Evidence Extraction Sheet - GP / Medical Records

Patient: Sharon Andrews | Source: SA meds.pdf | 559 PDF pages | Interim reviewed-evidence version

Scope and status	This sheet records the strongest evidence that has been verified from the material reviewed so far. It is deliberately conservative: unclear handwriting has not been converted into firm findings, and no causal link to childhood abuse or care is asserted unless the medical record itself makes that link. The full 559-page file contains substantial scanned historic material, so this should be treated as an interim extraction rather than a final exhaustive schedule.

A. Verified evidence entries

PDF page	Date / period	Clinician / source	Category	Exact evidence / faithful summary	Link to care / abuse	Evidential value / follow-up
1	Active problem list (record current at report generation)	iGPR problem list; Mrs Alison Dorward shown beside problem entries	Mental health condition	Active problem recorded as **“Anxiety with depression.”**	No childhood-care or abuse link recorded in this entry.	**Impact / treatment context.** Strong evidence of a recorded mental-health condition; not proof of cause.
17	01-Jan-2003	Historical problem list / diagnosis entry	Mental health condition	Diagnosis recorded as **“Anxiety with depression.”**	No institution, childhood trauma or abuse is named in the diagnosis entry.	**Impact evidence.** Shows the diagnosis was recorded historically, not only recently.
15	17-Nov-2023	Dr Kate Macdonald - surgery consultation	Third-party / safeguarding / medication security	Telephone entry discusses a rheumatology-letter concern that the patient’s daughter had been taking her pregabalin. A social-work referral had been made and reviewed. Medication was being made safer and dispensed weekly, with the possibility of twice-weekly dispensing if concerns continued.	Adult safeguarding issue. No connection to childhood care or historic abuse is recorded.	**Safeguarding / treatment evidence.** Relevant to vulnerability and medication management, but should not be presented as corroboration of childhood abuse.
16	20-Sep-2023 and 18-Aug-2023	GP / COPD review entries	GP transfer / practice history	Record refers to medication/inhaler supplied by a **previous practice**. The COPD review records that she was a new patient to the surgery.	No link to a childhood placement. This is an adult GP-practice transfer.	**Neutral / administrative.** Useful only for tracing transferred primary-care records; not placement evidence.
18-34	2025-2026 medication record; repeated issues	Prescription / repeat medication section	Mental-health medication / sleep medication	**Zopiclone 3.75 mg** appears repeatedly, generally as one tablet at night with weekly dispensing. The reviewed medication section shows repeated prescribing across multiple months.	No childhood-trauma or abuse link is stated by the prescription entries alone.	**Treatment evidence.** Supports ongoing pharmacological management of sleep; reason should be read with consultation notes before attributing causation.
19-34	2025-2026 medication record; repeated issues	Prescription / repeat medication section	Mental-health medication	**Mirtazapine 45 mg** appears repeatedly, generally one tablet at night with weekly dispensing.	No causal link to childhood abuse or care is stated in the medication list.	**Treatment evidence.** Supports sustained antidepressant prescribing; medication by itself does not establish trauma.
492	Feb-2013 (entry appears late February 2013)	Downfield Surgery historical GP record; clinician name partly obscured / difficult to read	Mental health symptoms / trauma context	Consultation records low mood / tearfulness and poor sleep. The entry refers to **previous traumas** in the patient’s history and depression. The wording reviewed does not identify what those traumas were.	**Possible corroborative indicator only.** The entry does not expressly say the trauma was childhood abuse, occurred in care, or name an institution.	**Potentially important retrospective corroboration.** Preserve the wording “previous traumas” but do not expand it beyond what the record says.
492	Same Feb-2013 consultation	Downfield Surgery historical GP record	Self-harm / suicide	The entry records **no intent** for self-harm, while also recording thoughts only. It does not record a plan or attempt in the wording reviewed.	No link to childhood abuse is recorded.	**Mixed positive/negative risk evidence.** Present accurately: thoughts were recorded, but intent was denied / absent.

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492	Same Feb-2013 consultation	Downfield Surgery historical GP record	Mental-health treatment	The consultation records discussion of antidepressant treatment, including restarting **amitriptyline**, with **zopiclone** for sleep.	Treatment follows low mood / poor sleep and a history mentioning previous trauma, but the record does not state that childhood abuse caused the symptoms.	**Treatment / impact evidence.** Useful when read together with the symptoms and trauma-history wording on the same page.
492	Feb-2013 - separate nearby consultation on same printed page	Downfield Surgery historical GP record	Mental health symptoms / medication decision	A separate entry records the patient feeling very low / depressed and upset, asking about antidepressant treatment and raising concern about interaction with epilepsy medication.	No childhood-care or abuse link is recorded in the wording verified.	**Impact / treatment evidence.** Supports contemporaneous low mood and treatment-seeking.
220	Historic record - dates on card include 1980s/1990s	Manchester Medical Summary Card	Third-party / attached historic record	Scanned NHS medical summary card for Sharon Andrews is included in the GP file, confirming that historic paper records from an earlier area/practice form part of the transferred record.	No care-setting address or abuse disclosure was verified on this page.	**Record provenance.** Supports the existence of transferred historic notes; not substantive abuse evidence by itself.
273-275	Childhood period; entries include 1972-1974	Historic handwritten NHS clinical notes	Historic childhood medical records / neutral evidence	Handwritten childhood consultations are present, including entries from 1972-1974. Some notes concern ordinary childhood illness / pain. The reviewed pages do not show a verified institutional address or an explicit disclosure of abuse.	These records overlap the childhood period, but overlap in date alone does **not** prove residence in care.	**Neutral / provenance evidence.** Useful for chronology and identifying which historic GP notes survive; not yet placement or abuse evidence.

B. Categories not established in the material verified so far

Requested category	Current reviewed finding	How it should be treated
Evidence of placement in care	No verified GP entry reviewed so far names St Francis Children's Home, Carolina House or another care setting as the patient's address, confirms GP registration while resident there, or records correspondence with that institution.	Do not use the reviewed GP pages as primary placement proof at this stage. Historic notes overlapping care dates are only neutral chronology unless an institutional address or care reference is found.
Physical abuse in care	No verified reviewed entry records the patient being hit, kicked, beaten, restrained or otherwise physically abused by care staff / carers / residents during childhood.	Not identified in the reviewed subset. This is not a finding that abuse did not occur.
Sexual abuse	No verified reviewed entry contains an explicit or indirect disclosure of childhood sexual abuse, sexual assault in care, genital injury linked to abuse, or a named perpetrator.	Not identified in the reviewed subset. Do not infer sexual abuse from nonspecific symptoms.
Emotional / psychological abuse	No verified childhood GP entry reviewed so far describes humiliation, threats, staff intimidation, fear of returning to care, or similar treatment by care staff.	Adult low mood and historical "previous traumas" should not be converted into a specific allegation without supporting wording.
Neglect	No verified reviewed entry presently demonstrates untreated injury/illness, deprivation, lack of supervision or safeguarding failure while resident in care.	Not identified in the reviewed subset.
Contemporaneous childhood disclosure	No verified reviewed childhood entry records Sharon telling a GP or other clinician that a staff member / resident hurt her, that she felt unsafe, or that she did not want to return.	Not identified in the reviewed subset.
Counselling / psychology / psychiatric care	No specific counselling, psychotherapy, EMDR, psychology or psychiatric service episode has yet been verified from the reviewed pages.	Leave open pending fuller review of scanned correspondence and attachments.

Requested category	Current reviewed finding	How it should be treated
Substance / alcohol use linked to trauma	No verified reviewed entry expressly states that alcohol or drugs were used to block memories, cope with abuse, manage trauma, or cope with being in care.	Do not infer causation from any substance-use history unless the record makes the link.
Adult physical consequences linked to childhood abuse	No verified reviewed entry states that a later physical condition was caused by or followed childhood abuse / neglect in care.	Not established in the reviewed subset.

C. Evidence-weight summary

Evidence level	Material identified
Strong impact / treatment evidence	Recorded anxiety with depression (pp. 1 and 17); repeated mirtazapine and zopiclone prescribing (pp. 18-34); low mood / tearfulness / poor sleep and antidepressant treatment on p. 492.
Potential retrospective corroboration	The p. 492 entry referring to “previous traumas.” Its value is limited because the trauma is not identified as childhood abuse, care-related trauma or a named institution.
Safeguarding / vulnerability evidence	Adult social-work / medication-security concern on p. 15. This relates to adult circumstances and must not be presented as proof of childhood abuse.
Placement evidence	Not established from the GP pages verified so far. Historic notes prove the survival of childhood medical records but do not yet verify a care-setting address.
Direct abuse evidence	No direct physical, sexual, emotional-abuse or neglect entry has been verified in the reviewed subset.

Important: *“Not identified” means only that the item was not established in the material verified for this interim extraction. It should not be used as a conclusion that the event did not occur. The scanned historic records and attached correspondence require further review before a final exhaustive schedule can be produced.*