Evidence Extraction Sheet - GP / Healthcare Record

Patient: Agnes Murdoch (historic surname Watson) | Source: SAR-A-Murdoch-29-Apr-2026-15-30-23.pdf | 212 PDF pages

Scope and caution. This schedule records material relevant to the categories requested. It distinguishes adult events from possible childhood-care evidence and does not infer that later mental-health symptoms, medication, assault, or self-harm were caused by childhood abuse where the GP record does not make that link.

Headline findings

• **Placement:** No explicit institutional care address or named care setting was located in this GP file. PDF 197 is a historic GP card from the 1977 period showing the home address “82 Wellhouse Cres., G33”, not a residential-school address.

• **Direct abuse in care:** No explicit GP-recorded disclosure of physical or sexual abuse by care staff/residents was located. Adult assaults are recorded on PDFs 12 and 21 and are kept separate.

• **Mental health:** The record contains anxiety, depression, sleep disturbance, panic symptoms, antidepressant treatment, psychiatric/CMHT referral, and historical self-poisoning. The record does not expressly attribute these to childhood care abuse.

• **Self-harm:** A coded event records suicide/self-inflicted drug poisoning on 17-Aug-1985. Later consultations contain several negative findings (“no thoughts self harm”).

• **Treatment:** Mental-health medications include escitalopram, sertraline, mirtazapine and short-course benzodiazepine treatment; a CMHT referral for stress/depression is recorded in 2006.

Detailed extraction schedule

	Document	PDF page	Date	Clinician / role	Category	Exact evidence / faithful summary	Care setting	Link to abuse	Relevance / interpretation	Evidential value
	iGPR problem list	PDF 1	17-Aug-1985	GP coded record	Self-harm / suicide	“Suicide + selfinflicted poisoning by other drugs/medicines.”	No care setting recorded	No link recorded	Direct clinical history of self-poisoning; applicant aged 20. Important impact/risk history, but record does not connect it to childhood care or abuse.	Self-harm / impact
	iGPR problem list	PDF 1; repeated PDF 22	02-Sept-1993	GP coded record	Mental health	“Anxiety states.”	None recorded	No link recorded	Recorded anxiety diagnosis. No childhood/care causal connection stated.	Impact
	GP consultation	PDF 12	24-Apr-2013	Newhills Medical Practice	Mental health / treatment	Feeling depressed for 3-4 weeks with poor sleep and “NO RECOGNISABLE PRECIPITANTS”; sertraline 50 mg then 100 mg prescribed.	None recorded	No link recorded	Clear depressive episode and antidepressant treatment; note expressly records no recognisable precipitant.	Impact / treatment / neutral
	GP consultation	PDF 12	01-Oct-2012	Newhills Medical Practice	Physical assault / injury	After an assault, patient had an unsettled period; later learned the girl who attacked her and scratched her face was an IV drug user; HIV testing discussed.	None recorded	No link recorded	Direct evidence of an adult assault and facial scratching. No indication this occurred in care or was historic institutional abuse.	Direct evidence of adult assault
	GP consultation	PDF 12	24-Aug-2011	Newhills Medical Practice	Counselling / psychosocial impact	Patient very upset; social work arranging counselling.	None recorded	No link to applicant’s childhood abuse recorded	Supports contemporaneous distress and counselling involvement. Surrounding entry concerns abuse involving a redacted third party and should not be treated as applicant disclosure without further evidence.	Impact / treatment
	GP consultation	PDF 15	17-Sept-2008	Newhills Medical Practice	Mental health medication	Still feeling low and sleeping poorly; weaning down sertraline and starting mirtazapine 15 mg.	None recorded	No link recorded	Medication change for low mood / poor sleep.	Treatment
	GP consultation	PDF 15	27-Nov-2008	Newhills Medical Practice	Mental health medication / self-harm negative	Stopped sertraline about 2 months earlier and did not receive mirtazapine; felt medication had been helping; “no self harming thoughts.”	None recorded	No link recorded	Medication non-continuation with negative self-harm finding.	Treatment / negativ finding
	GP consultation	PDF 15	04-Feb-2009	Newhills Medical Practice	Mental health / medication	Mood low, worse since stopping medication; mirtazapine caused excessive sleepiness; loss of interest; “no thoughts self harm.”	None recorded	No link recorded	Depressive symptoms, side effect from mirtazapine, and explicit negative self-harm finding.	Impact / treatment / negative finding

	Document	PDF page	Date	Clinician / role	Category	Exact evidence / faithful summary	Care setting	Link to abuse	Relevance / interpretation	Evidential value
	GP consultation	PDF 18	13-Nov-2006	Newhills Medical Practice	Mental health medication	Mood low and irritable; plan to reduce escitalopram over a week before starting sertraline.	None recorded	No link recorded	Medication switch for low mood/irritability.	Treatment
	Psychiatric / GP follow-up	PDF 18	28-29 Nov 2006	Newhills Medical Practice / CMHT	Psychiatric care	“See letter psychiatry”; referral to Community Mental Health Team, Auchinlea Resource Centre, reason “Stress and depression.”	None recorded	No childhood/care link stated	Clear CMHT referral and psychiatric involvement.	Treatment / impact
	GP follow-up	PDF 18	28-Dec-2006	Newhills Medical Practice	Mental health medication	“Feeling much better. On sertraline 150mg.” Social work / health visitor involved.	None recorded	No link recorded	Documents response to sertraline and professional support.	Treatment / positive/neutral
	GP consultation	PDF 19	26-Apr-2006	Newhills Medical Practice	Mental health / self-harm negative	Under great stress; weepy; history of postnatal depression; shouting at children; “no thoughts of self harm at present”; antidepressant started.	None recorded	Stress attributed to partner illness/pregnancy circumstances, not childhood care	Mental-health episode with negative self-harm finding and an alternative contemporaneous stressor.	Impact / treatment / contradictory-neutra
	GP consultation	PDF 19	18-May-2006	Newhills Medical Practice	Mental health medication / self-harm negative	Sleeping better on escitalopram; still “a bit panicky”; “no thoughts of self harm.”	None recorded	No link recorded	Anxiety/panic symptoms with treatment response and negative self-harm finding.	Impact / treatment / negative finding
	GP consultation	PDF 19	26-Sept-2006	Newhills Medical Practice	Sleep / medication	Antidepressant felt to be working but sleep remained poor; short course benzodiazepine planned.	None recorded	No link recorded	Treatment for sleep disturbance in context of depression/stress.	Treatment
	GP consultations	PDF 21	18-26 Aug 2004	Newhills Medical Practice	Adult physical assault / anxiety / medication	Assaulted; later recorded as alleged victim of assault and arson. Anxiety “++”; diazepam requested and continued, then tapered when feeling less anxious.	None recorded	No link to childhood care	Direct evidence of adult assault and acute psychological impact; not evidence of abuse in care.	Direct adult assault impact / treatment
	Referral summary	PDF 62	29-Nov-2006	GP referral record	Psychiatric care	Referral to Community Mental Health Team (Greater Glasgow), Auchinlea Resource Centre; reason: “Stress and depression.”	None recorded	No link recorded	Corroborates CMHT referral.	Treatment / corroboration
	Clinical coding summary	PDF 69	24-Apr-2013	GP coded record	Mental health	Depression screen; HAD anxiety score 16/21; HAD depression score 13/21; coded “Depressed.”	None recorded	No link recorded	Objective screening scores corroborating clinically significant anxiety/depressive symptoms at that time.	Impact / corroborati
	Historic Lloyd George GP card	PDF 197	13-Jul-1977 onward	Historic GP record card	Placement / address / neutral	Card for “Watson, Agnes”, DOB 30/3/65, records address “82 Wellhouse Cres., G33” and contains consultations dated in 1977.	No institution named; home address shown	No abuse link	Potentially useful historical healthcare evidence of identity and GP registration around the care period, but it does NOT itself record a care setting. If other records establish residential placement at the same time, the home address on the card should be explained rather than treated as disproving placement.	Historical corroboration / neut
	Whole GP file review	PDF 1-212	Full record	Multiple	Evidence of placement in care	No explicit reference located to Thorntoun School, Nerston Residential School, a children’s home/foster placement, “looked after”, or a care-setting address in the searchable GP material or reviewed scanned attachments.	None identified	Not applicable	This GP record should not be relied upon by itself as primary proof of residential placement. Separate social-work/institutional records are stronger placement evidence.	Negative finding
	Whole GP file review	PDF 1-212	Full record	Multiple	Childhood abuse disclosure	No explicit GP-recorded disclosure located that residential staff or another resident physically or sexually abused the patient, and no entry located expressly connecting later mental-health symptoms to childhood care abuse.	None identified	No link recorded	Important negative finding: adult mental-health and assault records exist, but causal linkage to childhood care is not stated in this GP file.	Negative finding

Category-by-category findings

1. Evidence of placement in care

No explicit care-setting address, residential-school name, foster placement, “looked after” wording, or care-staff consultation was located. PDF 197 is the principal historic childhood GP record reviewed: it identifies Agnes Watson, DOB 30/3/65, at 82 Wellhouse Crescent during the 1977 period. This is a home address, not proof of residential placement.

2. Physical abuse / injury

No childhood in-care physical-abuse disclosure was located. Adult assault evidence appears on PDF 12 (2012 facial scratching by a girl) and PDF 21 (2004 assault/arson episode). PDF 22 also lists a metatarsal fracture in 1998, with no abuse link recorded.

3. Sexual abuse

No explicit or indirect GP entry was located connecting sexual assault, sexual-health symptoms, pregnancy, genital injury or intimate-examination difficulty to childhood care abuse.

4. Emotional / psychological abuse

No explicit record was located describing emotional abuse by residential staff or fear of returning to a care setting. Later adult records document depression, anxiety, panic, sleep disturbance and psychosocial stress.

5. Neglect

No explicit GP evidence was located of medical, physical or safeguarding neglect in a care setting.

6. Contemporaneous disclosures

No contemporaneous childhood disclosure to a GP of abuse by staff or residents was located in this file.

7-9. Mental health, medication and psychiatric care

Relevant records include anxiety (1993), depression and HAD scores (2013), low mood/panic/sleep problems, sertraline, escitalopram and mirtazapine treatment, and CMHT referral in 2006. The notes do not expressly connect these to childhood care abuse.

10. Self-harm and suicide

A coded record lists suicide/self-inflicted poisoning by drugs/medicines on 17-Aug-1985. Later notes in 2006, 2008 and 2009 explicitly record no current self-harm thoughts.

11. Substance and alcohol use

Routine alcohol-use entries are present, but no clear record was located of alcohol/drug dependence, addiction treatment, or substance use expressly linked to coping with childhood abuse.

12-13. Adult physical and social impact

The record documents later health and psychosocial difficulties, but no clinician statement located expressly attributes chronic physical or social consequences to childhood abuse or care experiences.

14. Third-party / attached records

The GP export contains extensive attachments and historic scanned Lloyd George records. These were reviewed at page level; the relevant historic childhood card is PDF 197. Other attachments primarily concern later maternity, ENT, orthopaedic and hospital care.

15. Contradictory / neutral entries

PDF 197 displays the home address 82 Wellhouse Crescent during the 1977 period. This should be preserved as a neutral/potentially inconsistent record if separate institutional records establish residence in care at the same time. Several later mental-health notes also record alternative contemporaneous stressors and explicit denials of self-harm.

Highlight legend for accompanying annotated copy

Yellow	Placement / historical address context
Orange	Physical assault or injury
Blue	Mental-health symptoms / diagnoses
Pink	Self-harm / suicide history
Green	Mental-health treatment / referral
Grey	Neutral or potentially contradictory historical material