needs and risk assessment, carried out according to the GIRFEC principles, in written form. Such an assessment would have provided the means by which Robyn's needs, and the risks pertaining to them, were identified and properly considered by social work staff and other agencies. It is by this means that the risk of harm to a child is not only identified but also mitigated. An assessment would have incorporated an assessment of Ms Goldie's parenting capacity and in particular the impact of her disability upon her parenting capacity.

[390] A comprehensive assessment in written form should then have informed a child's plan. The child's plan sets goals, assigned for the purpose of mitigating risk and ensuring the child's needs are being met. The child's plan should then have been reviewed on a regular basis in order to ascertain whether the goals were being met. The child's plan should also have incorporated contingency plans for Robyn in the event that the goals were not being met. The child's plan should have been set out in written form in order that it could be effectively reviewed for success.

[391] There was an absence of a written comprehensive assessment and a written child's plan in Robyn's case. These precautions were measures which formed part of the national GIRFEC model. NLC practice guidance on assessing the needs of children, young people and their families was in place at the time and was supported by other

documents. Given the existence of these documents at the time of involvement with Robyn in 2017 to 2018, the precautions identified could reasonably have been taken.

[392] Another precaution to be considered was the earlier implementation of child protection measures. I accept the evidence of Ms Mellon and Mr Anderson that there were significant concerns by October 2017 which should have triggered a formal child protection approach. An IRD, with input from health and education, should have taken place. The concerns were such that a child protection investigation should have been initiated, with Child Protection Registration being warranted. The Notification of Child Protection Concern received from Robyn's school in October 2017 should have led to an IRD being held, irrespective of there being a protocol which allowed for a notification to be screened out from an IRD. The screening out of the school's notification meant that no child protection investigation was initiated, and that decision was made without the input of education or health. As was pointed out in submissions by NLC, it has to be acknowledged, in identifying this as a failure on the part of social work, that Police Scotland had a partnership role in the decision not to proceed with an IRD in October 2017.

[393] There were further points, later in 2017 and in early 2018, when children protection measures should have been initiated. A child protection investigation would have necessitated a structured assessment, which, as already noted, was absent. It would have also have resulted in a written plan being formulated.

[394] Should the child protection investigation have resulted in a decision to place Robyn's name on the Child Protection Register, which both experts considered was

warranted, reviews at least every 3 months would have resulted in consideration of an updated structured assessment and a review as to whether the goals in the child's plan were being met. This is a more formal level of monitoring a child's welfare and safety, and a greater level of protection, than if Child Protection Registration were not in play. Implementation of earlier child protection measures was a precaution which could reasonably have been taken.

[395] Another precaution to be considered was whether an earlier referral to SCRA could have been made. A referral to the Children's Reporter may result in a compulsory supervision order being made by the children's hearing in respect of a child. A compulsory supervision order means that the children's hearing have an overview of the child's circumstances. Such an order is in place for up to a year at a time. The order provides structure and a statutory basis for the local authority's involvement with the child. It provides that the local authority is responsible for giving effect to the measures in the order. The order can include a measure that the child is accommodated away from home by requiring that the child reside in a specified place. Interim compulsory supervision orders may be made by a children's hearing pending determination of an application to the children's hearing. Interim orders have the same effect and may contain the same measures as a compulsory supervision order. An order can have the effect of improving parents' engagement with agencies and improving the child's situation. Conversely, if there is no improvement or if there is a deterioration, the measures in the order or interim orders may be quickly reviewed by the children's

hearing and varied to make it more effective. An incidental consequence of making a referral is that it should, in itself, cause social work to prepare a structured assessment.

[396] I accepted the evidence of both expert witnesses that an earlier referral should have been made to the Children's Reporter in October 2017. A referral continued to be warranted up until the point that it was in fact made in May 2018. The senior social worker also conceded that an earlier referral should have been made.

[397] In making a finding in terms of section 26(2)(e) it must be determined not only whether any precautions could reasonably have been taken but also whether, had they been taken, they might realistically have resulted in the death being avoided. I have considered what evidence there was before the Inquiry as to what the consequences of the above precautions being in place might have been. The evidence before the Inquiry was that, although a comprehensive assessment and a child's plan should have resulted in a more proactive and structured approach to agencies' intervention with Robyn, it was unlikely that she would have been accommodated away from her mother's care. That is also the case in respect of earlier child protection measures. This was the evidence not only of the workers involved with Robyn but also Mr Anderson. If Robyn had been accommodated out with her mother's care, it is highly likely that her death would have been avoided. However, there was not evidence before the Inquiry that this would have occurred by the time of Robyn's death and therefore there was not evidence that those precautions might realistically have resulted in the death being avoided in this way.

[398] There is also the question of whether, even if she remained within her mother's care by July 2018, the precaution of earlier child protection measures, in the form of Child Protection Registration, might realistically have resulted in the death being avoided. If Robyn's name had been placed on the Child Protection Register by the time of her death, there would have been a requirement, in terms of registration, that a worker would "lay eyes" on her at least once a week. There was no evidence to suggest that, if Robyn had been subject to Child Protection Registration when she was last seen by social work and health on 20 July, social work would have required to insist on seeing her before 27 July. Therefore, there is no evidence to support that Child Protection Registration might realistically have resulted in Robyn's death being avoided.

[399] Again, in applying the two part test in section 26(2)(e), I could not be satisfied that the precaution of an earlier referral to SCRA might realistically have resulted in Robyn's death being avoided. That is because the evidence before the Inquiry is that any order or interim order put in place was unlikely to have included a measure that she reside away from her mother and there is not evidence to the contrary.

[400] In summary, given what was reported and otherwise known to social work, actual harm and the potential for harm to Robyn could, and should, have been perceived. In order to address that harm, the precautions of a written comprehensive assessment, a written child's plan, earlier child protection measures and an earlier referral to SCRA should have been in place. However, harm in the nature of Robyn's death could not be foreseen in an assessment or in a child protection case conference. The evidence does not support that it would or should be expected that a child's plan or

child protection measures would have been designed or developed in such a way as would realistically result in her death being avoided. Similarly, any measures put in place by a children's hearing before her death would have been unlikely to have resulted in Robyn being removed from her mother's care or otherwise realistically resulted in her death being avoided.

[401] Section 26(2)(f) poses the question of whether there were any defects in any system of working which contributed to Robyn's death or any accident resulting in the death.

[402] Ms Mellon's evidence was that there was a systemic failing. Ms Mellon explained that she had concluded that there had been a systemic failing because no one picked up on the lack of compliance with the guidance policies and procedures which were contained within North Lanarkshire Council's practice guidance on assessing the needs of children, young people and their families. The whole system went along with it. It was not just the actions of one worker, it was the way that the system worked. Other agencies were involved. Mr Anderson was of the view that he could not comment on whether there had been systemic failing on the part of social work as he would need to look at other cases and interview staff before he could come to a conclusion on the issue. I conclude that there was systemic failure on the part of social work to the extent of failure to comply with policy and procedures in Robyn's case. That included not only the lack of a written comprehensive assessment and child's plan but also a lack of supervision. However, the evidence did not support that the systemic failure contributed to Robyn's death.

[403] While the systemic failure noted above did not contribute to Robyn's death, the nature of that failure disclose facts which raise significant concern and are relevant to the circumstances of her death, in terms of section 26(2)(g). These facts have been recognised by the council at an earlier stage to this Inquiry and acted upon by the council. A number of changes have been implemented or are in the process of being implemented and are detailed earlier in this determination.

[404] The failure to implement child protection measures, or refer Robyn to SCRA, at an earlier stage were directly attributable to a lack of a comprehensive assessment and child's plan. The changes provide an improved means of ensuring:

That a comprehensive assessment and child's plan is created;

that parenting capacity assessments are carried out comprehensively, in a consistent manner, and inform the general assessment;

that assessments take account of the risks and needs of older children and young people;

that assessments and child's plans are recorded and are in an easy to utilise format;

that patterns of harm and neglect are clearly identified and reflected upon;

that all relevant agencies are involved in the assessment process, planning and decision making;

specifically, that notifications of child protection concerns may no longer be screened out from an inter-agency referral discussion.

[405] There is a system for auditing case records and ensuring compliance with procedures as well as for ongoing evaluation of the quality and effectiveness of practice and procedure.

[406] Workers are supported by online access to a single comprehensive package of guidance and resources, by the use of improved mechanisms for recording, and by the fostering of improved supervision and critical reflection in a supportive environment.

[407] I am satisfied that the changes made by the council address the issues of concern for the Inquiry. It is for this reason that I conclude that it is unnecessary for the Inquiry to make recommendations in terms of section 26(1)(b).

[408] I conclude by joining the representatives at this Inquiry in extending my sympathies to all those affected by Robyn's tragic death.

Appendix 1

List of witnesses

1) Sharron Goldie
2) Brian McNott (social worker, locality office, NLC)
3) Victoria Logan (child and family support worker, Community Alternatives, NLC)
4) Leeann Hoskins (school nurse, NHS),
5) Karen Murray (sexual health nurse, NHS)
6) Christian Anderson (senior social worker, locality office, NLC)
7) Martin Jess (Children's Reporter, SCRA)
8) Pamela Ferry (pupil support teacher, Clyde Valley High School, NLC)
9) Fiona Swift (Senior Education and Families Manager, social work, NLC)
10) Alison Gordon (Chief Social Work Officer, NLC)
11) Andrew Blair (Education and Families Manager, social work NLC)
12) Maggie Mellon (expert witness)
13) Colin Anderson (expert witness)

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14) James McClafferty (locality reporter manager, SCRA)
15) Iain Kenneth McLennan Macaulay (service manager, Community Alternatives, NLC)
16) Anthony Peter Scott (senior social worker, Community Alternatives, NLC)
17) Stephanie Jane O'Hara (support worker, locality office, NLC)
18) P M (child and family support worker, Community Alternatives, NLC)
19) Sarah Louise Friel (social worker, Women's Community Justice Service, NLC)
20) Sharon Coats (locality social work manager, NLC)
21) Margaret Elizabeth Hamilton (attainment mentor, Clyde Valley High School, NLC)
22) Lindsey Mitchell (Child Protection Officer, education, NLC)
23) Laura McFarlane (head teacher with portfolio Community Alternatives education unit, NLC)
24) Mary Jane Hunter (Virtual School lead, education, NLC)
25) Jill Woodward (senior manager, education, NLC)
26) Morna McGreish (class teacher, Community Alternatives, NLC)
27) Bridget Rothwell (lead reviewer, Significant Case Review in respect of Robyn Goldie)
28) Evelyn Neilston (deputy head teacher, Clyde Valley High School, NLC)

Appendix 2

Amended charge to which Sharron Goldie pleaded guilty

"Between 12 July 2017 and 26 July 2018, both dates inclusive, at 19 Lomond Drive and the Melody Bar, Caledonian Road, both Wishaw and elsewhere you SHARON GOLDIE, being a person having attained the age of 16 years and who had parental responsibilities in relation to a child or a young person, namely Robyn Goldie, your daughter, born 20 February 2005, 19 Lomond Drive, Wishaw did willfully ill-treat, neglect and expose said Robyn Goldie, in a manner likely to cause her unnecessary suffering or injury to health in respect that on various occasions you did strike her on the head and body, push her, pull her hair, bite her on the body, spit at her, fail to provide her with adequate food, clothing or heating, supply her with and permit her to drink alcohol and smoke cannabis, expose her to unhygienic living conditions and cat faeces and cat urine whereby she contracted fleas, lock her in 19 Lomond Drive, Wishaw and leave her unattended without supervision and fail to ensure she attended school regularly or that she maintained an adequate sleep pattern, repeatedly fail to obtain, and prevent or obstruct said Robyn Goldie from obtaining, appropriate, timely and adequate medical examination and treatment whereby she developed peritonitis due to a perforated duodenal ulcer and died on 26 July 2018. CONTRARY to the Children and Young Persons (Scotland) Act 1937, Section 12(1) as amended

Appendix 3

Sentencing Statement of Lord Beckett

[1] "The Crown accepted your plea of not guilty to culpable homicide and I must sentence you on the charge to which you have pled guilty. In doing so, I have taken account of all of the information before me which includes the words of the charge to which you pled guilty, an agreed narrative of the facts of the case and a number of reports. I have considered carefully the content of the two reports from a psychologist, a report from a psychiatrist and the social work report. I also have some information from your GP records.

[2] I have taken into account of everything said in mitigation on your behalf and there are some mitigating circumstances in this case. There is no doubt that you suffered a brain injury in an accident when you were 9 and that it has enduring consequences for you. Your consequential emotional immaturity, as found by Dr Raja who is a consultant forensic psychiatrist, is something the court can take account if in assessing the level of your culpability. A particularly important feature in sentencing in this case is that you do not present a risk of serious harm to the public at large. You have a very limited criminal record and no significant previous convictions. You have ped guilty in this case and have at times have expressed remorse. I recognise that you and your mother have suffered the tragic loss of your adult daughter this month in very distressing circumstances.

[3] It is a very regrettable situation that in 2017 you found yourself with responsibility to care for a daughter aged 12 who you had ceased to care for because of child protection concerns over physical neglect when she was 4. I note that you declined the offer by social workers of parenting classes when Robyn was returned to you in 2017.

[4] It is troubling to learn from the narrative that warning signs were picked up at school, by neighbours and social workers and yet this situation was allowed to continue for more than a year, culminating in considerable pain, anxiety and suffering and the death of a child of 13. Even as the situation deteriorated in the last week of Robyn's life, no effective intervention was made although your actions have a lot to do with that situation.

[5] In light of what has been reported and said in mitigation, I have to assess very carefully your level of responsibility for this crime. I have understood from Dr Raja's report that cognitive difficulties consequent on your brain injury are considered to have had some part to play in your committing the crime charges, but the extent of that is not and cannot be known in a situation where you were also drinking and smoking cannabis regularly. I must make a judgement in the light of all of the information available.

[6] I will first examine some of the detail of what you did to determine to what extent I should reduce my assessment of your culpability.

[7] Even if your daughter could sometimes be challenging and difficult, she was subjected to a terrible ordeal of neglect and ill treatment by you over a long period. You had enough money to provide sufficient food for your daughter but you chose not to do so, and it seems that you preferred to spend significant sums on cannabis and alcohol. You gave these substances to your daughter instead of providing her with adequate nutrition. Your daughter was left to ask for money for food from neighbours and in the pub you frequented. You hit her on the head and body, pulled her hair, but her on the body and spat at her. Your versions of events to the reporting social worker and to Dr Raja contain extensive denial which is inconsistent with your plea of guilty, substantial minimization, attempts to shift the blame onto others and much victim-blaming.

[8] From 19 July, your daughter was complaining of pain in her legs and stomach. On 21 July you locked her in the house while you went to the pub. By 22 July she had been sick and had not eaten for days.

[9] On 24 July she was seen to be looking drained, pale, shivering and speaking weakly and you knew she was unwell. She told you that she needed an ambulance and you refused to call for it. She summoned a taxi herself to take her to hospital confirming both the gravity of her condition and her awareness of it. Your friend offered to accompany her to hospital but you prevented your daughter from taking the taxi when it arrived. I reject your contrived explanation to Dr. Raja, that you could not know this because she covered it up with fake suntan cream, as simply untrue given the terms of the agreed narrative.

[10] On 25 July, your daughter was in the garden asking a neighbour for help and to get an ambulance, saying she could not breathe when you intervened and took her back into the house. Your 13 year old daughter was so unwell in the early hours of 26 July that she wet and soiled her bed and remained there, indicating quite how ill she was. You knew this and still you did nothing to seek medical assistance for her. You sent a social worker away without allowing her in the house. Your daughter was still in pain that afternoon and rather than getting her medical help, you gave her a painkiller and went to the pub. When you returned home, by which time your daughter was slumped on the sofa and unresponsive, you and your friend went outside to the garden to have a drink because the weather was nice. She was certainly dead less than an hour later.

[11] You have pled guilty to wilfully ill-treating and neglecting your daughter and exposing her in a manner likely to cause unnecessary suffering or injury to health. Accordingly I cannot accept the suggestion in the psychologist's supplementary report provided by your lawyer that what you did was no wilful neglect.

[12] In light of the opinion of Dr Raja, whose diagnosis I prefer to that proposed by a psychologist, I reject the suggestion that paranoid mental illness accounts for what you did to, and failed to do for, your daughter. Dr Raja found no indication that you have a major mood disorder.

[13] Whilst you suffered a serious brain-injury aged 9, you went on to pass standard grades in your teen years and your verbal IQ has recently been assessed probably to lie between 87 and 100 in the low-average to average range of functioning which is

significantly more advanced than someone who would be considered to have a learning disability or significant impairment of social functioning. Dr Raja found that whilst you may lack emotional intelligence, your "attention, concentration [and] short term memory was reasonable and [your] use of language suggested reasonable verbal intelligence."

[14] Despite your brain injury and its consequences, other than having the unwanted responsibility of caring for your daughter which you found inconvenient and difficult, you were able to function in the community, choosing to prioritise smoking cannabis and drinking and socialising in the pub and at home over her care. I conclude from the known facts that, when your daughter became ill and was repeatedly trying to get to hospital, you were substantially motivated by protecting yourself from the potential for closer scrutiny by the authorities which would inevitably have followed hospital admission.

[15] I note that Dr Raja considers that you would be vulnerable in prison and may struggle to cope, but she would liaise with the prison mental health team to ensure your needs are met as she would if you were at liberty. Given that protection of the public is not a material consideration in your case, I have considered very carefully whether I can deal with you in some other way than imprisonment.

[16] However, yours was a crime involving considerable cruelty over a prolonged period. Taking account of all of the information before me including what I have learned of your limitations and difficulties, I conclude that this is a crime so serious, and your responsibility for it is such, that there is no suitable alternative to a sentence of imprisonment in order to punish you, to seek to deter those who would wilfully ill-treat their children, to mark the gravity of such a concerning crime and to express society's disapproval of such conduct.

[17] I take account of your having pled guilty and that your plea was, in effect first offered to the Crown on 28 February 2020. However, you had first appeared on petition in September 2018 and you had been indicted to a preliminary hearing on 23 August 2019. By 28 February 2020 a trial had already been fixed.

[18] On the charge to which you have pled guilty, and bearing in mind all of the mitigating features of the case, but particularly the absence of the need to protect the public and the consequences of your brain injury and its implications, a suitable sentence would be imprisonment for 4 years. Since you pled guilty, it is reduced to imprisonment for 3 years and 6 months."