Lee Johnstone GP Records - Scottish Redress Evidence Review

Source reviewed: Lee Johnstone GP Records(3).pdf (290 PDF pages). Page numbers below are the PDF page numbers printed in the iGPR report.

Important: No explicit contemporaneous GP record of physical or sexual abuse in a care setting was identified in the reviewed material. Symptoms such as enuresis, behaviour problems or later mental-health/substance-use conditions are not treated as proof of abuse unless the record itself makes that connection.

Extraction schedule

DF page	Date / document	Category	Exact evidence / faithful summary	Care setting / person	Treatment / follow-up	Evidential value / link
	28 Aug 2024 GP telephone note	Mental health / impact	Struggling with anxiety and low mood; legal proceedings relating to childhood trauma; awaiting psychology.	No institution named	Psychology appointment awaited	Impact; explicit childhood-trauma reference but no abuse details.
	Historic problem list	Injury / behavioural indicators	Closed fracture neck/shaft of right femur (1983); enuresis (1982); encopresis (1984); behaviour problem (1985); alcohol misuse coding from 1990.	No care address recorded	See detailed letters on pp. 273, 277, 281	Corroborates childhood medical history; does not establish abuse or placement.
	Medication list, 2001-2025	Mental-health medication / substance treatment	Citalopram, paroxetine, venlafaxine, mirtazapine; chlordiazepoxide for detoxification; Buvidal.	N/A	Medication and addiction services	Treatment/impact evidence; medication alone does not prove trauma.
1-18	2025 addiction psychiatry letters	Mental health / substance use / neutral findings	Opioid dependence treated with Buvidal; low mood, anxiety, insomnia, social isolation and relationship/work difficulties. Repeated notes record no recent self-harm/suicidal thoughts or major psychotic disorder.	N/A	START addictions team; mirtazapine considered/trialled; psychological support discussed	Treatment and impact; includes important negative risk findings.
1-22	Dec 2024 GP-addictions correspondence	Mental health medication	Severe insomnia while on Buvidal, affecting daytime function; psychiatrist suggested psychosocial approaches and possible mirtazapine or sertraline.	N/A	GP/consultant correspondence	Treatment and impact.
7-28	Aug 2024 addiction psychiatry letter	Substance use / mental health / social impact	Abstinent after methadone-to-Buvidal transfer; anxiety, lowered mood, broken sleep, unemployment/benefits and family stress. No recent self-harm/suicidal thoughts.	N/A	START addictions service and CPN	Treatment, social impact and neutral risk findings.
5-37	Mar-Apr 2024 addiction letters	Substance use	Long heroin history; methadone 40 mg; occasional unprescribed benzodiazepines; transfer to Espranor/Buvidal.	N/A	Addictions psychiatry and START	Direct evidence of dependence and treatment; no recorded link to childhood abuse.
73	12 Feb 1985 child psychiatry report	Child mental health / emotional indicators	School behaviour difficulties, enuresis, aggression/peer issues, restlessness and distractibility. Clinician recorded no serious psychiatric disorder, no fears or worries, and no clear emotional problem suitable for psychotherapy.	Home address appears to be Girvan; no care placement identified	Short psychotherapy trial and haloperidol 1.5 mg at bedtime	Contemporaneous childhood assessment; includes neutral/contradictory findings.
76	Historic referral, date unclear	Child health / behavioural indicator	Referral mentions school difficulties and persistent nocturnal enuresis.	No care setting named	Assessment requested	Possible corroborative indicator only; not linked to abuse.
77	15 Aug 1983 orthopaedic letter	Physical injury	Admitted 4 July 1983 after closed fracture of right femur; manipulated under general anaesthetic, treated in splint, post-manipulation X-rays satisfactory; mobilised and discharged home with follow-up. Cause is not stated in the letter.	Home, not institution	Surgery/manipulation, splint, X-rays, fracture clinic follow-up	Direct injury/treatment evidence; no perpetrator, abuse link or safeguarding action recorded.

DF page	Date / document	Category	Exact evidence / faithful summary	Care setting / person	Treatment / follow-up	Evidential value / link
81	26 Jul 1982 paediatric letter	Child health / emotional indicator	Nocturnal enuresis after prior bladder control; described as apprehensive; normal examination and urine testing.	Home address in Maybole; no care setting named	Observation/review; previous drug therapy noted	Possible indicator only; no abuse connectio recorded.
88	6 Sep 2001 GP referral to CMHT	PTSD / injury / substance use	Burns to trunk, genitals, arms and hands in chip-pan fire; nightmares, flashbacks and fear of kitchen; drinking and smoking excessively to calm nerves. GP diagnosed/referred for post-traumatic stress disorder.	No care setting	Citalopram 20 mg; supportive/insight-oriented psychotherapy requested	Direct trauma-treatment evidence, but trauma was an adult domestic fire, not childhood care abuse.

Category findings

1. Evidence of placement in care

No GP entry identified that records Kerelaw, Newfield, Redbrae or another care setting as the patient home address, or records admission/discharge/GP registration linked to a placement. The GP file therefore does not independently prove the residential placements identified in the social-work records.

2. Physical abuse

No explicit disclosure that staff, carers or residents hit, restrained or otherwise physically abused the patient was identified. The childhood femur fracture is documented on page 277, but the cause is not stated and no abuse connection is made.

3. Sexual abuse

No explicit or indirect disclosure of sexual abuse in care was identified. The record of burns to the genitals on page 288 relates to an adult chip-pan fire and is not evidence of sexual abuse.

4. Emotional or psychological abuse

No explicit staff-based humiliation, threats or fear of a care setting was identified in the GP file. Childhood behaviour, apprehension and enuresis are recorded, but without an abuse link.

5. Neglect

No clear medical, physical or safeguarding neglect attributable to a care placement was identified.

6. Contemporaneous disclosures

No contemporaneous disclosure that a staff member or resident hurt the patient, or that he was unsafe or did not wish to return to a care setting, was identified.

7-10. Mental health, medication, therapy, self-harm

Relevant pages are 3, 7, 11-18, 21-22, 27-28 and 288. The records document anxiety, low mood, insomnia, panic/social anxiety, PTSD after an adult fire, antidepressant treatment and psychiatry/addiction follow-up. Several psychiatric letters explicitly record no recent self-harm or suicidal thoughts.

11. Substance and alcohol use

Relevant pages are 1, 5, 7, 11-18, 27-28 and 35-37. The file records alcohol dependence/misuse, heroin/opioid dependence, methadone, Espranor/Buvidal, detoxification and occasional benzodiazepine use. No explicit statement links substance use to childhood abuse.

12-13. Adult physical and social impact

Adult PTSD symptoms after a fire are on page 288. Work, benefits, isolation and relationship difficulties are described in psychiatry letters on pages 12, 14, 18 and 28. The records do not expressly attribute these impacts to abuse in care.

14. Third-party records

The file includes extensive hospital, respiratory, psychiatric and addiction-service correspondence, plus scanned historic paediatric and orthopaedic letters. The highlighted copy marks the pages most relevant to the requested categories.

15. Contradictory or neutral entries

Page 273 records no fears/worries and no serious psychiatric disorder; multiple modern psychiatry letters record no recent self-harm/suicidal thoughts or psychosis. These neutral findings should be retained in context.