Evidence Extraction Sheet

Agnes Murdoch - Glasgow Royal Infirmary records

Source reviewed: Agnes Murdoch - Glasgow Infirmary.pdf. The source is an image-only hospital record. The PDF contains 583 pages, including many blank/interleaved pages. The substantive scanned pages and embedded GP referral summaries were visually reviewed. Page numbers below are the exact PDF page numbers.

Overall findings

Placement in care: No children's home, residential school, foster placement, assessment centre, institutional care address, admission/discharge to care, GP registration while resident in care, residential staff attendance, social-worker accompaniment, or hospital correspondence to a care establishment was identified.

Direct abuse evidence: No direct disclosure of physical, sexual or emotional abuse in care was identified. No hospital entry attributes an injury to residential staff, carers or another resident, and no safeguarding referral about historic institutional abuse was identified.

Mental health / self-harm: The record repeatedly carries the coded history *Anxiety states* dated 02-Sep-1993 and *Suicide + self inflicted poisoning by other drugs/medicines* dated 17-Aug-1985. The hospital material does not state the precipitating event, drug, treatment, intent, or any link to childhood care or abuse.

Medication: Sertraline and lormetazepam are documented in 2006-2007. Sertraline 100 mg daily is later recorded as started 20-Feb-2014 and remains present in referral / discharge records through 2024. No record reviewed states that the medication was prescribed for childhood trauma, PTSD or abuse.

Alcohol / drugs: Alcohol entries range from a historic "trivial drinker - <1u/day" to 10 units/week (2019), 4 units/week (2021) and 1 unit/week (2023). Later inpatient assessments record no alcohol and no recreational/illicit drug use. No addiction service, methadone/buprenorphine, detoxification or rehabilitation evidence was identified.

Important neutral coding: Several GP referral summaries contain "Vulnerable child in family" and later "Child no longer vulnerable". The former names Nadine & Brendan Bennett and should not be treated as evidence that Agnes herself was in residential care.

Category-by-category result

Category	Result
1. Evidence of placement in care	No supporting in-care address or placement record identified in this hospital file.
2. Physical abuse / injuries	No assault in care identified. Adult metatarsal fracture is recorded on p.18 without cause or abuse link.
3. Sexual abuse	No explicit disclosure or medical entry linking sexual-health/urogenital findings to sexual abuse.
4. Emotional / psychological abuse	No direct disclosure of humiliation, intimidation, fear of staff, fear of return, or care-related emotional abuse identified. Anxiety is recorded, but no abuse/care link is stated.
5. Neglect	No medical, physical or safeguarding neglect in a care setting identified.
6. Contemporaneous disclosures	No disclosure that staff/residents hurt her, that she felt unsafe in care, or that she ran away because of treatment was identified.
7. Mental-health conditions	Anxiety states repeatedly recorded; no PTSD/complex-trauma diagnosis or explicit childhood-abuse linkage identified.
8. Mental-health medication	Sertraline and lormetazepam documented; details below.
9. Counselling / psychiatric care	No counselling, psychology, psychotherapy, CMHT, crisis-team or psychiatric-admission material identified in this GRI file.
10. Self-harm / suicide	Historic coded entry: suicide + self-inflicted poisoning by other drugs/medicines, 17-Aug-1985. No contextual narrative located.
11. Substance / alcohol use	Low-level alcohol entries and later negative alcohol/drug screens; no addiction-treatment evidence identified.

Category	Result
12. Physical consequences in adulthood	No condition in this file is explicitly linked by a clinician to childhood abuse or neglect.
13. Long-term personal / social impact	No social-impact entry explicitly linked to childhood abuse/care identified.
14. Third-party / attached records	The hospital file contains GP referral letters and electronic referral summaries; relevant pages are included in the schedule below.
15. Contradictory / neutral entries	Family vulnerability coding, unrelated adult injury and negative alcohol/drug responses are retained below rather than omitted.

Detailed extraction schedule

Repeated copies of the same GP-coded history are grouped, but every identified PDF page carrying that repeated evidence is listed.

Ref	PDF page	Date / document	Document	Category	Exact evidence / faithful summary	Care setting / perpetrator	Injury or impact	Treatment
E1	9, 15, 18, 117, 146, 156, 165, 175, 192, 200	Underlying code dated 02-Sep-1993; repeated in GP referrals 2007-2024	GP referral / clinical summary	Mental health	"Anxiety states" appears in the pre-existing-conditions / past-medical-history list.	None recorded	Anxiety diagnosis/history. No narrative symptoms on these pages.	No treatment stated in this row.
E2	9, 15, 18, 117, 146, 156, 165, 175, 192, 200	Underlying code dated 17-Aug-1985; repeated in GP referrals 2007-2024	GP referral / clinical summary	Self-harm / suicide	"Suicide + self inflicted poisoning by other drugs/medicines."	None recorded	Self-poisoning code; no drug, dose, injury or precipitant specified.	Not stated in these extracts.
E3	18	19-Mar-2007 referral (page 2 of 3)	General Surgery GP referral	Injury - neutral	"Metatarsal bone fracture" recorded 18-Mar-1998.	None recorded	Adult fracture; cause and circumstances not stated.	Not stated.
E4	18-19	19-Mar-2007 referral; medication issues dated Dec-2006 to Feb-2007	General Surgery GP referral	Mental-health medication	Sertraline 50 mg / 100 mg appears repeatedly. Page 18 lists sertraline 100 mg, 1 tablet in the morning, course started 27-Feb-2007. Lormetazepam 1 mg at night is also listed, started 27-Feb-2007; page 19 contains repeated sertraline dose entries and lormetazepam dating back to 20-Dec-2006.	None	Psychotropic / sleep medication use.	Sertraline; lormetazepam.
E5	117	11-Jul-2024 GP referral (page 3 of 5)	GP referral to GRI	Neutral / third-party safeguarding coding	"Vulnerable child in family" - comment names "Nadine & Brendan Bennett" with start date 01/08/2007; "Child no longer vulnerable" dated 18-May-2011.	Not an institutional placement	Family safeguarding coding; does not identify Agnes as the vulnerable child or as being in care.	None
E6	119	11-Jul-2024 GP referral (page 4 of 5)	GP referral to GRI	Mental-health medication	Sertraline hydrochloride 100 mg: "ONE TO BE TAKEN EACH DAY"; date started 20-Feb-2014; date last issued 09-May-2024.	None	Long-term antidepressant prescribing.	Sertraline 100 mg daily.
E7	119	11-Jul-2024 GP referral (page 4 of 5)	GP referral to GRI	Alcohol use	Alcohol consumption recorded as 10 units/week (08-Aug-2019), 4 units/week (03-Jun-2021), and 1 unit/week (01-Jun-2023).	None	Low-level alcohol use entries; no dependence/withdrawal described.	None
E8	132	April 2024 immediate discharge letter (page 2 of 3)	GRI discharge medication record	Mental-health medication	Sertraline 100 mg tablets: "ONE TO BE TAKEN EACH DAY" appears in active medication.	None	Continued antidepressant treatment.	Sertraline 100 mg daily.
E9	134	April 2024 immediate discharge letter (page 3 of 3)	GRI discharge letter	Mental health	Clinical comments list background: "T2DM, epilepsy, HTN, anxiety."	None	Anxiety remains part of active background history.	Not specified in this entry.
E10	146, 156, 165, 175, 192	GP referrals dated 01-Jun-2023; 22-Jul-2019; 14-Mar-2019; 14-Jun-2017; 25-Jul-2014	GP referral summaries	Mental health + self-harm	These referral summaries repeat both "Anxiety states" (02-Sep-1993) and "Suicide + self inflicted poisoning by other drugs/medicines" (17-Aug-1985).	None	Longitudinal repetition of the coded history.	See medication rows below.
E11	148	01-Jun-2023 orthopaedic hip referral (page 4 of 5)	GP referral summary	Mental-health medication + alcohol	Sertraline hydrochloride 100 mg, one daily, started 20-Feb-2014, last issued 22-May-2023. Alcohol: 10 units/week (2019), 4 units/week (2021); historic trivial drinker <1u/day.	None	Long-term antidepressant treatment and low-level alcohol history.	Sertraline 100 mg daily.
E12	156	22-Jul-2019 General Surgery referral (page 3 of 5)	GP referral summary	Mental-health medication	Sertraline hydrochloride 100 mg, "ONE TO BE TAKEN EACH DAY", started 20-Feb-2014, last issued 14-Jun-2019.	None	Ongoing antidepressant prescribing.	Sertraline 100 mg daily.
E13	165	14-Mar-2019 ENT referral (page 3 of 5)	GP referral summary	Mental-health medication	Sertraline hydrochloride 100 mg, "ONE TO BE TAKEN EACH DAY", started 20-Feb-2014, last issued 27-Feb-2019.	None	Ongoing antidepressant prescribing.	Sertraline 100 mg daily.
E14	175	14-Jun-2017 General Surgery referral (page 3 of 5)	GP referral summary	Mental-health medication	Sertraline hydrochloride 100 mg, one daily, started 20-Feb-2014, last issued 12-Jun-2017.	None	Ongoing antidepressant prescribing.	Sertraline 100 mg daily.
E15	192	25-Jul-2014 ENT referral (page 3 of 4)	GP referral summary	Mental-health medication	Sertraline hydrochloride 100 mg, one daily, started 20-Feb-2014, last issued 22-Jul-2014.	None	Antidepressant prescribing shortly after recorded start date.	Sertraline 100 mg daily.

Ref	PDF page	Date / document	Document	Category	Exact evidence / faithful summary	Care setting / perpetrator	Injury or impact	Treatment
E16	401	07-Aug-2024 inpatient admission record	GRI inpatient record	Mental health	Relevant past medical history includes "anxiety".	None	Anxiety noted during acute admission.	Not stated here.
E17	403	07-Aug-2024 inpatient lifestyle assessment	GRI inpatient record	Substance / alcohol - negative finding	Recreational/illicit drugs or opiate replacement therapy: "No". Alcohol: "No".	None	Negative substance-use findings during admission.	None
E18	450	26-Aug-2024 inpatient admission record	GRI inpatient record	Mental health	Relevant past medical history includes "Anxiety".	None	Anxiety noted during acute admission.	Not stated here.
E19	452	26-Aug-2024 inpatient lifestyle assessment	GRI inpatient record	Substance / alcohol - negative finding	Recreational/illicit drugs / ORT: "No". Alcohol: "No".	None	Negative substance-use findings.	None
E20	512	18-Nov-2024 inpatient admission record	GRI inpatient record	Mental health	Relevant past medical history: "T2DM. Epilepsy. HTN. Anxiety. Arthritis."	None	Anxiety noted during acute admission.	Not stated here.
E21	514	18-Nov-2024 inpatient lifestyle assessment	GRI inpatient record	Substance / alcohol - negative finding	Recreational/illicit drugs / ORT: "No". Alcohol: "No"; frequency of >6 units marked "Never".	None	Negative substance-use findings.	None

Interpretation notes

No causation inferred: Anxiety, antidepressant use, self-poisoning and alcohol entries are recorded exactly as clinical history. The reviewed GRI records do not attribute them to childhood abuse, neglect, residential care, a named institution or a Redress application.

Sexual-abuse indicators: The file contains routine obstetric/urogenital history in referral summaries, but no clinician connects those entries with sexual abuse. They have therefore not been treated as corroborative sexual-abuse evidence.

Family vulnerability coding: "Vulnerable child in family" / "Child no longer vulnerable" is retained because it could be misunderstood if seen out of context. The named children and dates indicate family safeguarding coding, not proof that Agnes was a looked-after child.

Highlighted copy: Yellow highlighting has been applied to the principal pages carrying the evidence summarized above. Highlights are broad because the source is scanned image material without searchable text coordinates.

Limit: This extraction reports what is present in this Glasgow Royal Infirmary file. Absence of a record here does not establish that an event did not occur or that other GP, social-work, school, police or care-establishment records will not contain evidence.