

GP Evidence Extraction Sheet

Matthew Ross - SAR medical records (119 PDF pages)

Review scope. This schedule records material relevant to care placement, abuse, injury, mental health, medication, counselling, self-harm, substance use, adult impact, third-party records and contradictory/neutral evidence. It does not infer abuse or causation where the medical record does not do so. Handwritten scans were treated cautiously.

Key conclusion

No clear evidence of residence in a children's home, residential school, foster placement or other care setting was identified in this GP file. No explicit disclosure of physical, sexual or emotional abuse in care was identified. The file does contain childhood injury records, adult anxiety and alcohol-dependence evidence, counselling/support, medication, imprisonment, chronic pain and a negative suicide finding. These may be evidence of injury or impact, but the GP record does not connect them to abuse in care.

Category	Finding	Pages
Placement in care	No institutional address, residential-school registration, care-home correspondence or GP registration while in care clearly identified.	Whole file; historic scans 64-113 checked
Direct abuse disclosure	No clear explicit physical, sexual or emotional abuse disclosure identified.	Whole file
Childhood injury	Extensive superficial burns in 1970, recorded as a fall into a fire; no abuse link.	1, 12, 64
Mental health / substances	Anxiety, low mood, tearfulness, poor sleep, racing thoughts, alcohol dependence/use as a coping crutch.	3-5, 8, 54-59
Self-harm / suicide	No positive self-harm entry found; 2023 note records no suicidal intent.	3
Counselling / support	RCA attendance/contact and alcohol-service information.	3-5, 54-59

Detailed extraction schedule

No.	Document / PDF page	Date / clinician	Category	Exact evidence / faithful summary	Care setting / perpetrator	Impact / treatment / link	Evidential value / follow-up
1	GP record summary Pages: 1	Current summary Dr Cassidy & Partners / iGPR	Identity / record source	Patient identified as Matthew Ross, DOB 07-Mar-1965; full record supplied.	Care: No care setting recorded. Perpetrator: - Frequency: -	Impact: - Treatment: - Link: No link recorded	Record identity / source Confirms the person and that this is a full GP record.
2	GP record summary Pages: 1 and 12	22-Aug-1970 Historic coded entry	Physical injury	Extensive superficial burns after reportedly falling into a fire: left forearm and hand, right forearm and upper arm, and left side of face.	Care: No care setting named. Perpetrator: No perpetrator recorded Frequency: Single recorded event	Impact: Extensive burns Treatment: Historic treatment not detailed in summary Link: No abuse link recorded	Corroborative injury evidence Important childhood injury, but the record attributes it to a fall into a fire and does not connect it with care or abuse.
3	Historic scanned notes Pages: 64, 66-70, 72, 74, 76-77	Childhood period; dates partly handwritten Historic GP / hospital notes	Historic medical history	Scanned handwritten childhood clinical notes and medical cards. Several entries are faint or difficult to read.	Care: No residential institution clearly identifiable from the legible portions. Perpetrator: Not recorded Frequency: Multiple historic entries	Impact: Various childhood presentations Treatment: Clinical care recorded in handwritten notes Link: No abuse link recorded	Historic record / possible corroboration Requires human checking against the original scans before formal quotation.
4	GP consultation / problem list Pages: 1, 3	01-Aug-2023 Dr Joe Cassidy, GP	Mental health; substance use; self-harm negative finding	Alcohol use described as at least a case and a half of beer daily for several months; unable to reduce or stop. Low mood and anxiety recorded, with no suicidal intent.	Care: Adult home setting Perpetrator: - Frequency: Several months	Impact: Low mood, anxiety, relationship/housing instability Treatment: Alcohol service contact details provided Link: No childhood-abuse link recorded	Impact / treatment Negative suicide finding should be retained: the note expressly says no suicidal intent.
5	GP consultations Pages: 5	05-Feb-2015 to 02-Jun-2015 Dr Honor Harkin / Dr Susie Noble	Mental health; bereavement; substance use	Tearfulness, anxiety, poor sleep, racing thoughts, reduced concentration and use of alcohol as a coping "crutch" following bereavement.	Care: Adult community Perpetrator: - Frequency: Repeated over several months	Impact: Anxiety, low mood, sleep disturbance, impaired concentration Treatment: Propranolol; short course diazepam; reviews; fit notes Link: Explicitly linked to bereavement, not care abuse	Impact / treatment The records state there was no previous history of anxiety/depression and that alcohol had not previously been used to cope with stress.
6	GP consultations / medication list Pages: 4-5, 8, 54-59	Feb-Jun 2015 GPs at Linden Medical Centre	Counselling / mental-health treatment	Repeated reference to attendance at RCA and contact with Frank; frequency later reduced to monthly as anxiety and mood improved.	Care: Adult community Perpetrator: - Frequency: Repeated	Impact: Anxiety, tearfulness, sleep disturbance Treatment: RCA support; propranolol; diazepam Link: No childhood-abuse link recorded	Treatment / impact Likely alcohol or counselling support; the record does not spell out the service name in full.
7	GP / hospital records Pages: 1, 6, 44, 60-61	15-Oct-2006 GP and Royal Alexandra Hospital	Physical injury	Traumatic dislocation of the right middle/long finger requiring closed reduction and fracture-clinic follow-up.	Care: Adult community Perpetrator: No perpetrator recorded Frequency: Single event	Impact: Joint dislocation Treatment: Closed reduction; hospital follow-up Link: No abuse link recorded	Physical consequence / treatment Mechanism is not stated in the summary pages reviewed.

No.	Document / PDF page	Date / clinician	Category	Exact evidence / faithful summary	Care setting / perpetrator	Impact / treatment / link	Evidential value / follow-up
8	GP consultation / referral Pages: 2, 42-45	Oct 2024 / Mar 2024 referral bundle Ms Wendy Wallace; Dr Honor Harkin; Dr John Dempster	Adult physical consequences	Longstanding right-sided back pain with sciatica, sleep disturbance and intermittent walking limitation; analgesia and physiotherapy advice recorded.	Care: Adult community Perpetrator: - Frequency: About three years	Impact: Chronic pain; sleep disturbance; functional limitation Treatment: Naproxen, co-codamol, PPI, self-referral to physiotherapy Link: No childhood-abuse link recorded	Impact / treatment No medical opinion connects this pain with childhood injury or abuse.
9	GP consultation Pages: 2	25-Oct-2024 Dr Honor Harkin	Sexual health / examination response	Patient reported being "taken by surprise" and "not prepared" for a proposed rectal examination; declined and was offered a male colleague. Erectile dysfunction/low libido also recorded.	Care: Adult community Perpetrator: - Frequency: Single consultation	Impact: Distress/reluctance around intimate examination; ED Treatment: Alternative clinician offered; sildenafil prescribed Link: No sexual-abuse link recorded	Possible impact only This must not be treated as proof of sexual abuse; the record makes no such connection.
10	GP record Pages: 9	09-Dec-2015 Ms Esther Fleming	Third-party / missing historic records	Immunisation status states that no childhood immunisations were documented in the notes.	Care: - Perpetrator: - Frequency: -	Impact: Missing childhood immunisation documentation Treatment: None Link: No abuse link	Record gap / neutral evidence Potentially relevant gap when assessing completeness of historic records.
11	GP record Pages: 1 and 12	16-Jun-2015 Practice data entry	Long-term social impact	"In prison" recorded as an active/problem entry.	Care: Prison Perpetrator: - Frequency: Single coded period	Impact: Imprisonment Treatment: Not stated Link: No abuse link recorded	Social impact The GP record does not connect imprisonment with childhood care or abuse.
12	GP and attached records Pages: 13-16, 19-63, 83-113	Various Hospitals, GP practice and other NHS services	Third-party / attached records	The file contains scanned hospital letters, referral forms, historic paper notes, investigation reports, registration pages and hospital treatment records.	Care: Various healthcare settings Perpetrator: - Frequency: Multiple	Impact: Various Treatment: Various Link: No general abuse link recorded	Record source / treatment These attachments were reviewed; no clear care-placement address or explicit abuse disclosure was identified in the legible material.

Limitations and verification notes

1. Many historic pages are scanned handwritten notes. Some are faint and not reliably legible; no uncertain wording has been presented as a definitive quotation. 2. A medical symptom or reluctance around an examination has not been treated as proof of sexual abuse. 3. The childhood burn record gives an accidental explanation and contains no safeguarding or perpetrator information. 4. The mental-health and alcohol entries are clinically linked to bereavement and adult circumstances, not expressly to childhood care or abuse. 5. Page references are PDF page numbers.