# Medical Records Evidence Review

**SAR-H-Andrews - page-referenced extraction schedule**

Prepared from the 475-page iGPR report supplied for review

Important review note: Pages 52-475 largely comprise scanned attachments. The strongest relevant scanned psychiatric report is at PDF pages 90-92. OCR wording from scanned pages has been checked against the page image where relied upon, but names redacted in the source remain redacted. No medical symptom is treated as proof of abuse unless the record itself makes that connection.

## Executive findings

- Placement evidence is limited: page 3 records uncertainty about family history because the patient was “looked after”; the psychiatric assessment at pages 90-92 appears to record residence in a care home, but the institution name and dates are not legible/identified.
- Direct abuse-related evidence includes a historic entry dated 15 March 1996 recording suicidal ideation with “disclosure of previous rape” (PDF page 24), and a 4 September 2023 GP entry describing symptoms as mostly PTSD related to sexual abuse and rape (PDF page 19).
- The records contain extensive evidence of mental-health impact, suicidal ideation, previous attempts/overdoses, self-harm history, psychiatric care, and long-term quetiapine/trazodone prescribing.
- No clear direct entry was identified in the verified passages describing physical abuse, a named perpetrator, a named residential institution, admission/discharge dates, or safeguarding/police action concerning historic abuse.

## Detailed extraction schedule

| PDF page | Date | Document / clinician | Category | Exact evidence / faithful summary | Care setting / perpetrator | Impact / treatment / follow-up | Link & evidential value |
|---|---|---|---|---|---|---|---|
| 3 | 20-Feb-2026 | GP consultation - Dr Helen Blanchfield | Placement | Family history recorded as uncertain “as looked after”. | No institution named. | None specific. | Explicit placement-status reference; supporting placement evidence, but no dates/address. |
| 5 | 07-Jan-2026 | GP telephone triage - Dr Helen Blanchfield | Self-harm / suicide | “Suicidality comes and goes”; no clear planning. Medication lock box and family oversight discussed. | Not recorded. | Weekly dispensing restored with supervision; low threshold to contact practice. | Direct current risk-management evidence; no abuse link recorded. |
| 6 | 17-Dec-2025 | GP consultation - Dr Heather Wightman | Self-harm / mental health | Low mood and daily suicidal thoughts involving medication or standing in the road; frequent flashbacks to a previous traumatic event; distressed and short-tempered. | The traumatic event described here concerns a redacted person dying beside her, not childhood abuse. | CMHT duty worker contact; urgent referral if unsupported; medication changed to daily dispensing. | Direct risk and treatment evidence; trauma link explicit but not to historic care abuse in this entry. |
| 7 | 03-Jul-2025 | GP consultation - Dr Helen Blanchfield | Self-harm / substance use / impact | Fleeting suicidal thoughts; felt like “cutting throat”; no current plan. Smoking cannabis (“weed”). Not | Not recorded. | CMHT referral, crisis numbers, Hope Point information; fit note to 03-Sep-2025. | Direct mental-health, substance-use and social-impact evidence; no abuse link recorded. |

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| | | | | fit for work certificate issued. | | | |
| 7 | 16-Oct-2025 | Nurse cervical screening - Mrs Moira Bennett | Possible indicator / neutral | Very anxious throughout cervical screening; small speculum used. | Not recorded. | Screen completed. | Possible corroborative indicator only; record makes no abuse connection. |
| 9 | 11-Nov-2024 | General Psychiatry outpatient letter | Psychiatric care / medication | EUPD review; reduce quetiapine by 50 mg every two weeks to target 300 mg daily. | Not recorded. | Medication reduction plan. | Treatment evidence; no abuse link in summary entry. |
| 9 | 30-Oct-2024 | GP administration | Placement / transfer | Patient registered by GP-to-GP electronic record transfer. | No placement identified. | Electronic record transfer. | Neutral transfer evidence; no connection to care placement recorded. |
| 13 | 12-Aug-2024 | GP consultation - Dr Terry Johnston | Neglect / mental health / impact | Dramatic weight loss, poor appetite, “couldn’t be bothered”, not caring for self, poor hygiene, dirty clothes, flat presentation; clinician considered self-neglect the likely main factor. Weight 42 kg, BMI 16.9. | Not recorded. | Urgent CT, dietician referral, bloods, CMHT referral, medication-risk discussion. | Direct evidence of severe adult self-neglect and mental-health impact; no historic-abuse link in this entry. |
| 13 | 18-Jun-2024 | GP telephone consultation - Dr Eilidh O’Neil | Mental health / suicide / medication | Mental health deteriorated following quetiapine reduction; statement “might as well jump over rainbow bridge”. | Not recorded. | Medication discussion and weekly dispensing. | Direct mental-health and suicidal-language evidence; no abuse link recorded. |
| 18 | 02-May-2024 | GP consultation - Dr William Wilson (ST2) | Medication / physical impact | Long-term quetiapine 300 mg twice daily and trazodone 450 mg daily; dizziness and hypotension considered likely medication-related. | Not recorded. | Bloods/ECG; proposed dose reduction. | Treatment and side-effect evidence; no abuse link recorded. |
| 19 | 04-Sep-2023 | GP consultation - Dr Terry Johnston | Sexual abuse / mental health / sleep | Long history of depression and symptoms described as mostly PTSD “in relation to sexual abuse by [redacted]/[redacted]/rape”; wakes every hour. | Perpetrators redacted; no care setting named. | PALMS appointment arranged; high-dose trazodone and quetiapine noted. | Explicit clinician-recorded link between sexual abuse/rape and PTSD symptoms; strong impact/corroborative evidence. |
| 21 | 10-Aug-2023 | COPD annual review - Ms Naomi Wilson | Mental health / suicide / therapy / neutral | Positive depression screen; dip in mood and previous attempts to end life. Explicit negative finding: no current thoughts of suicide or self-harm. Previously attended psychology but discharged; wished to re-engage. | Not recorded. | GP discussion/referral for further mental-health support. | Direct impact and treatment evidence; negative current-risk finding preserved. |
| 24 | 15-Mar-1996 (summary code) | Historic computer summary | Sexual abuse / disclosure / suicide | Suicidal ideation - “disclosure of previous rape”. | Perpetrator and setting not recorded. | No safeguarding or referral detail visible in the summary. | Contemporaneous historic disclosure recorded in the GP summary; strong direct |

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| | | | | | | | disclosure evidence, although context is limited. |
| 24 | 1996-2020 (multiple dates) | Historic computer summary | Self-harm / suicide / mental health | Overdose codes on 26-Jun-1996, 25-Jul-1996, 07-Aug-1996, 01-Nov-1996, 09-Jul-2010 and 18-Jul-2019; repeated suicidal ideation; personality-disorder diagnoses; panic attack, depressed mood, insomnia and hallucinations. | Not recorded. | Details of methods and follow-up are not contained in this summary page. | Strong longitudinal evidence of psychiatric impact and repeated overdose/risk; causal link to abuse not stated for each event. |
| 27-28 | 2010-2020 attachments indexed | Transferred records / attached correspondence | Third-party records | Mental-health referrals and letters include Kandahar House Mental Health, Alloway CMHT, Dundee Adult Psychology, Carseview Psychiatry, Crisis Resolution Team and Psychological Therapies Service. | No care setting named. | Shows extensive psychiatric and psychological service involvement. | Third-party treatment evidence; individual letters should be read with their scanned pages where needed. |
| 90-92 | Referral 12-Aug-2024; assessment 16-Sep-2024; authorised 24-Sep-2024 | NHS Tayside psychiatric assessment - Advanced Nurse Practitioner | Placement / abuse / mental health / neglect / self-harm / substance use / therapy | Long psychiatric history from 1996; previous alcohol misuse, self-harm and overdoses. The report appears to state she had been in a care home. It records multiple traumas of abuse and loss, self-neglect, low mood, intermittent suicidal thoughts, past attempt to cut her throat, occasional auditory hallucinations, and that hallucinations related to past abusers. | Care-home name and dates not legible; abusers not named. | Quetiapine 600 mg/day and trazodone reported; medication review/reduction, CRUSE grief counselling, social-work referral and CMHT dietician involvement. | Strong psychiatric corroboration and impact evidence; placement wording is supportive but incomplete. OCR uncertainty means the care-home sentence should be checked against the original image before quoting verbatim. |

## Category findings not identified in the verified entries

No clear verified entry was identified describing physical assault in care, corporal punishment, unexplained childhood injury attributed to staff/residents, named institutional staff, institutional correspondence, admission/discharge dates, neglect by a care provider, or safeguarding/police action following a historic disclosure. This is not proof that such evidence does not exist; many attachments are scanned and some text is degraded.

## Recommended evidential use

The strongest passages for a redress application are PDF pages 19, 24 and 90-92. Page 3 supports looked-after status. Pages 5-7, 13, 18, 21 and 24 support long-term mental-health, self-harm, treatment and social-impact evidence. The care-home wording on page 91 should be compared with any local-authority chronology or placement records to identify the institution and dates.