John Cavanagh

GP and Healthcare Records Review - Four-Part SAR

Outcome: no direct medical-record evidence of a named care placement, physical abuse, sexual abuse, emotional abuse, neglect or a contemporaneous childhood disclosure was identified. The records do contain later evidence of mental-health symptoms, self-harm thoughts without recorded intent, substance dependence, treatment, imprisonment, chronic pain and social impact. No clinician or patient entry expressly links those later difficulties to childhood abuse or care.

Documents reviewed

Document	PDF pages	Printed iGPR pages	Pages highlighted
SAR-J-Cavanagh-23-Jul-2026-11-34-18.part1.pdf	326	1-326 of 830	1-3, 11-13, 43, 46, 80-81, 83, 125-127, 129, 135, 144, 151, 162, 166-167, 174, 179-181, 217
SAR-J-Cavanagh-23-Jul-2026-11-34-18.part2.pdf	213	327-539 of 830	59-61, 149-151
SAR-J-Cavanagh-23-Jul-2026-11-34-18.part3.pdf	190	540-729 of 830	105-107
SAR-J-Cavanagh-23-Jul-2026-11-34-18.part4.pdf	101	730-830 of 830	No independent relevant entry identified

Headline findings

Requested category	Finding	Principal pages
Placement in care	No children’s home, residential school, foster placement, assessment centre, institutional address, GP registration in care or residential-staff attendance is recorded. A March 2025 questionnaire answers “no” to having been in foster care. A 13.09.1976 code says “arrested in police custody” but does not identify a care setting and is not placement proof.	Part 1 pp.3, 46 and 180
Physical/sexual/emotional abuse; neglect	No allegation, disclosure, assault narrative, safeguarding action or abuse-linked injury is recorded.	None
Mental health	Depressive episode, low mood, apathy, isolation, poor sleep, bereavement-related death thoughts, and later personality/functional change. No entry links these symptoms to childhood or care.	Part 1 pp.11-13, 126-129 and 162
Self-harm/suicide	08.07.2016: thoughts of deliberate self-harm but stated he would not act because of wife and daughter. 09.09.2016 and Lifeline letter record no suicide/DSH thoughts. 19.05.2026: thinking about death but denied suicidal ideation or plans. A 06.04.2025 “suicidal thoughts” code is not supported by the attached ambulance records, which concern abdominal pain.	Part 1 pp.12, 43, 126 and 129; Part 2 pp.59-61; Part 3 pp.106-107
Substance/alcohol use	Problem drinking (60 units/week in 1996), heroin/speed dependence in 1997, history of prison and drug/alcohol abuse in 2000, cannabis-related police involvement in 2006, heroin relapse and methadone/Lifeline treatment in 2016, and prescribed-codeine dependence/withdrawal management in 2022.	Part 1 pp.2, 80-83, 129, 144, 174 and 179-180; Part 2 pp.149-151; Part 3 pp.105-107
Physical/social impact	Long-term right ankle/foot disability, chronic pain, restricted mobility, benefits/work difficulties and periods of being housebound are attributed to a childhood road-traffic accident, not abuse. Later imprisonment and unemployment are recorded without a care/abuse link.	Part 1 pp.125, 135, 151, 162 and 179-180

Mental-health, treatment and risk chronology

Date	Entry	Treatment/response	Link to care/abuse	Source
02.11.2010	Depression screening: “feels as if stuck in house”. Mobility problems are recorded elsewhere.	No mental-health treatment recorded in this entry.	No link recorded.	Part 1 p.162 (internal 162)
08.07.2016	Depressive episode; PHQ-9 12. Low mood, little activity, five hours’ sleep, pain, weight loss and heroin use. Thoughts of DSH, but stated he would not act because he had a wife and daughter.	SSRI started; continue Lifeline; telephone review planned.	No link recorded; GP considered situation and substance use.	Part 1 p.129 (internal 129)
22.07-09.09.2016	No sertraline side effects; later said mood improved, getting out more and brighter. “No TOSH/suicide.”	Sertraline continued; further supply issued.	No link recorded.	Part 1 pp.126-127; medication pp.217
28.07.2016	Lifeline letter records recurrent heroin dependence, withdrawal symptoms, anxiety/low mood and no thoughts of DSH/suicide. Wife described as supportive.	Methadone treatment commenced; supervised arrangements and follow-up described.	No link recorded.	Part 3 pp.105-107 (internal 644-646)
06.04.2025	GP summary contains a positive code for “suicidal thoughts”. The attached NHS111/ambulance records for that date describe abdominal pain and septicaemia triage, not a suicide or mental-health presentation.	No psychiatric treatment or risk plan appears in the attached narrative.	No link recorded; coding inconsistency.	Part 1 p.43; Part 2 pp.59-61 (internal 385-387)
19.05.2026	Low mood, apathy, reduced eating/medication adherence and thinking about death after loss of friends/family. Denied suicidal ideation, plans or thoughts of harming others.	Counselling/support links and crisis contacts; sertraline 50mg; safety advice and review.	Symptoms framed around bereavement; no care/abuse link.	Part 1 p.12 (internal 12)
22-26.05.2026	Wife reported isolation, sleepiness, disorientation, falls and major personality change. Clinicians considered depression versus physical/neurological causes.	Face-to-face review; sertraline stopped after stomach worsened; urgent physical investigations and referrals.	No care/abuse link recorded.	Part 1 pp.11-12 (internal 11-12)

Substance use, medication dependence and coping

Date	Evidence	Treatment/impact	Express link to abuse/care?	Source
16.08.1996	“Problem drinker” and “60 u per week”.	No addiction treatment stated in entry.	No.	Part 1 pp.2 and 180
17.06.1997	Drug dependence: “heroin / speed”. Poor sleep recorded the following month.	No treatment stated.	No.	Part 1 pp.2 and 180
08.05.2000	Recently released from prison; history of drug and alcohol abuse; reported no current substance abuse and was looking for work.	Registration history/context.	No.	Part 1 p.179
18.05.2006	Reported police action for smoking cannabis.	No addiction treatment stated.	No.	Part 1 p.174
06.06.2014	Described as an ex-heavy alcohol user who stopped seven years earlier. Took excessive paracetamol for pain, recorded as an accidental overdose.	Sent to A&E; for paracetamol level.	No; not recorded as self-harm.	Part 1 p.144
Jul. 2016	Heroin relapse: smoking daily for months; previous dependence approximately 20 years earlier; withdrawal included sweating, poor sleep, aches, agitation and anxiety.	Lifeline involvement and methadone; wife supervision/support; SSRI for mood.	No.	Part 1 pp.127 and 129; Part 3 pp.105-107
Mar-May 2022	Chronic pancreatitis pain treated with codeine 30mg up to eight daily. Difficulty reducing due to severe “come down” and anxiety; long history of dependence noted.	Pain clinic; Butec/Butrans patches; structured taper and monitoring.	No.	Part 1 pp.80-83; Part 2 pp.149-151

Physical injury and long-term impact

The records contain no care-related or assault-related injury. They repeatedly attribute the long-term right ankle/foot disability to a childhood road-traffic accident: the historic problem list records a fractured tibial shaft on 01.01.1973; a 2016 entry says he had walked with a limp since age nine after an RTA and describes the ankle as fixed/screwed; later records describe chronic pain, fused ankle, use of crutches, reduced mobility, being unable to leave the house, difficulty exercising, benefit appeals and not-fit-for-work certificates. This is neutral/alternative-cause evidence, not evidence of abuse.

Key sources: Part 1 pp.2-3, 125, 135, 151, 154-155, 162, 165, 178 and 180. No staff member, resident, care setting, safeguarding referral or changed injury explanation is recorded.

Findings by requested category

Category	Conclusion
1. Placement in care	No positive placement evidence. Negative foster-care response on Part 1 p.46. Police-custody code on 13.09.1976 is not a care placement.
2. Physical abuse/injuries	No physical-abuse disclosure or safeguarding action. Childhood leg injury is attributed to an RTA, with chronic adult consequences.
3. Sexual abuse	No disclosure, symptom expressly linked to sexual abuse, sexual-health referral or safeguarding entry identified.
4. Emotional abuse	No recorded humiliation, threats, fear of staff, rejection, forced isolation or fear of returning to a placement.
5. Neglect	No childhood medical, physical, emotional or safeguarding neglect identified.
6. Contemporaneous disclosures	None identified.
7. Mental-health symptoms	Depressive episode/low mood, isolation, apathy, sleep disturbance, anxiety and bereavement-related death thoughts; no care/abuse link.
8. Mental-health medication	Sertraline 50mg in 2016 and May 2026. Improved mood documented in 2016; stopped after a few days in 2026 because stomach symptoms worsened.
9. Counselling/psychiatric care	Counselling and support links/crisis contacts sent in May 2026. No evidence of attendance, psychiatric admission, CMHT or trauma-focused therapy.
10. Self-harm/suicide	2016 DSH thoughts without intent; later negative risk entries. 2026 death thoughts with explicit denial of suicidal ideation/plans. 2025 positive code conflicts with abdominal-pain attachments.
11. Substance/alcohol use	Alcohol misuse, heroin/speed and cannabis history, heroin relapse and methadone treatment, later prescribed-opioid dependence/taper. No abuse/care causation stated.
12. Adult physical consequences	Chronic pain and mobility impairment linked to childhood RTA/ankle injury, not abuse or neglect.
13. Personal/social impact	Imprisonment, unemployment/work limitation, benefits appeals, isolation and reliance on pain/addiction services. No care/abuse link.
14. Third-party records	Relevant Lifeline Project, Pain Clinic, NHS111 and ambulance documents were checked, not merely the GP consultation summary.
15. Contradictory/neutral entries	Negative foster-care answer; multiple negative suicide/depression screens; 2025 suicide code unsupported by attachments; childhood injury consistently attributed to RTA.

Page-reference extraction schedule

PDF page numbers refer to the individual four-part files. The printed internal iGPR page is shown separately.

Document / PDF page	Internal	Date; clinician/source	Category and evidence	Value / link
Part 1 pp.1-3	1-3	Historic problem summaries; authors mostly unknown	Depressive episode (2016), opioid dependence; 1996 problem drinking 60 units/week; 1997 heroin/speed dependence; 2025 suicidal-thoughts code; 1980/1976 police custody; 1973 tibial fracture.	Impact/neutral. No abuse or placement link.
Part 1 pp.11-13	11-13	19-26.05.2026; Dr Terry, Dr Kyaw, Dr Brooks	Low mood, apathy, isolation, death thoughts, explicit denial of SI/plans, counselling advice, sertraline; later marked personality/functional change and depression-versus-physical differential.	Treatment/impact; no abuse link.
Part 1 p.43	43	06.04.2025; Katie Reynolds; attachments	Read code “Suicidal thoughts”; linked document titles include ambulance/NHS111 material.	Positive code, but contradicted by attachments.
Part 1 p.46	46	28.03.2025; online questionnaire	Denied homelessness in preceding ten years; answered “no” to foster care; stated no current alcohol use.	Neutral/negative evidence.
Part 1 pp.80-83	80-83	Mar-May 2022; clinical pharmacists/Dr Terry	Long dependence on pain medication; codeine withdrawal anxiety; Butec/Butrans initiation and supervised taper.	Substance treatment; no abuse link.
Part 1 p.125	125	14.10.2016; Julie Smithies	Walked with limp since age nine after RTA; ankle fixed/screwed; chronic foot pain and limited weight-bearing.	Alternative injury cause / adult impact.
Part 1 pp.126-129	126-129	08.07-09.09.2016; Dr Maloney/Dr Bennett and others	Depression/PHQ-9 12; heroin relapse; DSH thoughts without intent; Lifeline referral; sertraline; later improved mood and no TOSH/suicide.	Mental health/substance treatment; no abuse link.
Part 1 pp.135, 151 and 162	135, 151, 162	2010-2015; nursing and GP entries	Old traumatic foot injury; RTA as child; chronic pain/mobility and “stuck in house” depression-screen response.	Physical/social impact; no abuse link.
Part 1 p.144	144	06.06.2014; Dr Jane Maloney	Ex-heavy alcohol use, reportedly stopped seven years earlier; accidental paracetamol overdose for abdominal pain; A&E; referral.	Substance history/medical treatment; not self-harm.
Part 1 pp.166-167	166-167	09.11.2009; diabetes review	Depression screening recorded “no”.	Negative mental-health evidence.
Part 1 pp.174, 179-180	174, 179-180	Historic entries 1996-2006	Cannabis/police; prison release; history of drug/alcohol abuse; heroin/speed dependence; problem drinking; current abstinence reported in 2000.	Substance/social impact; no abuse link.
Part 1 pp.181 and 217	181, 217	Medication lists 2016 and 2026	Sertraline 50mg prescriptions in July/September 2016 and May 2026.	Mental-health medication.
Part 2 pp.59-61	385-387	06.04.2025; NHS111/Yorkshire Ambulance Service	Attendance concerns abdominal pain/septicaemia triage. One generic pathway line says the main reason was not a probable suicide attempt; ambulance outcome records abdominal pain.	Contradicts/does not substantiate suicidal-thoughts code.
Part 2 pp.149-151	475-477	12.04.2022; Anaesthesia & Pain Management/Pain Clinic	Chronic pancreatitis pain; codeine 60mg four times daily/co-codamol; past heroin addiction; wished to avoid codeine addiction; Butrans and codeine taper.	Third-party treatment/corroboration; no abuse link.
Part 3 pp.105-107	644-646	28.07.2016; Lifeline Project	Heroin dependence relapse, withdrawal/anxiety/low mood, no DSH/suicide thoughts, supportive wife, methadone commencement and supervision/follow-up.	Third-party addiction/mental-health evidence; no abuse link.
Part 4	730-830	Multiple historic medical attachments	No independent entry within the requested placement/abuse/mental-health/substance categories beyond information already represented in the GP summary was identified.	No highlights.

Important limitations and recommended follow-up

1. These records should not be used as the primary placement proof. Obtain the original local-authority, institutional, education and social-work records for Calder House, St Philip's School and Blackburn Community Home.

2. The absence of an abuse disclosure in a GP record does not disprove abuse. The supplied record is predominantly adult healthcare material and contains very little contemporaneous childhood clinical narrative.

3. The 06 April 2025 "suicidal thoughts" code should be clarified with the practice. The attached same-date NHS111 and ambulance documents describe an abdominal-pain presentation, so the code may be erroneous or may relate to a missing clinical note.

4. The March 2025 answer denying foster care should be presented accurately. It does not necessarily contradict residence in residential institutions, because the question asked only about foster care.

5. No record expressly says heroin, alcohol, prescribed-opioid dependence, depression, imprisonment, chronic pain or relationship/social difficulties were caused by childhood abuse or care. Causation should not be inferred.

Review method: all 830 pages were text-indexed and searched; relevant GP entries and attached Lifeline, Pain Clinic, NHS111 and ambulance records were visually inspected. Highlighting is yellow. Part 4 contains no independent highlighted entry. This schedule is an evidential extraction, not a medical diagnosis.