Robyn Goldie

Sep 9, 2025

Sheriff Linda Nicolson has issued her determination following a Fatal Accident Inquiry into the death of Robyn Goldie, age 13, who died at home after suffering a severe infection.

Sheriff Nicolson found that a reasonable precaution which might have prevented the death would have been for Robyn's mother, Sharron Goldie, to seek or allow her daughter access to medical attention.

The sheriff found there were no defects in any systems of working which contributed to the death, however she determined that the policies and procedures in place at North Lanarkshire Council's social work department at that time were not complied with. Child protection measures should have been put in place at an earlier stage.

Sheriff Nicolson made no recommendations as North Lanarkshire Council has already implemented a number of changes following Robyn's death.

Background

Robyn was born on 20 February 2005 and initially lived with her mother Sharron Goldie. However, due to concerns about Ms Goldie's care of Robyn, the child moved to live with her grandmother when she was 4 years old. This arrangement was made following intervention by North Lanarkshire's Council's social work services. Robyn received good care with her grandmother and social work withdrew their involvement.

In 2017, when Robyn was aged 12, she returned to live with her mother. This decision was made without the family notifying social work services. NLC social work became of Robyn's move after the event and became involved in her life again in September 2017.

In the months leading to Robyn's death, social work services were made aware of a number of issues with Robyn's care, including physical assaults, emotional abuse, physical neglect and truancy from school. Social workers encouraged Ms Goldie to take part in parenting courses and made arrangements for Robyn to stay with her grandmother at weekends.

In the days prior to Robyn's death, the child complained to her mother about pain in her legs and stomach. She had also vomited and was unable to eat for several days.

On 24 July 2018, Robyn told her mother that she was seriously unwell and needed an ambulance, but Ms Goldie refused to call one. Robyn called a taxi to take her to hospital, but Ms Goldie prevented her from getting in the taxi, telling a friend that Robyn was 'attention seeking'.

The following day, a neighbour spoke to Robyn in the garden and she said 'help me, I cannae breathe, get me an ambulance'. Ms Goldie told Robyn to 'get in' and took her back into the house.

On the day of Robyn's death, 26 July 2018, a support worker attended at the house at 9.40am to take her to a club that she attended, however Ms Goldie told the worker through the letter box that Robyn was unwell and the worker left. At 4.35pm in the afternoon, Ms Goldie went to a nearby pub, returning home with a friend at around 6.30pm. Robyn was slumped on the couch unresponsive, and Ms Goldie and her friend went outside to the garden to have further drinks. The friend later went back inside and formed the view that Robyn looked unusual. He checked her pulse and realised that she was dead.

Robyn died at approximately 7.25pm. The cause of death was peritonitis and a perforated duodenal ulcer.

Reasonable precautions

A precaution which could reasonably have been taken was for Robyn's mother to have sought medical attention for her or, at least, allowed her to access medical attention. Sheriff Nicolson found that had that precaution been taken, it might realistically have resulted in the death being avoided.

Defects in systems of working

Sheriff Nicolson found that there were no defects in any systems of working which contributed to the death.

Other facts relevant to the circumstances of the death

Sheriff Nicolson found that the policies and procedures in place at the time at NLC social work services were not complied with.

There was no written comprehensive assessment of the risks faced by Robyn, which would have included an assessment of Ms Goldie's mental capacity following a brain injury, and no written child's plan or adequate supervision of workers.

The Sheriff found that 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

Sheriff Nicolson made no recommendations as North Lanarkshire Council has already implemented a number of changes following Robyn's death.

These include changes to ensure that:

- a comprehensive assessment and child's plan is created for children brought to the attention of social work services;
- parenting capacity assessments are carried out comprehensively and in a consistent manner;
- assessments take account of the risks and needs of older children and young people;
- assessments and child's plans are recorded in an easy to use format;
- patterns of harm and neglect are clearly identified and reflected upon;
- all relevant agencies are involved in the assessment process, planning and decision making;
- and notifications of child protection concerns may no longer be screened out from an inter-agency referral discussion.

Condolences

To conclude, Sheriff Nicolson extended her sympathies to all those affected by Robyn's death.

The full Determination is available on the Scottish Courts and Tribunals Service website and is the only authoritative document.

https://www.judiciary.scot/home/sentences-judgments/fai-determination-summaries/2025/09/09/robyn-goldie