SHERIFFDOM OF NORTH STRATHCLYDE AT DUNOON

[2021] FAI 47

DNN-B1-21

DETERMINATION

BY

SHERIFF THOMAS WARD

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

into the death of

KIRSTY McGREGOR

Dunoon, 18 August 2021

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

1. In terms of Section 26(2)(a) that Kirsty McGregor died at 17.32pm on Friday 30 December 2016 within Cowal Community Hospital, Dunoon.

2. In terms of Section 26(2)(c), the cause of her death was by hanging.

3. In terms of Section 26(2)(e), there are no precautions which could reasonably have been taken that might realistically have resulted in her death being avoided.

4. In terms of Section 26(2)(f), there are no defects in any system of working which contributed to her death.

5. In terms of Section 26(2)(g), there are no other facts relevant to the circumstances of her death.

6. In terms of Section 26(1)(b), there are no recommendations to make.

NOTE

Introduction

[1] This Inquiry was held into the death of Kirsty McGregor who was born on 20 March 2003. At the time of her death, Kirsty McGregor had been placed within Dunclutha Children's Home, Dunoon.

[2] A number of preliminary hearings were held in this case by way of Webex on 27 April, 7 May, 25 May, 14 June, and 17 June. The Inquiry itself was held on 28, 29 and 30 June 2021. The Inquiry was conducted by Webex. I adjourned the Inquiry until 15 July to allow submissions to be lodged and heard final oral submissions on that date. I then made avizandum.

[3] At the Inquiry, the Crown was represented by Miss Amanda Allan, Procurator Fiscal Depute. Kirsty McGregor's parents David and Judith McGregor represented themselves. Gavin Anderson, Counsel, represented Argyll & Bute Council. Mr Mark Fitzpatrick, Counsel, represented Highland Health Board. Ms Lyndsey Combe, Solicitor, represented Barnardo's Scotland.

[4] A substantial joint minute, comprising thirty one pages, was signed on behalf of all participating parties, apart from Mr and Mrs McGregor.

[5] I heard evidence from David McGregor and his wife Judith McGregor, Laura Litster, Lorraine Prentice and Gillian Clark. All of these witnesses adopted as their evidence in chief, the Affidavits which had been prepared for them. I also had a substantial number of other Affidavits from a variety of witnesses which were all lodged in evidence.

[6] The following witnesses provided Affidavits:

(a) Joanna McNeish, Senior Practitioner, Barnardo's;

(b) James Houston, Consultant Paediatrician;

(c) John Mathieson, Primary Care Mental Nurse;

(d) Peter Cartwright, Mental Health Nurse;

(e) Viviane Rodgers, Clinical Specialist;

(f) Donna McGivern, Residential Manager;

(g) Sarah Simpson, Alternative to Care Worker;

(h) Sabrina Ayachi, Social Care Worker;

(i) Laura Dickie, Social Worker;

(j) Kirsty Taylor; Family Placement Social Worker;

(k) Arlene Ross, Clinical Psychologist;

(l) Elizabeth Farrar, Medical Practitioner;

(m) Brian Reid, Acting Head of Services for Children and Families and Justice Social Work;

(n) Siobhan Carroll, Assistant Director Barnardo's.

The Legal Framework

[7] This is a discretionary Inquiry under Section 4(1)(a)(ii) and 4(1)(b) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, the Lord Advocate having considered that the death of Kirsty McGregor 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.

[8] In terms of Section 1(3) of the Act:

> The purpose of an Inquiry is to-
>
> (a) Establish the circumstances of the death, and
>
> (b) Consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[9] The Procurator Fiscal, Miss Allen, represents the public interest in such an Inquiry, and an Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Preliminary Matters

[10] I made an order in terms of Rule 4.2(a) of the Act of Sederunt. That order restricted the information presented to particular issues or particular sources in terms of that rule. I decided that the Inquiry should focus on the seven particular issues identified by the Crown. These issues specifically related to:

> (a) Whether Miss McGregor should have been placed with the foster carer closer to the family home, instead of being moved to Dunclutha Children`s

Home, approximately 75 miles away from her home address and causing her to move again to a new school;

(b) Whether additional support should have been put in place for Miss McGregor to assist her and her family at an earlier stage; in particular the period between her first referral to CAMHS and the time of her first appointment;

(c) Whether there should have been arrangements put in place for Miss McGregor to maintain contact with her adoptive brother following her removal to Dunclutha Children's Home;

(d) Whether Miss McGregor's reports of assault on her by her adoptive father should have been reported by her general practitioner or by CAMHS staff to the police, social work or the Child Protection Advisors;

(e) Whether an earlier, more comprehensive, risk assessment should have been undertaken to consider what was in Miss McGregor's best interest; in particular, in relation to her adoptive parents' capacity to meet her care needs;

(f) Whether and to what extent, Miss McGregor, should have been involved in the decisions directly affecting her;

(g) Whether there should have been an earlier referral to the Scottish Children's Reporters Administration, and as a result, a legal basis for Miss McGregor's removal from her parents, rather than this removal having been facilitated on a voluntary basis.

[11] I also concluded that the scope of the Inquiry should be limited to events from December 2014, apart from the prior history narrated in the joint minute. That would allow the Inquiry to concentrate on the events from that date up until the date of death.

Background

[12] Kirsty McGregor was 13 years old at the time of her death on 30 December 2016. She was a school pupil who had formerly resided with her adoptive parents David McGregor and Judith McGregor, and her adoptive brother who was 16 years old at the time of her death.

[13] Miss McGregor was adopted when she was 11 months old, having resided in foster placements since birth. Miss McGregor's birth was a result of a concealed pregnancy and details of her birth father were never provided.

[14] Miss McGregor and her adoptive family initially resided in the Helensburgh area, prior to moving to Ford, Mid-Argyll in October 2015. Whilst living in Helensburgh Miss McGregor had been under the care of the Child and Adolescent Mental Health Services (CAMHS) following a referral by her general practitioner in December 2014. Social Work services became involved in January 2016 when a child protection investigation was initiated following an allegation by Miss McGregor of her father hitting her. The CAMHS team worked with Miss McGregor and her family from May 2015 until September 2015 before she was transferred to another CAMHS team in the new locality area. There was a three months delay in the new team's involvement

with Miss McGregor, which began in January 2016. She was thereafter discharged from CAMHS in February 2016.

[15] Following the move Miss McGregor was enrolled as a pupil at Lochgilphead High School. Social Work Services began supporting the family on a voluntary basis in January 2016, the family having been referred to them by CAMHS. Various support services were put in place over the following months, including a Primary Mental Health Worker and Alternative to Care Worker (ACW). A referral was made by the social worker to the Scottish Adoption Support Services (SASS). Miss McGregor was also prescribed ADHD medication.

[16] On 30 September 2016 Miss McGregor's adoptive parents made the decision that they could no longer care for her as she was out with parental control. Paperwork in terms of Section 25 of the Children (Scotland) Act 1995 was signed by Miss McGregor's adoptive parents for her to be removed from their care on a voluntary basis and accommodated by the local authority.

[17] Miss McGregor was placed within Dunclutha Children`s Home, Dunoon located 75 miles away from the family home, on 1 October 2016. Dunclutha Children`s Home is a residential home for children within the care system and, at the time of Miss McGregor's placement, there were five other female children residing there all aged between 13 and 15 years. Miss McGregor was the youngest resident. Each resident was allocated their own bedroom and they had access to communal living areas. Miss McGregor's room was located on the first floor and no other residents were

situated in neighbouring rooms. Individual rooms can be locked from the inside, however staff members retain keys to all rooms.

[18] On Christmas day 2016, Miss McGregor was visited by her adoptive parents who stayed for about one hour. After they left Miss McGregor became upset and was comforted by staff. On 29 December 2016 Miss McGregor was taken shopping by a staff member. On her return to Dunclutha Miss McGregor's behaviour became erratic and she became argumentative with staff. Later that evening Miss McGregor made comments which caused staff to be suspicious that she intended to self-harm. She was thereafter checked by staff at regular intervals.

[19] Throughout the day on 30 December 2016 Miss McGregor remained within Dunclutha watching television with other residents in the communal area. She was described as appearing fine during this time. At approximately 14.25 hours she returned to her bedroom. A staff member attended at her room to check on her at approximately 15.00 hours. On there being no reply to knocking at the door the staff member entered the room which was unlocked, and discovered Miss McGregor to be partially suspended from a rail within her wardrobe. A ligature (black belt) was attached to the rail at one end with the other around Miss McGregor's neck.

[20] Miss McGregor was freed from the ligature and cardio pulmonary resuscitation was commenced by staff. Emergency services were contacted, and Miss McGregor was transferred to Cowal Community Hospital, Dunoon arriving there by ambulance at approximately 16.40 hours. At 17.32 hours on Friday 30 December 2016 Miss McGregor's life was pronounced extinct.

[21] A scenes of crime examination was undertaken within Miss McGregor's bedroom. Two further belts, both snapped, were found within Miss McGregor's wardrobe attached one end to the railing, indicative of Miss McGregor having made two earlier, unsuccessful suicide attempts. Also found within Miss McGregor's bedroom were three notes which appeared to be suicide notes written in her handwriting.

[22] On 5 January 2017 a post mortem examination was carried out and the cause of death was recorded as:

1(a) Hanging

Submissions for the Crown

[23] Miss Allan on behalf of the Crown lodged written submissions. She asked me to make the mandatory findings, ie to determine when and where the death of Kirsty McGregor occurred, and the cause or causes of Miss McGregor's death. As Miss McGregor's death did not result from an accident, the Crown made no submissions in respect of Sections 26(2)(b) and (d) of the 2016 Act. As I understood all the submissions there was no dispute as to when and where the death occurred and the cause or causes of death.

[24] The main thrust of the Crowns submissions were in relation to Section 26(2)(e) of the 2016 Act –

> "Any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death, or in any accident resulting in the death, being avoided. "

The Crown highlighted the following:

(a) Whether the deceased should have been placed with the foster carers closer to the family home, instead of being moved to Dunclutha Children`s Home approximately 75 miles away from the deceased`s home address and causing her to move again to a new school.

(b) The Crown`s submission put short was that there was a need to take into account both locality, and available resources. No identifiable foster placement was available. The decision to place Kirsty McGregor in Dunclutha Children`s Home was a result of an emergency. Essentially what had happened was that Kirsty's mother, Judith McGregor, had contacted the social work department to advise that because of the current circumstances relating to Kirsty McGregor, she was unable to cope with looking after her and Kirsty therefore required to be accommodated elsewhere. Mrs McGregor at that time was suffering extreme stress and was at breaking point. The consequence of these circumstances was that social work staff had to identify an emergency admission for Kirsty McGregor during the course of that day. Dunclutha Children`s Home was identified as being available. Consideration was given to what should have been best for Kirsty MacGregor and her family. Placing Kirsty McGregor with another foster family would have been difficult because of circumstances highlighted by Mr and Mrs MacGregor in relation to Kirsty staying with them. Kirsty's mother, Judith considered that Dunclutha was a better option as this would involve "24 hour care from trained professionals".

(c) The second issue raised by the Crown in their submissions was "whether additional support should have been put in place for the deceased thus enabling earlier help for the deceased and her family; in particular during the period between the deceased first referral to CAMHS and the time of her first appointment;"

(d) At that time according to the Crown, the only parties outside of the family home to have been made aware of any concerns were the school and the GP. The GP took the view that there was no apparent risk of immediate self-harm and the issues were behavioural. The local GP, Dr Elizabeth Farrar did not see a child in immediate danger. She saw a child and a family in need of help and support.

(e) The third issue raised by the Crown was "whether there should have been arrangements put in place for the deceased to maintain contact with her adoptive brother following her removal to Dunclutha Children`s Home".

(f) Kirsty McGregor's adoptive brother did not have any contact with Kirsty following her admissions to Dunclutha Children`s Home. By the time of Kirsty's admission to Dunclutha, he was 16 years old, had left school and was working. Although he could have had contact with Kirsty when she was admitted to Dunclutha he chose not to. He refused to attend on any occasion. He did not wish to have contact with Kirsty by telephone or by other means. He and Kirsty did not have a good relationship.

[25] Although it was the Crown's submission that the previous points were precautions which might reasonably have been taken they were not realistic in view of the circumstances that pertained at the relevant time. The Crown's position was that from December 2014 to the end of CAMHS in Helensburgh involvement in October 2015, there was no suggestion that Kirsty was at any risk of serious self-harm or suicide. It was also difficult to criticise the decision to place Kirsty in Dunclutha Children`s Home in view of the circumstances as they pertained on 30 September 2016. Even if a foster carer had been found, it does not follow that there would have been a different outcome.

[26] The Crown raised the question in their submissions of the alleged failure by services to identify "attachment disorder" at an early stage. Both Mr and Mrs McGregor described this aspect as a fundamental issue. According to her parents Kirsty was a compulsive liar and agencies involved with the family did not verify the information which Kirsty gave them. Kirsty's mother Judith stated that "attachment disorder" was not mentioned during their early interactions with the CAMHS teams and was first mentioned by Laura Dickie who began working with the family in 2016 following the involvement of social work. Although it was recorded "attachment" had been considered by the CAMHS team in Helensburgh detailed in Crown production number 4.1 at page 791, and the CAMHS Lochgilphead team at page 687, Judith McGregor's position was that at no time in their appointments with the CAMHS team was "attachment disorder" mentioned or discussed. The Crown's submission was that earlier recognition of "attachment disorder" would not have realistically avoided

the death of Kirsty. The recognition of such a disorder would be a matter for individual professionals as would the particular weight of such recognition, in light of the behaviours displayed by Kirsty McGregor during this period. No formal diagnosis was ever made that Kirsty McGregor ever suffered from "attachment disorder". Despite that, individuals involved in the care of Kirsty, from as early as Kirsty's involvement with CAMHS Helensburgh team, did consider that this may have been a contributory factor in Kirsty's behaviour.

[27] The Crown then turned to Section 26(2) (f) - "any defects in any system of working which contributed to the death or any accident resulting in the death". Issues identified by the Crown in advance of the Inquiry relating to this provision were as follows:

> I. Whether the deceased reports of assaults on her by her adoptive father should have been reported by her General Practitioner or by CAMHS staff to the police, social work or the health child protection adviser;
>
> Dr Elizabeth Farrar did not report any alleged assaults. Dr Farrar said that she had no reason to think that there was any reason for other agencies to be involved as long as CAMHS were made aware of the situation. She did not see the child in immediate danger but saw a child and a family in need of support. CAMHS Helensburgh staff were made aware of the allegation within the referral and it is also a matter of agreement that CAMHS staff accepted the opinion of Dr Farrar that there were no concerns concerning Kirsty's welfare within the family home at that time.

[28] The next issue raised by the Crown was whether

> "a more comprehensive risk assessment should have been undertaken to consider what was in the deceased best interests; in particular in relation to the deceased adoptive parents' capacity to meet her care needs".

According to the Crown the picture presented at the Inquiry is one of professionals doing their utmost to keep the family together during the period of social work involvement with the family. Professionals had introduced a number of supports to the family in their attempt to keep Kirsty at home. Returning Kirsty to the family home was the priority even after her admission to Dunclutha. Although Dunclutha was a voluntary placement by Mr and Mrs McGregor it was treated as an emergency placement and the professionals recognised the need to ensure a placement was secured for Kirsty by the end of the school day. In addition social workers were already looking at available resources to place Kirsty McGregor in advance of 30 September following an earlier call from Mrs McGregor on 27 September. An Options Appraisal Meeting had already been scheduled for 30 September at the time of Mrs McGregor's second call. The purpose of that was to consider alternative arrangements albeit for a short period of time.

[29] The Crown also raised the issue of "whether and to what extent, the deceased should have been involved in the decision directly affecting her"; Kirsty McGregor's views were not taken into account at the time of the decision making to place her in Dunclutha. Essentially the social work department had no choice. They had to find somewhere for Kirsty to go as she could not go home at the end of the school day. As a result the ability to take any views from her was really limited. Miss McGregor wanted

to return to her old school in Lochgilphead and she was unhappy at Dunclutha. However the decision was taken at the six week LAAC review that Kirsty McGregor would remain at Dunclutha for at least a further three months. During that time professionals were continuing working towards having Kirsty McGregor return home and specifically trying to maintain regular contact between the family and her. The priority as far as professionals were concerned was to work towards having Kirsty McGregor return home.

[30] The next submission was in relation to "whether there should have been an earlier referral to the Scottish Children's Reporter Administration, and, as a result, a legal basis for the deceased removal from her parents, rather than this be done on a voluntary basis." This recommendation was first made following on from the 72 hour meeting and thereafter following the 6 week LAAC review. The referral was not made until 7 December 2016. It was conceded by Laura Litster that the referral could have been made earlier. Brian Reid in his affidavit stated that the assessment of the team was that the voluntary placement had been agreed for Kirsty and it was difficult to see what a compulsory supervision order would have added.

[31] The Crown`s submissions was that none of these points are points which could be said to contribute to the death of Kirsty McGregor. Dr Farrar was of the opinion that Kirsty McGregor was not in any immediate danger. An earlier referral to the SCRA could have been made but professionals were also of the view that this was not necessary or could not see what such a referral would have added in the circumstances. There was therefore no causal link between the lateness of the referral and the death of

Kirsty McGregor. The evidence was clear that those working with Kirsty McGregor and the family were working towards keeping the family together. That was an important factor in the decision making processes throughout. The Crown did not submit that there was a defect in this approach but if that decision making process was defective it could not be said in the Crown's submission that there was a causal link between that decision making and the death of Kirsty McGregor.

[32] Mr and Mrs McGregor highlighted an issue "that the service provided by Barnardo's Scotland could have been better co-ordinated in terms of the frequency and location of appointments". Mr and Mrs McGregor felt that driving to appointments in Helensburgh from Lochgilphead was difficult because of the distances involved. Mr McGregor thought it was a good service but thought there were too many breaks in appointment times and there could have been better continuity. Judith McGregor noted that contact between Barnardo's and Kirsty could have been better co-ordinated once Kirsty was admitted to Dunclutha. However, the Crown pointed out that Barnardo's Scotland is a voluntary service and not a crisis service and one which is designed to meet with service users in a neutral location. Because of that it was not possible for members of Barnardo's to travel to the McGregors` local area. The restriction in terms of travel was dictated by staff capacity and a number of existing service users. The Crown's submission was that it cannot be stated that there is any causal link between this issue and the death Kirsty McGregor. The Crown's submission was that it is difficult to see how Kirsty McGregor's death could have been reasonably prevented, or to identify any particular defect in the care of Kirsty McGregor that contributed to her

death. Her behaviour was complex and difficult to define. Kirsty could be untruthful and manipulative and her parents view was that Kirsty told professionals what she felt that they wanted to hear. Her behaviour "flip flopped".

[33] The Crown pointed out that at no point did any professional in Kirsty McGregor's life consider that she was at risk of significant self-harm or suicide. Specifically, Gillian Clark, in her oral evidence described how there was no indication on 30 December 2016 that Kirsty McGregor was going to do what she did. Miss Clark stated she had been with Kirsty McGregor approximately 30 minutes prior to her discovery. There were no signs at all that anything was going to happen. The Crown then submitted that there were no reasonable precautions which might realistically have prevented the death and no defects in any system of working, contributed to the death and, as such, the Crown made no submission in respect of Section 26(2)(e) and (f).

[34] The Crown then addressed Section 26(2)(g) "any other facts which are relevant to the circumstances of the death". The Crown pointed out that this Section offered me wide scope, since unlike in subsections (e) and (f) there is no requirement for there to be causal connection or link between the "fact" and the death. There is, nonetheless, a requirement for the facts established under this subsection to be relevant to the circumstances of the death. The Crown considered that all the identified issues are relevant in the circumstances of the death of Kirsty with the exception of the issue in relation to contact between Kirsty McGregor and her brother.

Submission for Highland Health Board

[35] Submissions on behalf of Highland Health Board began with a narration of Kirsty McGregor`s original referral to CAMHS at Helensburgh by her GP in December 2014 and her management there in the period up until the family moved to Ford, Lochgilphead in October 2015. Essentially the submission was that this was a routine referral and in the absence of any express mental health concerns, there was no basis in the evidence for criticism of the CAMHS response to the referral. Waiting list times were well known to be fact of life affecting any clinical referrals in association with the allocations of public resources from taxation. CAMHS were not advised between the periods of Kirsty McGregor`s referral and her first appointment for any need for additional support or help for the family and were not asked to be involved in any effort to secure any additional support or help. Records showed that there were a considerable number of attendances, namely nine, at which either Kirsty herself or Kirsty and Mrs McGregor attended. In addition Dr Catherine Smith the Clinical Psychologist and Viviane Rodgers the Clinical Specialist had sessions with Kirsty McGregor.

[36] The submission on behalf of Highland Health Board was that Kirsty McGregor`s management at the hands of those for whom Highland Health Board have responsibility cannot legitimately be the subject of any significant criticism. It was submitted that there was evidence from Dr Smith`s note, the Clinical Psychologist at CAMHS, that she was alive to a background issue of "attachment".

[37] According to the submission by the time the family moved to the Lochgilphead area in October 2015 a significant improvement appeared to have been achieved in the problematic family relationship.

[38] CAMHS at Lochgilphead were briefed and invited to offer "some maintenance appointments". A child protection problem arose in January 2016 when Kirsty was first due to be seen. That involved an allegation by Kirsty McGregor that her father had hit her. The social work department were advised of what had happened and the police became involved. Mr McGregor was interviewed by the police and no further action was taken. Mr and Mrs McGregor were unhappy that the police had been involved. Mrs McGregor's opinion of CAMHS was poor due to the fact that they had contacted police without even having met her and her husband and made a judgement without actually investigating the matter fully or even asking them what had happened. According to Mrs McGregor's affidavit she and her husband told CAHMS at the time they wanted nothing to more to do with them. She felt that CAMHS did not help them in the slightest and did not ask or take into account anything that they, the parents had to say about their situation. The submission was that since there was no identified mental health concerns, that since the McGregors wanted nothing more to do with CAHMS and since other appropriate support was put in place, it was entirely reasonable that Kirsty McGregor should be discharged from CAMHS service at that time.

[39] In its submission Highland Health Board pointed to the affidavit of Mr McGregor at paragraph 7 where he said

> "Judith and I had carried out a significant research into attachment disorder, which essentially is the effect of a very young child not being able to form a bond with a parent or guardian in the early stages of life. We fully believed that Kirsty's behaviour was a reflection of this disorder … CAHMS seemed to dismiss this and would not listen when we tried to explain that we considered this to be the cause of Kirsty's behaviour. If anything Kirsty's behaviour deteriorated whilst she had input from CAHMS".

The submission for the Health Board was that that particular statement was unwarranted. Mr McGregor was never actively involved with CAHMS during their work. Secondly the issue of attachment had been raised by Dr Smith with Mrs McGregor during their June 2015 meeting and Mrs McGregor was noted to be resistant to the idea at that time. Thirdly Mrs McGregor had said that she learned of what she calls "attachment disorder" from Laura Dickie, whose involvement began normally at the time that the CAHMS involvement was effectively over, in February 2016.

[40] The submission was that Mr and Mrs McGregor would only be part receptive, if at all, to the many efforts made to encourage them to the view that Kirsty's behaviour was essentially a problem of family relationships; and that, while attachment issues helped explain their origin a resolution required reciprocal efforts to rebuild these relationships; but that they tended to adhere to the view that Kirsty had a problem which required to be fixed, which they felt must be a mental health one for which some medical intervention must be available.

[41] According to the Health Board there was no evidence to support the view that a medical or mental health condition lay behind Kirsty McGregor's behaviour. No medical professional diagnosed any medical or mental health condition. Nor was there

any evidence before the Inquiry as to what drove Kirsty suicide. There is no evidence that at the material time she was suffering from any mental illness as opposed to unhappiness following the failed attempts to rebuild the family relationships.

[42] As a consequence the Highland Health Board proposed findings that Kirsty McGregor died on 30 December 2016 at Cowal Community Hospital, Dunoon and that the cause of death was hanging. No other findings were proposed.

Submissions on behalf of Barnardo's Scotland

[43] Miss Combe provided written submissions on behalf of Barnardo's Scotland. Her submissions, supplemented by her oral submissions, were that a formal determination under Section 26(2)(a) and (c) was appropriate in this Inquiry. In essence that was to establish (a) when and where the death occurred and (c) the cause or causes of the death.

[44] The submission was concerned with the support provided by Barnardo's Scotland to Kirsty McGregor during 2016. Mr and Mrs McGregor took no issue with the terms of the joint minute as far as it related to Barnardo's Scotland involvement. The submissions contained a summary of the evidence in the case. I will not repeat that since it will be referred to elsewhere in this Determination. The submission concentrated on Section 26(2)(e) of the 2016 Act. That relates to "any precautions which – (i) could reasonably have been taken and (ii) had they been taken, might realistically resulted in the death, or any accident resulting in the death, being avoided. The submission was that there was no evidence as to any precaution that could

reasonably have been taken by Barnardo's Scotland or by their employee Jo McNeish that might realistically have avoided Kirsty McGregor's death.

[45] Section 26(2)(f) is in the following terms – "any defects in any system of working which contributed to the death or any action resulting in the death". Mr and Mrs McGregor considered that the contact that Jo McNeish of Barnardo's had with Kirsty could have been more frequent. However the undisputed evidence was that Mrs McGregor had a greater amount of contact with Jo McNeish than Mr McGregor had. Although Mrs McGregor's oral evidence was that she could not recall the details of the meetings, letters and telephone calls with Jo McNeish she had no reason to dispute the record Jo McNeish's affidavit which is supported by the records provides a full and accurate account of her involvement with Kirsty and her family. It was submitted that the evidence showed that Jo McNeish was in regular contact first with Mr and Mrs McGregor and then with Kirsty throughout 2016.

[46] The submission was that the support provided by Barnardo's was provided on a needs basis. The service was voluntary and the support that Jo McNeish offered to Kirsty McGregor depended and to what extent Kirsty chose to engage with the service. Kirsty did not engage with Jo McNeish's initial letters and she refused to attend a scheduled meeting in May 2016. It was a conscious and deliberate decision to allow Kirsty time to settle into Dunclutha Children`s Home and her new school before arranging further appointments. After Kirsty McGregor had settled in Dunclutha Jo McNeish offered Kirsty appointments on a monthly basis and met with her on

17 November and 9 December 2016. Further appointments were to be offered in January and February 2017.

[47] No independent expert evidence was led criticising the approach taken by Jo McNeish. The independent expert evidence of Miss Mearns and Miss Edwards was that there were no defects in the system of working which caused or materially contributed to Kirsty's death. It was therefore submitted that there was no defect in Barnardo's system of working in relation to the frequency of appointments and in any event no causal connection between the frequency of the appointments and Kirsty's death.

[48] It was noted in the submission that Mr and Mrs McGregor were critical of the distance that they had to travel in order to meet with Jo McNeish. However detailed evidence as to the nature of the service and its limitations were provided in Jo McNeish's and Mrs Carroll's affidavits. The parameters of the service were well defined. It was submitted that there was no evidential basis for a finding that there was a defect in the system of working in relation to the geographical areas that the service covered. No evidence was led of a causal link between the location of the meetings and the outcome for Kirsty McGregor. It was therefore submitted that a determination in relation to Barnardo's in terms of Section 26(2)(f) of the Act was not appropriate.

[49] Section 26(2)(g) relates to "any other factor which are relevant to the circumstances of the death". The submission pointed out that Barnardo's involvement was limited to a period from February 2016 to December 2016. The submission was that there was no evidence to suggest that Jo McNeish's involvement was relevant to the

circumstances of Kirsty McGregor's death. It was therefore submitted that no findings should be made in relation to this section.

Submissions of David and Judith McGregor

[50] Mr and Mrs McGregor were unrepresented. As a consequence their submissions did not relate directly to what is required in terms of Section 26. The original submissions which were supplemented by further submissions can be summarised as follows. The parents contend that there are a number of key failings where systems, procedures and policies were not followed properly or were in adequate:-

1. Kirsty's behaviour problems started early in life and no action was taken.

2. The views of those that knew Kirsty were either not given credence or not sought.

3. "Attachment Trauma" was not acknowledged by professionals.

4. CAHMS misinterpreted a slight improvement in behaviour in summer 2015 as evidence of successful treatment.

5. There were many instances of lack of communication and joined up approach that came within Argyll & Bute Council, namely (a) it was submitted that the evidence in the Inquiry was extremely contradictory in defining Kirsty's condition. It was suggested that Kirsty's behaviour was that of a normal teenager but that was clearly contradictory with the truth; (b) there were contradictory views within the care teams about the attitudes of the parents; (c) there was a lack of communication between the teams when alternative

accommodation was being sought in September 2016; (d) the parents were left without support in a critical period of five months in 2016 due to staff changes; (e) Lorraine Prentice should have been aware of specific details of work done by her staff; (f) the process and procedures of providing support to the family was tainted by a half-hearted attitude to the parents by the team leader.

6. The systems failed to recognise and give sufficient consideration to the risk of self-harming and reports of Kirsty being on suicide websites. This was compounded by the lack of mention of the risk being recorded in the referral paperwork to Dunclutha.

7. The contract awarded by Argyll & Bute Council to Barnardo's was seriously unfit for purpose because staff were not permitted to travel any closer than the extreme edge of the wide geographical Argyll & Bute area.

8. There were omissions in the admission paperwork to Dunclutha. It was deficient in terms of Kirsty's self-harming and her condition. There was a problem with communication between staff members. Not everything was written down. There were inconsistencies and failings in reports and risk assessments. The risk profile was not increased to very high on 29 December 2016 when Kirsty asked for a tie and Donna McGivern reported seeing red marks on her neck. They were not taken as a warning that she was contemplating suicide. There was a lack of information being handed over between shifts. There were communication failings when looking to establish whether alleged bullying and panic attacks took place. The significant case review was severely

flawed. It contained a number of material factual errors. It was an incorrect record.

[51] Mr and Mrs McGregor accept that it may not have been possible to prevent Kirsty taking her own life but contend that there were clear warning signs that were ignored or at best given cursory acknowledgement which resulted in a failure to report such risks and incidents. They continued to assert that there was insufficient understanding and credence given to Kirsty's attachment disorder, and the approach of short meetings by agencies failed to give a true understanding of her condition and thus determine the appropriate support to her and the family. As a result the parents were viewed as uncaring, old fashioned and "the problem".

Submissions of behalf of Argyll & Bute Council

[52] The submissions of Argyll & Bute Council (the Council) were that in terms of Section 26(1)(a) the Inquiry was invited to determine that the deceased died on 30 December 2016 at Cowal Community Hospital in Dunoon.

[53] In terms of Section 26(2)(c) the Inquiry was invited to determine that the cause of death was suicide by hanging.

[54] In terms of Section 26(2)(e) the Inquiry was invited to determine that there were no precautions which reasonably could have been taken and had they been taken they might realistically have resulted in the death being avoided.

[55] In terms of Section 26(2)(e) the Inquiry was invited to determine that there were no defects in any system of working which contributed to the death.

[56] In terms of Section 26(2)(g) the Council does not concede that the issues raised by Mr & Mrs McGregor and the Crown are relevant to the circumstances of the death.

[57] In terms of Section 26(1)(b) and (4) of the Act, the Council does not invite the Inquiry to make any recommendations as to the matters mentioned in subsection (4).

[58] Mr Anderson on behalf of the Council in the course of extensive written submissions, then dealt with the various issues which had been raised and identified by the Crown as being germane to the Inquiry. The first of those was

> "whether the deceased should have been placed with a foster carer closer to the family home instead of being moved to Dunclutha Children`s Home, approximately 75 miles away from the deceased home address and causing her to move again to a new school".

The Council's submission was that this issue does not give rise to a matter falling within Section 26(1)(a) and (2)(e) or (g) of the Act. I hope that I do not do a disservice to the Council`s submissions on this matter if I summarise them as follows. This was an emergency situation. Mr and Mrs McGregor could no longer cope with Kirsty. Alternative care arrangements had to be made as a matter of urgency. Mrs McGregor did not want Kirsty to be placed in foster care. The chronology of events was to the effect that no foster placement was realistic and Dunclutha Children`s Home was the only realistic option. It was Mrs McGregor, not social work who insisted that the relocation happen that day. The only other possibility was Shellach View in Oban. It was discounted because of the presence of another child who presented a particular risk in relation to sexualised behaviour and also its proximity to where Mr McGregor worked, the family having expressed the view that they did not wish Kirsty to be in the

Oban area for that reason. There was no availability elsewhere. Mr and Mrs McGregor consented to Kirsty being accommodated at Dunclutha. It was a voluntary arrangement. The suggestion that Kirsty could be placed with a foster carer was not viable. There was an urgent need to find alternative care accommodation which Kirsty could move to that afternoon and not at a later date. In any event, the submissions stated, it was not a precaution which could realistically have resulted in the death being avoided.

[59] The next decision was

> "whether additional support should have been put in place for the deceased thus enabling earlier help for the deceased and her family; in particular during the period between the deceased's first referral to CAHMS and the time of her first appointment".

The submission for the council was that this issue had no relevance to them.

[60] The next submission related to

> "whether there should have been arrangements put in place for the deceased to maintain contact with her adoptive brother following her removal to Dunclutha Children`s Home".

Put shortly Kirsty's brother simply wished to have no involvement with her. He is an adult. The Council could not do anything to require him to have contact with Kirsty. The submission continued to the effect that it was clear that he, because of previous experience with Kirsty did not want any communication or contact with her. Even on 25 December 2016 he declined to accompany his parents to visit Kirsty.

[61] The next submission was to

> "whether an earlier, or comprehensive, risk assessment should have been undertaken to consider what was in the deceased`s best interest; in particular in relation to the deceased`s adoptive parents' capacity to meet her care needs".

The Council position is that this issue does not give rise to matters falling within Section 26(1)(a) and (2)(e) of the Act. Nor does it accept that it gives rise to a matter within Section 26(2)(g). The Council`s submission is that the evidence was clear that those working with the deceased and her family were initially working to keeping the family together and post admission to Dunclutha, were working towards that. In any event there was no causal connection between this approach and the death. According to the submission the picture presented is one of professionals doing their utmost to keep the family together during the period of social work involvement with the family. The Council provided social work assistance to both the parents and Kirsty through the social work teams respectively. The Council submits that the issue of risk assessment is not relevant to the circumstances of the death. Further, and in any event, Dunclutha approached the matter by way of both formal intermittent and dynamic risk assessment. She was risk assessed upon arrival. There was an ongoing process. She was constantly monitored. Although there were periods of bouts of self-harm the risk that the deceased posed to herself was assessed as low. According to the submission the evidence of Donna McGivern, namely that notwithstanding the incident on 17 November 2016, dates and frequency of such events together with the control measures that were in place around the deceased allowed for a reduction in assessed risk of self-harm from medium to low. The Council therefore submitted that there was no evidence before the Inquiry from which it could be properly determined that the deceased`s level of risk was

miscategorised. The incident on the evening of 29/30 December 2016 was dealt with appropriately and with a positive outcome. The deceased gave no indication on 30 December 2016 of an intention to self-harm, suicide or suicidal ideation. There had been no previous suicide attempts.

[62] The next issue addressed in the submissions was "whether and to what extent: the deceased should be involved in the decision directly affecting her". The Council submitted that this issue does not give rise to any matter falling within Section 26(1)(a) and (2)(f) of the Act. The Council also submits that the issue does not give rise to a matter falling within Section 26(2)(g). Even if it was incorrect, there was no causal connection between it and the death. The deceased was able to express her views in relation to matters affecting her. Kirsty McGregor was still a child. On occasion it was not appropriate for her to be party to the decision making process. The Council required to act in Kirsty McGregor`s best interest. There were numerous occasions when Kirsty McGregor had meetings with the social work department. As far as her placement at Dunclutha was concerned that was an emergency situation and it was not practicable to have regard to Kirsty McGregor`s views prior to the alternative care arrangements being put in place. All the LAAC review meetings took into account Kirsty McGregor`s views.

[63] The next issue was

> "whether there should have been an earlier referral to the Scottish Children's Reporters Administration and result in a legal basis for the deceased removal from her parents' rather than this be done on a voluntary basis".

The Council submitted that this issue did not give rise to any matters falling within Section 26(1)(a) and (2)(f) of the Act. Nor does the Council submit that the issue gives rise to matter falling within Section 26(2)(g). The Council submitted that it was appropriate for it to have referred the matter to the Scottish Children's Reporters Administration (SCRA) as it did in December 2016. It was speculative whether SCRA would have applied for a formal order pertaining to the deceased and whether such an order would have been made. In any event Kirsty McGregor was not removed from her parents. Her parents indicated that they were not willing to care for the deceased and as such they requested that alternative care arrangements be put in place. The parents subsequently consented to such an arrangement at Dunclutha.

[64] Mr and Mrs McGregor expressed concern at the apparent lack of appreciation by the social work department that Kirsty McGregor had Attachment Disorder and this was not properly managed. The Council submitted that this issue did not give rise to any matter falling within Section 26(1)(a) and (2)(a) of the Act. Nor does the Council accept that the issue gives rise to a matter in Section 26(2)(g). The Council submits that it had due regard to the attachment issues displayed by the deceased and called upon appropriate specialists in external services in assist in addressing those issues. They submit that the social work records indicate an awareness of this assertion and make further submissions in that regard. As far as the Council was concerned the social work department, CAHMS, staff at Dunclutha and Barnardo's all were aware of and took into account the possibility of Attachment Disorder in their dealings with Kirsty McGregor.

[65] Mr and Mrs McGregor had an issue regarding out of hours social work services. The Council submitted that this did not give rise to any matter falling within Section 26(1)(a) and (2)(e) to (g). The Council submits that appropriate emergency out of hours assistance was provided to the McGregor family when sought. The submission then outlines the evidence which they say supports that contention.

[66] Mr and Mrs McGregor had an issue regarding Dunclutha Children`s Home`s awareness of suicide websites and self-harm in relation to Kirsty. The Council submitted that this issue did not give rise to any matter falling within Section 26(1)(a) and (2)(a) to (g) of the Act. Further and in any event the Council submitted that Dunclutha Children`s Home was aware of reports that the deceased had access to suicide website and self-harmed prior to her admission to Dunclutha and addressed both issues adequately. The Council`s submission then documents the evidence which supports their contention.

[67] Mr and Mrs McGregor raised the issue regarding parental visits to Dunclutha. The Council submitted that this issue did not give rise to any matter falling within Section 26(1)(a) and (2)(e) to (g) of the Act. Further and in any event the Council submits that no restrictions were placed on the McGregor family making contact with Kirsty McGregor by whatever means they wished. The Council points to the record of contact with the parents both by telephone and in person.

[68] Kirsty had been prescribed ADHD medicine, The Council submits that this issue does not give rise to any matter falling within Section 26(1)(a) and (2)(e) to (g) of the Act. The Council points out that Kirsty McGregor had not been diagnosed with the

condition. It was prescribed to her to address issues of impulsivity. There was evidence according to the submission that Kirsty McGregor did not routinely take her ADHD medicine throughout her time at Dunclutha. The Council`s submission was that there was no evidence before the Inquiry that the deceased`s cessation of Concerta medicine (for ADHD) from 25 December 2016 onward is relevant to her mind set on 30 December 2016 and thus the circumstances of her death.

[69] The Council submits that the death of Kirsty McGregor was an unforeseeable event. It was unavoidable. The Council submits that the Inquiry should determine that all of the professionals who were involved with Kirsty McGregor and the McGregor family took the role seriously and displayed care, consideration and compassion in discharge of their duties. It was an unfortunate tragedy.

[70] On the basis of evidence led, the submissions from the Council finally was that the Inquiry should make formal findings under Section 26(1)(a) and (2)(a) and (c) only.

Involvement of Highland Health Board

[71] One of the major criticisms by Mr and Mrs McGregor was that CAHMS Helensburgh and CAHMS Lochgilphead failed to recognise "attachment disorder" a major symptom of which is compulsive lying, and took a one sided approach listening only to the child. According to Mr and Mrs McGregor the conclusions of CAHMS are taken only from interviews with a stressed mother and a child whose condition include lying to getting attention rather than help. Mr and Mrs McGregor took the view that the condition of "attachment" trauma meant that Kirsty was a compulsive liar which was

not acknowledged by professionals and that their information was corrupted and incorrect conclusion drawn.

[72] As far as Highland Health Board are concerned the issue identified by the Crown for the court to consider was

> "whether additional support should have been put in place for the deceased thus enabling earlier help for the deceased and her family; in particular the period in between the deceased's first referral to CAHMS and the time of her first appointment."

[73] Kirsty's first referral to CAHMS was by her GP in December 2014. Dr Farrar, the family GP, referred Kirsty to CAHMS on 18 December 2014. The referral, according to the doctor`s notes, was "routine". The referral letter detailed that Mrs McGregor reported that the deceased had been displaying some concerning behaviour in the years prior, but more recently the deceased had been stealing money and hiding food while at home, had been having problems at school which required her parents attendance, and that she had been telling neighbours that Mr McGregor was punching and hitting her. Dr Farrar, in the referral letter, describes the allegation of assault as "quite untrue". No additional enquires were undertaken into the allegations by Dr Farrar nor does she refer to or seek guidance from the police, social work or the health child protection advisor. Dr Katherine Smith the Clinical Psychologist at CAHMS spoke to Dr Farrar on 22 January 2015 to ascertain if there were any child protection concerns. Dr Farrar is recorded as having confirmed that she knew the family well and had no concerns regarding the deceased and her professional opinion was accepted by Dr Smith. The family were told there was a waiting list for initial assessment and the deceased had

been placed on that list. Mrs McGregor was advised that should there be any deterioration in Kirsty's mental health during the waiting period she should discuss this with her GP in the first instance. Kirsty was offered her first appointment with CAHMS Helensburgh on 11 May 2015. She attended with Mrs McGregor. Mrs McGregor described keys issues as Kirsty's deteriorating behaviour in that she would steal, lie and not admit to anything, that she was attention seeking and always had to be in control. She had difficulty in having relationships with other pupils at school. She was easily distracted and impulsive. Between May 2015 and October 2015 Kirsty and Mrs McGregor attended at a further seven CAHMS appointments in Helensburgh. Four of these appointments were with Mrs McGregor alone. One was with the deceased alone and both attended at one session together although they were seen separately and both attended a joint appointment for the final session. Following the final session at CAHMS Helensburgh on 30 September it was noted that Kirsty's behaviour at home had improved and there was also an improvement in her relationship with Mrs McGregor. No concerns regarding suicide or self-harm were noted. The period between the GP referral and the first appointment at CAHMS was five months. This was a routine referral. There was not an emergency. At no time did the family seek additional support between the first referral and her first appointment. In the note of the session of 20 May 2015 which Mrs McGregor attended she was given a book by Dan Jones on Parenting Techniques. There are also queries whether Kirsty may have "attachment" issues. Dr Katherine Smith, Clinical Psychologist at CAHMS wrote a "base and transfer" e-mail to Dr Arlene Ross on 9 October 2015. This was written in view of the

family's move away from Helensburgh. Dr Smith's conclusion was that Kirsty had been referred to the service for mood/behaviour problems and on assessment the main problem was identified as relationships at home.

[74] In October 2015 Kirsty's care was transferred from Helensburgh to Lochgilphead. Again Arlene Ross the clinical psychologist at Lochgilphead was advised that Kirsty's care would be transferred from Helensburgh to Lochgilphead. The main problem which had previously been identified was relationships at home. The first appointment with Dr Ross was scheduled for 14 January 2016. Mrs McGregor phoned Dr Ross to advise that Kirsty was refusing to leave the room and go to the meeting. Kirsty thought it was a waste of time as there was nothing wrong with her. Mrs McGregor described lots of challenging behaviour including shouting and swearing, lying, stealing and refusing to go to school. She described being exhausted and having had enough. Kirsty could be heard shouting in the background stating that her dad had hit her. It was an allegation by Kirsty that her dad had hit her round the head. Kirsty phoned Dr Ross asking her not to phone social work as she didn't want to end up in a care home. Dr Ross contacted her supervisor because of the allegation. The police became involved and no further action was taken. The next contact Dr Ross had was on 21 January 2016. Mr and Mrs McGregor attended but Kirsty did not. She did not want to be there. Because of the allegation of assault the social work department became involved from that day. Mr and Mrs McGregor were unhappy with CAHMS Lochgilphead that the child protection issue had been entertained and the police had

become involved. Mr and Mrs McGregor indicated that they wanted nothing more to do with CAHMS.

[75] On 9 February 2016 the CAHMS team met to discuss Kirsty's case. It was agreed that a referral to Dr Jamie Houston (Consultant Paediatrician) would be helpful to assess for ADHD. A letter was sent to the GP in Lochgilphead, Dr Romans, dated 24 February 2016. It details Kirsty's history. In that letter it is said "she has shown behaviours that are an indication of insecure attachment difficulties". Eventually the ADHD assessment went ahead, and Dr Houston thought it appropriate to treat Kirsty with a stimulant medication that he would typically use with children with ADHD. He did not however give a further diagnosis of ADHD because of the co-existing "attachment" difficulty. Dr Houston's letter back to Dr Roman diagnoses Kirsty "insecure attachment" amongst other things.

[76] John Mathieson is a mental health nurse at Lochgilphead Hospital. He had been asked by Dr Houston to explore Kirsty's difficulties in some detail. He saw Kirsty in person three times. He did not carry out any work with Kirsty's parents. His last meeting with Kirsty was on 8 September 2016. Subsequently Kirsty was transferred to Dunclutha Children`s Home in Dunoon. He discharged Kirsty from his list. He contacted his equivalent in Dunoon, Peter Cartwright. He told him Kirsty's history.

[77] Kirsty McGregor was referred to Peter Cartwright in Dunoon. Peter Cartwright is a Mental Health Nurse. The transfer was to continue work with Kirsty and engage with her and to assess her mental state. Mr Cartwright's first meeting with Kirsty was

on 12 October 2016 in Dunclutha Children`s Home. Kirsty didn't really want to talk to Mr Cartwright.

[78] On the second meeting on 18 October 2016 Mr Cartwright met with Kirsty again. He asked her about suicide. He asked if she thought of considering killing herself and she said no, she never thought about it. She continued to be uncooperative. Because Kirsty was not co-operative Mr Cartwright sent a letter to Kirsty's social worker, Laura Litster. Because of Kirsty's lack of engagement she was discharged with a recommendation to be referred back if there were any concerns or if Dunclutha staff would like to refer her again. On 1 November 2016 a letter was sent to Kirsty's parents to confirm her discharge.

[79] Looking to the involvement of Highland Health Board I cannot see how they can be criticised. Throughout this period when Kirsty was involved with CAHMS a considerable number of professionals had been involved in her care. Although Mrs McGregor said that she wanted "nothing more to do with them", it does seem to me that a considerable number of professionals were involved with Kirsty both in Helensburgh and in Lochgilphead and all these various issues were either recognised or investigated. There were no identified mental health concerns. The social work department also had become involved after the allegations of assault. Looking at the records it is difficult to see how CAHMS in Helensburgh or Lochgilphead could be criticised for the work which they did. That is pointed out in the submissions. Mr McGregor stated that

> "Judith (his wife) and I had carried out a significant amount of research into attachment disorder, which is essentially the effect of a very young child not being able to form a bond with a parent or guardian in the early stages of life. We fully believed that Kirsty's behaviour was a reflection of this disorder. CAHMS seemed to dismiss this and wouldn't listen when we tried to explain that we considered this to be the cause of Kirsty's behaviour. If anything Kirsty's behaviour deteriorated while she had input from CAHMS."

As it is pointed out in the submissions Mr McGregor was never actively involved with CAHMS during their work with Kirsty. "Attachment" had been raised by Dr Smith with Mrs McGregor during that June 25 meeting. Mrs McGregor was noted to be resistant to the idea at the time. Mrs McGregor said she learned of what she called "attachment disorder" from Laura Dickie whose involvement began only at the time that CAHMS involvement was effectively over in February 2016. It seems to me having heard all the evidence and in particular the evidence of Mr and Mrs McGregor that they viewed "attachment disorder" as the major issue with regard to Kirsty. However all of the professionals dealing with Kirsty seemed to take the view that Kirsty's behaviours were essentially related to family relationships. In all of the investigations in relation to Kirsty no mental health problems were ever established.

[80] In those circumstances it does seem to me that the treatment of Kirsty McGregor by Highland Health Board was appropriate in all of its facets.

Involvement of Barnardo's Scotland

[81] Barnardo's Scotland provides a service known as the Scottish Adoption Support Service (SASS). SASS provided support for Kirsty and her family during 2016.

[82] Mr and Mrs McGregor queried whether the service contacted Barnardo's, which would only come to Helensburgh for meetings, 100 miles away from the family home, is unrealistic and impossible for the objectives of the service to be provided. They also queried whether the extended period between appointments and frequent changes of appointment times caused uncertainty and deterioration of the situation.

[83] SASS provided a leaflet to Mr and Mrs McGregor advising of the range of adoptive related supports that could be provided. This was a voluntary service. Kirsty`s case was allocated to Jo McNeish on 7 March 2016.

[84] Although in their oral evidence Mr and Mrs McGregor considered that the contact that Jo McNeish had with Kirsty could have been more frequent, it was apparent from the records produced by Barnardo's that Jo McNeish was in regular contact first with Mr and Mrs McGregor and then with Kirsty throughout 2016. Jo McNeish had worked with Mr and Mrs McGregor individually before meeting with the family as a whole. The service provided by SASS was not a crisis response. Support was provided on a needs basis. The service was voluntary. It was up to Kirsty McGregor as to whether she chose to engage with the service or not. Kirsty did not engage with Jo McNeish's initial letters and she refused to attend the scheduled meeting in May 2016. When she moved to Dunclutha there was a deliberate decision made by Jo McNeish and the manager of the service to allow Kirsty time to settle at Dunclutha and her new school before arranging further appointments. After Kirsty had settled in Dunclutha Kirsty was offered appointments on a monthly basis and met with Kirsty on 17 November and

9 December 2016. Further appointments were to be offered in January and February 2017 before her untimely death.

[85] The other aspect of criticism levelled by Mr and Mrs McGregor at SASS was the distance that they had to travel in order to meet with Jo McNeish. Argyll and Bute Council subscribed to SASS in 2016. It was not for the SASS to determine the parameters of the service. It was a matter for the Council as to how they managed their resources. SASS is comprised of a small team. There were geographical limitations as to what they could do. Their involvement with Mr and Mrs McGregor and Kirsty were confined to those parameters. This was not a statutory service. This was a service which was voluntary and this was made clear from the outset. In these circumstances I cannot see that any relevant criticism can be directed towards Barnardo's or SASS for what they did. Because of the nature of the service there were restrictions in terms of how far members could travel and that was dictated by staff capacity and a number of existing service users. I did gain the impression that apart from the specific criticisms levelled by Mr and Mrs McGregor they were on the whole happy with the work undertaken by Barnardo's and SASS. In my opinion Barnardo's and SASS worked within the confines of cost and locality in an appropriate manner.

Involvement of Argyll & Bute Council

[86] Argyll and Bute Council were a major participant in the Inquiry. The Council also used the external service of Barnardo's since Barnardo's had specialist expertise in relation to these issues.

[87] A number of issues were raised at the Inquiry by the Crown. Some of them related particularly to the Council's involvement. The first was

> "whether the deceased should have been placed with a foster carer closer to the family home, instead of being moved to Dunclutha Children`s Home, approximately 70 miles away from the deceased address causing her to move again to a new school".

This issue has to be looked at against the background of circumstances. In July and August 2016 Mrs McGregor told the social work department that she could no longer cope with Kirsty. She wanted to discuss alternative care arrangements. Social Work were keen not to remove Kirsty from the families care but to try and keep the family together. On 27 September 2016 Mrs McGregor contacted the social work department to advise that the parents were looking for social work to provide alternative arrangements for the deceased as they could no longer cope. From then until the 30 September 2016 various options were considered. Mrs McGregor understandably did not want Kirsty to be placed in foster care. Despite that a number of options were identified. Two of them involved possible placements with families offering foster respite. For different reasons both of those turned out to be unsuitable. Although the Council had pursued a proposal to offer a fostering placement up until the morning of 30 September 2016 that became impossible because Mrs McGregor contacted social work on 30 September 2016 and insisted that Kirsty be accommodated elsewhere that day. Kirsty had gone to school that day. Mrs McGregor insisted that she should not return from school to continue living at home. Mrs McGregor had clearly reached the end of the road as far as accommodating Kirsty was concerned. Dunclutha was identified. That placement may

not have been desirable but was in the circumstances absolutely necessary. Kirsty had to be accommodated somewhere appropriate. The two options that the Council had prior to 30 September were in Oban and Helensburgh and both turned out to be completely unsuitable. In these circumstances the only viable option was Dunclutha. In my opinion no criticisms should be attached to the decision of the Council to accommodate Kirsty McGregor at Dunclutha Children`s Home. In my opinion there was no option.

[88] The second issue relative to the Council was

> "whether there should have been arrangements put in place for the deceased to maintain contact with her adoptive brother following her removal to Dunclutha Children`s Home".

[89] The simple fact of the matter here is that Kirsty's brother, wanted nothing to do with her. He was an adult. He did not want to visit Kirsty at Dunclutha. He made his feelings perfectly clear. He had no direct contact with her during her time there. Although Kirsty might have wanted to keep in contact him that view was not reciprocated. All of the social work records produced by the Council make that fact clear. He ignored a letter Kirsty had written to him and he told his father that if Kirsty came back home then he would leave. He declined to go with his parents to visit Kirsty on Christmas day. It is clear from all the evidence that the relationship between Kirsty and her brother had deteriorated to the extent that he wanted nothing more to do with Kirsty. That was a choice he was entitled to make and he did so. Nothing that the Council did prevented Kirsty from attempting to maintain contact with her adoptive brother. At the same time it was not part of the Council's function to persuade him to

do something that he clearly did not want to do and that was to maintain contact with his sister.

[90] The third issue is

> "whether an earlier, more comprehensive risk assessment should have been undertaken to consider what was in the deceased interests, in particular in relation to the deceased's adoptive parents' capacity to meet her care needs".

The social work records in this regard are extensive. They run to hundreds of pages. Kirsty McGregor suffered from a number of difficult issues. They were complex. Numerous professionals were involved with her. Not only was Kirsty supported by professionals, Mr and Mrs McGregor were also supported by Laura Dickie and then Kirsty Taylor. Kirsty was also receiving support from Sarah Simpson with involvement and oversight from Laura Litster. Up until September 2016 it was not obvious to anyone that Mr and Mrs McGregor were completely incapable of looking after Kirsty. There were clearly many difficulties but it was not anticipated that Mr and Mrs McGregor would eventually feel that they were completely unable to look after Kirsty and that she would have to leave the family home.

[91] There was a risk assessment done on Kirsty when she arrived at Dunclutha. As was pointed out in the Council submissions risk assessment is not simply at one particular point in time. It is continuous. Daily case notes from Dunclutha confirm that. Laura Litster on 30 September on 2016 provided an integrated risk assessment. Although there had been previous reports of self-harm, the risk which the deceased posed to herself was assessed as low. Sabrina Ayachi was a social care worker at Dunclutha. She was aware that Kirsty had self-harmed prior to admission. In her

affidavit she stated that Kirsty did not admit to self-harming but she noticed cuts to her arms that were superficial. Donna McGivern who was employed at Dunclutha gave evidence in her affidavit of the controlled measures which were in place around Kirsty that allowed for a reduction in assessed risk of self-harm from medium to low. On 29 – 30 December 2016 any issues were addressed at the time and when Kirsty went to bed she was checked regularly. On 30 December 2016 she was checked throughout the morning with no issues arising.

[92] The fourth issue raised by the Crown was "whether and to what extent, the deceased should have been involved in the decision directly affecting her". Kirsty McGregor was a child. The whole emphasis during the Council's involvement with Kirsty was to attempt to keep the family together. It is clear from the records that throughout, Kirsty was aware of the various agencies that were involved with her. She made her feelings known on a number of occasions. She did not want to co-operate with some of those involved with her. She co-operated rather better with others. The Council's duty was to act in her best interest.

[93] The social work records make it clear that Kirsty was attended by social workers on a regular basis. From January 2016 until September 2016 she had approximately 25 meetings with social workers. During that period she was living with her parents. That only changed after the emergency on 30 September 2016 when her mother phoned the social work department to advise that she could no longer cope. For reasons which I have previously indicated what happened on 30 September 2016 was an emergency. Kirsty's views would not have been taken into account. There was no option but to

place her in Dunclutha. The LAAC review on 5 October 2016 gave an opportunity for everyone, including Kirsty and her parents, to plan for the future. A further review was held on 13 November 2016. Kirsty's views were relayed by Rosemary Drylie. Kirsty left the meeting at the appropriate time so that other issues could be discussed whilst she was not present. That was an appropriate step to take. Her views were at all times taken into account.

[94] The next issue raised by the Crown was

> "whether there should have been an earlier referral to the Scottish Children's Reporters Administration and, as a result, a legal basis for the deceased removal from her parents, rather than this be done on a voluntary basis".

As was pointed out in the submissions the deceased was not removed from her parents. Mr and Mrs McGregor requested alternative care arrangements be put in place. A recommendation that Kirsty's case should be referred to the SCRA was made following on from the Sunday to her meeting after Kirsty's admission to Dunclutha and thereafter following the 6 week LAAC review. The referral was not made until 7 December 2016. It clearly could have been made earlier. However a voluntary placement had been agreed and Brian Reid, the social worker said in his affidavit "it was difficult to see what a compulsory supervision order would have added". I agree with that conclusion.

[95] The previous instance where allegations of assault had been made were dismissed by Dr Farrar, the general practitioner, who was of the view that Kirsty was not in any danger at that time. An earlier referral could obviously have been made but all of the professionals involved were of the view that this was not necessary in the circumstances. The whole emphasis was working towards keeping the family together.

After admission to Dunclutha the emphasis was on Kirsty maintaining regular contact with her family and work was being done with a view to her returning eventually to the family home.

"Attachment Disorder"

[96] Mr and Mrs McGregor throughout the inquiry and in their submission express concern as to an apparent lack of appreciation by the social work department that Kirsty had "attachment disorder" and it was not "properly managed". However the social work records and Barnardo's records make it clear that "attachment disorder" was recognised and considered. On 31 March 2016 Laura Litster visited Mrs McGregor and Kirsty. Mrs McGregor asserted (although she denies this) that Kirsty was brain damaged and had attachment disorder. Similar comments by Mrs McGregor were recorded by Sarah Simpson the social worker. Laura Litster gave Mr and Mrs McGregor a publication to assist with attachment issues. Both Sarah Simpson and Laura Dickie discussed Mrs McGregor`s views on attachment issues with her. Kirsty Taylor advised that the deceased had attachment difficulties and discussed it with her parents. Lorraine Prentice was employed by the Council as the practice lead within the family placement team was asked about her knowledge and awareness of attachment disorder. In her affidavit she states

> "in terms of your social work training it is part of your bread and butter. All social workers will know about and understand attachment. It is the route of a lot of the difficulties that social workers deal with".

[97] Mr and Mrs McGregor raised the issue of out of hour's social work service. Mrs McGregor stated that in relation to calls to an out of hours emergency call centre in May and June, help is not available on a Saturday night at a point of crisis, the family being told that no one would be out to help them and that they should call the police. However that does not accord with the records. The records show that an initial call was made, and the on call social worker contacted the family and spoke with Mrs McGregor. A full history was taken. Mrs Gregor was called back by the on call social worker. It was agreed that social work would call the following morning. On each occasion telephone discussions took place to discuss in detail what was occurring. On each occasion matters calmed down. No further assistance was sought. The Council in my opinion cannot be criticised for their response in any of these cases.

Dunclutha Awareness of Suicide Websites and Self Harm

[98] Mrs McGregor asked Gillian Clark as to her knowledge regarding the deceased accessing suicide websites and whether she had self-harmed in the past. Laura Litster advised Dunclutha that this had taken place and Gillian Clark was informed. Sabrina Ayachi was also aware. Kirsty's electronic device histories were checked at night. She signed the electronic devices acceptable use policy. There was no evidence that Kirsty ever accessed any suicide website whilst at Dunclutha.

[99] As far as self-harm was concerned there was a reported history of self-harming whilst Kirsty was accommodated at home. In January 2016 low level self-harm scratches were noted. Mrs McGregor reported in June 2016 that Kirsty had self-harmed in the

past. Laura Litster also reports that Kirsty had self-harmed by cutting her arms in the admission/transfer form completed on 30 September 2016 when Kirsty went to Dunclutha. Sabrina Ayachi was also aware. The records show only one occasion when it was known that Kirsty self-harmed at Dunclutha. On 18 November 2016 Kirsty sustained superficial cuts to her right leg. These were cleaned and dressed. Mrs McGregor was advised of the incident.

[100] On 29 December 2016 staff suspected that Kirsty might have self-harmed. She had red marks on her neck. She asked for her school tie. That was not given to her. Because staff were suspicious of her demeanour she was checked at regular intervals during the period 23.00 – 0015. At 0015 Kirsty chatted to staff in the kitchen. Kirsty returned to her room at 0045. She was checked again at 0115 and at 0145 when she was asleep. No further issues arose during the course of the evening.

Parental Visits to Dunclutha

[101] Although this was raised by Mr and Mrs McGregor, I accept as accurate the Dunclutha record of contact with Mr and Mrs McGregor both by telephone and in person. No restrictions were placed family making contact with Kirsty by whatever means. The records make that perfectly clear.

ADHD Medication

[102] There was evidence at the Inquiry that Kirsty did not take her ADHD medication in her latter days. She did not regularly take it during her time at Dunclutha. However

there is no evidence that that had any bearing on the eventual outcome in this particular case.

[103] It was clear throughout the Inquiry that Mr and Mrs McGregor were profoundly upset at what had happened. Despite that and despite criticisms which they made with regard to all of the participants in the Inquiry I consider those criticisms to be unfounded. Of course on occasion things should be done more quickly. Notes should perhaps be more comprehensive. Appointments should ideally be nearer to home. However we live in an imperfect world. The crucial issue in this case is whether any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death being avoided. One might not agree with everything which was said or done but that does not mean that they were wrong. In my opinion none of these criticisms of the social workers is justified.

[104] Argyll and Bute Council submitted that the tragic event of the afternoon of 30 December 2016 was not foreseeable. They point out that on Thursday 29 December 2016 the deceased was recorded to have been in good spirits. Mrs McGregor attached significance to the events of 29/30 December 2016 and to what is recorded as bruising to Kirsty's neck. This occurred in the early hours of 30 December 2016. It gave no indication as to what was to occur later on. Kirsty's mood had improved and there was no concern for her throughout the night. Kirsty had bought a new dress for her grandmother's forthcoming birthday celebration which she was looking forward to. She went to her room and returned wearing the dress over her clothing. She talked about alterations to the dress even down to the detail of ensuring the thread was the correct

colour. She remained in the company of others until 14.25 when she returned to her room. There was absolutely no suggestion that she was going to do what she did.

Conclusions

[105] Any death in these circumstances is a tragedy. It is even more tragic if the death involves a child. This Inquiry had a plethora of evidence in the form of affidavits, social work records, medical records and oral evidence. There were substantial submissions from all of the parties involved. Those submissions were supplemented by oral submissions.

[106] The real issue in this Inquiry is in terms of Section 26(2)(e) "to determine any precautions which could reasonably have been taken, and had they been taken might realistically have resulted in the death being avoided." For reasons which I have previously indicated I do not consider that any other precautions which could reasonably have been taken might realistically have resulted in the death being avoided. One of the issues for Mr and Mrs McGregor was the evidence of self-harm which Kirsty McGregor had exhibited prior to her death and the fact that she had asked for and been refused her school tie. There is no doubt, on the evidence, that these matters were taken seriously by the staff at Dunclutha and had been noted to have taken place. The self-harming was superficial. The request for the tie was refused. Thereafter Kirsty was observed closely. The staff clearly were worried at that stage. However, on observation, Kirsty became better humoured and went to bed. She was observed until she fell asleep. Nothing untoward happened that time. When she got up from bed the next morning

she exhibited no suicidal or self-harming tendencies. On the contrary her mood was quite buoyant. No one, in my opinion, could have predicted that she was going to commit suicide.

[107] Section 26(2)(f) enjoins the Sheriff to "determine any defects in any system of working which contributed to the death or any accident resulting in the death in terms of Section 26(2)(f)". In my opinion the totality of the evidence does not indicate any defects in the system of working which contributed to the death. The oral evidence and the evidence contained within all of the records presented to the Inquiry makes it clear that all of the professionals involved in Kirsty's case dealt with her and her parents prior to her death in a professional manner. Kirsty was a difficult child. She had many and complex difficulties. All of them were enquired into and dealt with to the best of each of the professionals' ability. Kirsty's removal was caused by Mr and Mrs McGregor`s inability to continue to care for Kirsty because of her challenging behaviour. I do not criticise them for that. However it placed the Council in a difficult situation and in my opinion they dealt with that appropriately. In addition Kirsty's care while at Dunclutha was appropriate and although Mr and Mrs McGregor criticised the home for their reaction to Kirsty's self-harming and asking for the tie in my opinion the action that was taken at that time by the workers concerned was appropriate in the circumstances. I do not consider that they can be criticised for what they did. They did identify the problem which had emanated at that time and they dealt with it. What happened the next day in my opinion could not have been predicted.

[108] Mr and Mrs McGregor made a final submission to the Inquiry which was intended to highlight some key failures and procedures "which ultimately led to the death of our daughter whilst in the care of Argyll & Bute Council". Mrs and Mrs McGregor pointed out that Kirsty's behavioural problems started much earlier in life. This related to her time at primary school. That was not the focus of the Inquiry. Nor do I accept that the social work department and the other professionals did not take into account the issue of attachment trauma. In my opinion the evidence shows otherwise. Kirsty may have been a compulsive liar but it was incumbent upon the professionals to whom she spoke, to take into account what she was saying, in case there was any truth in it. In my opinion it is not unusual for different persons to have different opinions in relation to a child's behaviour. The fact that there were different views amongst the professionals does not mean that one side was wrong and the other right. There was a view expressed that Mr and Mrs McGregor`s parenting skills were "old style". Despite that, most of the professionals dealing with Mr and Mrs McGregor were aware that they were seeking help and willing to learn new techniques if they were told about them. As far as the complaint that there was a lack of communication when alternative accommodation was being sought for Kirsty in the last week of September 2016 I do not consider that to be a valid criticism. This was at a time when Mrs McGregor had indicated that she was at the end of her tether. Various options were considered. None of them proved to be suitable. There would have been no point in the social work department advising Mr and Mrs McGregor of every possible option when the majority of them were clearly not suitable. Matters came to a head when the social

work department were told that Kirsty could not come back home. In those circumstances there was an emergency situation which in my opinion was dealt with correctly. Mr and Mrs McGregor complained that they were left without support for a period of five months in 2016 due to staff changes. However the family placement team was available and at least two social workers were working with Kirsty at the time. There was no request as far as I can see in the papers before me for any extra support.

[109] The family practise lead within the family placement team was Lorraine Prentice. She was not aware of specific details of work done by her staff. That is criticised by Mr and Mrs McGregor. I do not think that is a justifiable criticism either. Lorraine Prentice had a managerial role. She would expect her own staff to carry out their duties conscientiously. The evidence suggests that was the case. Mr and Mrs McGregor also contend that there was an adverse attitude towards them by Lorraine Prentice. It is suggested that she had a prejudiced view. That again in my opinion is unjustified. Lorraine Prentice had no direct involvement with the family. She was in a managerial position. There is no reason why different social workers should not have had different opinions. It seems to be suggested in some way that an allegation of assault by Mr McGregor should not have reported to the authorities. Again I do not accept that. The matter was investigated and no further action was taken. It would be the social work department's responsibility to refer matters such as this to the appropriate authorities.

[110] As far as self-harming was concerned as I previously indicated it was recognised by the staff at Dunclutha and they were aware of it.

[111] The staff at Dunclutha were criticised by Mr and Mrs McGregor by not raising the risk profile attached to Kirsty after the incidents on 29 December 2016. However, as can be seen from the actions taken by the staff, they were aware of the problems and necessarily did raise the profile by having constant observation that evening on Kirsty.

[112] Mr and Mrs McGregor referred to a case involving the death of a person called BM. Without disregarding what Mr and Mrs McGregor said I think it fair to point out that the evidence in that particular case was completely different from what pertains here.

[113] The Crown invited me to determine in terms of Section 26(2)(g) of the Act "any other facts which are relevant to the circumstances of the death". The Crown invites me in terms of that section to make any other comments or findings which I consider appropriate. That is on the basis that this section offers me wide scope and there is no requirement for there to be a causal connection or link between the fact and the death. There is, nonetheless, a requirement from the facts established under the subsection to be relevant to the circumstances of the death. The Crown suggests that the issues which are identified are relevant to the circumstances of the death of Kirsty with the exception of the issue in relation to contact between Kirsty and her brother. I do not consider in this case that that would be appropriate. Even on the Crown's own submissions I find it difficult to see that any of the facts established in this case are relevant to the circumstances of the death.

[114] All of the parties to this Inquiry contributed to keeping this Inquiry within manageable bounds. There were a substantial amount of witnesses, evidence and affidavits. To all of them I am most grateful.

[115] I also offer my condolences to Mr and Mrs McGregor for their sad loss.