Helen Andrews - Care Records Evidence Review

Source: Helen Andrews_Redacted - Final (1).pdf | 137 scanned handwritten pages

Review conclusions

- The file is a residential daily log covering 19 December 1980 to 11 September 1984. It repeatedly identifies the subject as Helen Andrews and records daily life in a staffed establishment.
- Carolina House is expressly named on PDF pages 90-91. Those pages also contain Helen's own statements that she was in care, wanted to leave as soon as possible, sometimes disliked staff, and preferred staying with her grandmother.
- The strongest direct physical-abuse entry is PDF page 82, dated 1 September 1983, recording that another resident punched and kicked Helen several times and threw soapy water over her in bed.
- No clear direct disclosure of sexual abuse was located in this document. No explicit care order, Children's Hearing decision, admission form, discharge form, controlling authority, establishment address or date of birth was located.
- The handwriting is frequently faint, partly redacted and sometimes ambiguous. The schedule below uses cautious summaries and flags where wording is unclear rather than treating uncertain text as fact.

Proof of placement and eligibility

- Full name: Helen Andrews (visible repeatedly, including page 1).
- Date of birth / former names: not found in the reviewed pages.
- Care setting: Carolina House (explicitly named on pages 90-91). The establishment address is not shown.
- Placement period supported by this file: at least 19 December 1980 to 11 September 1984. These are the first and last dated entries, not necessarily formal admission/discharge dates.
- Placement authority / legal basis / funding / care order: not identified in the document.
- Professional involvement: social worker involvement and leave/interview planning are recorded, including pages 114 and 118.
- Education, medical care and family leave are repeatedly coordinated by residential staff, corroborating residence.

Category findings

Physical abuse: Direct peer-on-peer assault on page 82; further fights/peer conflict on pages 42 and 113. No clear entry was found alleging staff physically assaulted Helen.

Sexual abuse: No explicit or indirect sexual-abuse entry was identified in this file.

Emotional / psychological: Pages 90-91 record dissatisfaction with staff and a wish to leave care. Pages 82, 112, 118 and 123 contain significant distress, fear, conflict or low mood.

Neglect: No clear evidence of deprivation of food, clothing, accommodation, education or medical care was identified. The records frequently show meals, outings, school, GP/hospital care and family contact. This is neutral/contradictory evidence and does not exclude abuse.

Institutional knowledge / failure to act: The page 82 assault is recorded, but the same entry does not document a safeguarding referral or investigation. Absence from the entry should not be treated as proof no action occurred elsewhere.

Substance use: Page 124 records alcohol use associated with an argument and risky behaviour.

Life impact: The file records school attendance, work experience and a job interview/job offer (page 118), alongside repeated behavioural and emotional difficulties.

Page-reference schedule

PDF page	Date	Category	Factual extract / summary	Evidential value
1	19-24 Dec 1980	Placement / identity	The page is headed "Helen Andrews" and contains daily residential-care entries, including outings, meals, bedtime and contact with grandmother. Identifies the applicant and shows she was resident in a staffed care setting by December 1980.	Direct placement evidence
5	26 Jan 1981	Family contact / emotional impact	Detailed entry records a proposed stay with grandparents, uncertainty over whether they would have her, Helen being upset, and discussion about the length of the stay. Shows residential staff managing family contact and records distress connected with home leave.	Corroborative placement/impact
19	22 Jun 1981	Medical / placement	Entry records Helen attending a GP practice with other children. Medical attendance arranged from the residential setting supports residence and institutional care.	Corroborative placement evidence
42	16 Apr 1982	Peer violence	Entry records Helen had a fight with another child and later apologised for her behaviour. Contemporaneous record of peer-on-peer physical conflict in the placement.	Direct incident evidence
44	4 May 1982	Medical consequence	Entry records Helen being taken to hospital at night and returning without apparent difficulty. Shows institutional staff arranging hospital attendance; the underlying reason is partly unclear/redacted.	Corroborative medical evidence
68	14-15 Mar 1983	Bullying / peer conflict	Entries record Helen being "slagged" by another boy and then herself "slagging" another child. Evidence of repeated hostile peer interactions; wording should be read as	Corroborative impact/context

			bullying/peer conflict, not proof of staff abuse.	
82	29 Aug 1983	Psychological distress	After school Helen became highly distressed, crying, shouting and screaming, dialled 999, and police attended and spoke to her. Contemporaneous evidence of acute emotional/behavioural distress and police involvement.	Direct impact evidence
82	1 Sep 1983	Physical abuse by resident	A named/redacted resident "punched & kicked her a few times" and then threw soapy water over her in bed. Direct contemporaneous record of peer-on-peer physical assault in the care setting. No clear safeguarding investigation is recorded in the same entry.	Direct abuse evidence
90	Undated questionnaire	Placement / emotional complaint	Asked "Do you like living in Carolina House?" Helen answered: "No the staff gets on your back sometimes" and said she would prefer staying at her grandmother's. Explicitly identifies Carolina House as the care setting and records dissatisfaction with staff and a preference to live with family.	Direct placement and emotional evidence
90	Undated questionnaire	Home leave / residence pattern	Helen says she sometimes stays at the house, sometimes goes to her gran's or mother's, and stays with her gran every second weekend. Confirms Carolina House as her usual placement with regular family/home leave.	Direct placement evidence
91	Undated questionnaire	Leaving care / staff views	Asked when she was thinking of leaving care, Helen wrote "as soon as possible please". She wrote that some staff were very good, some quite good, and some she did not like. Direct evidence that she was in care, wanted to leave, and had mixed views of staff.	Direct placement/emotional evidence
96	22-29 Nov 1983	Hospital / placement	Entries record Helen being in hospital, staff visiting her, discharge home from hospital, continuing pain, and further medical appointments. Shows medical care being	Corroborative placement/medical evidence

			coordinated through the residential placement and documents a period of physical illness/pain.	
110	10-13 Mar 1984	Injury / behaviour	Entries record complaints of falling downstairs and ankle pain, bandaging, and later an incident in which she hit a staff member during an excitable episode. Records injury complaints and physical conflict. The notes portray some complaints as attention-seeking; this is a potentially contradictory/neutral characterisation that should not be omitted.	Direct incident and contradictory evidence
112	22-23 Mar 1984	Medical and psychological impact	Helen was taken to hospital for persistent wrist pain. The next entry records her being shaken and frightened after seeing a man she thought resembled someone connected with prison, and worrying he could harm her or her gran. Evidence of medical treatment and pronounced fear/anxiety. The record does not identify this as abuse in the placement.	Impact/medical evidence
113	27 Mar 1984	Peer assault / emotional distress	Following a school confrontation, Helen was involved in a fight, cried, required calming and was later restricted/grounded. Contemporaneous record of peer violence, distress and institutional response.	Direct incident evidence
114	28 Mar 1984	Social-work involvement / leave planning	A meeting was arranged to discuss overnight stays with her grandmother; the social worker could not attend due to illness and another meeting was to be arranged. Shows social-work oversight and formal planning of family contact while resident in care.	Direct placement evidence
118	23 Apr 1984	Social-work / transition	Helen was taken by her social worker to an interview and obtained a job due to start the following Monday. Shows named professional involvement and transition/aftercare-type planning while in placement.	Direct placement/aftercare evidence

118	25 Apr 1984	Emotional conflict / room restriction	After returning from her grandmother's, Helen said staff were always blaming her; she was sent to her room and was described as lashing out and refusing to talk. Records conflict with staff, perceived blame, emotional distress and room-based restriction. It does not by itself prove emotional abuse.	Possible corroborative emotional evidence
123	24 May 1984	Depression / low mood	Entry describes Helen as depressed and records a statement suggesting life felt pointless/useless, followed by crying and going to bed. Contemporaneous evidence of significant low mood and emotional distress. Exact wording is partly obscured/redacted.	Direct impact evidence
124	2 Jun 1984	Alcohol / risk behaviour	Entry describes Helen returning after drinking, an argument and an attempt to climb out through a window before being calmed. Evidence of alcohol use, acute behavioural risk and staff intervention.	Direct impact/substance evidence
137	11 Sep 1984	Placement chronology	Final page records Helen returning from work, spending the evening in the home, watching television and going to bed, with staff noting her mood. Shows continued residence in the staffed placement through at least 11 September 1984.	Direct placement evidence

Important limitations

This is an evidential review of a heavily redacted handwritten residential log. Some names and key words are obscured. The highlighted copy marks the relevant entry blocks, not only individual words. The absence of an item from this schedule means it was not clearly identifiable in this file; it does not establish that the event did not occur or that other records do not exist.