Evidence Extraction Sheet

Source: records.pdf | NHS / hospital clinical record bundle | 24 PDF pages

Placement in care	Yes - historic summary records "Social care - in social work care" dated 12/08/1980. No institution, address or placement dates are named.	19, 21, 23
Physical abuse	No direct record identified. Spinal/back pathology is documented, but no clinician links it to assault, abuse or a care placement.	3-8, 12, 15-17, 23
Sexual abuse	No explicit or indirect sexual-abuse disclosure or medical indicator linked to abuse identified in this bundle.	None identified
Emotional / psychological abuse	No direct description of abusive treatment identified. Historical anxiety and psychiatric assessment are present without cause.	19, 21, 23
Neglect	No medical, physical or safeguarding neglect by a care setting identified.	None identified
Contemporaneous disclosure	No contemporaneous disclosure of abuse by staff, residents or carers identified.	None identified
Mental health	Initial psychiatric assessment / anxiety in 1978; later antidepressant, antipsychotic and anxiolytic medication records. No abuse link stated.	19-24
Self-harm / suicide	Historical problem lists record deliberate drug overdose / poisoning in 1985, 1987 and 1998. Circumstances and intent details are not supplied here.	19, 21, 23
Physical consequences	Longstanding back pain/radiculopathy, surgery, persistent symptoms and nerve-root treatment. The record does not connect these to childhood abuse or care.	3-8, 12, 15-17, 23

Key placement finding

The strongest care-placement evidence in this hospital bundle is the repeated historical summary entry **"Social care - in social work care"** dated **12 August 1980** on PDF pages 19, 21 and 23. This supports that Craig Mein was recorded as being in social-work care at that date. It does **not** identify the children's home, residential school, foster placement or assessment centre, nor does it provide admission/discharge dates, placement address, responsible authority or care staff.

The same historical summaries also record an **initial psychiatric assessment / anxiety states on 13 October 1978** and an **at-risk-register entry on 6 February 1980 due to recurrent theft and house breaking**. Those entries may provide social-care context, but neither records abuse or identifies a care establishment.

Detailed extraction schedule

1. Identification / GP	PDF page(s): **2**
Date	Report details
Clinician / document	Patient & GP information
Exact evidence / faithful summary	Craig Mein, DOB 26/06/1967; address 142 Woodstock Avenue, Galashiels TD1 2EG; registered GP G Montgomerie at Waverley Medical Practice.
Care setting	None named
Link to abuse	No abuse link
Evidential value	Identity / healthcare provenance
Follow-up / caveat	None

2. Placement in care	PDF page(s): **19, 21, 23**
Date	12/08/1980
Clinician / document	Historic problem/procedure summary carried into NHS referral letters
Exact evidence / faithful summary	"Social care" with comment "in social work care".
Care setting	Not identified
Link to abuse	No abuse allegation recorded
Evidential value	Supporting evidence of being in social-work care on a specific date
Follow-up / caveat	No placement address, admission/discharge date or responsible authority stated.

3. Mental health	PDF page(s): **19, 21**
Date	13/10/1978
Clinician / document	Historic problem list
Exact evidence / faithful summary	"Anxiety states"; the same referral summaries list "Initial psych. assessment" dated 13/10/1978.
Care setting	Not identified
Link to abuse	No cause stated
Evidential value	Contemporaneous childhood mental-health evidence
Follow-up / caveat	No detail of assessment or treatment in this bundle.

4. Neutral / safeguarding context	PDF page(s): **19, 21, 23**
Date	06/02/1980
Clinician / document	Historic problem list
Exact evidence / faithful summary	"Theft - placed on at risk register due to recurrent theft and house breaking."
Care setting	Not identified
Link to abuse	No abuse link
Evidential value	Social/safeguarding context only
Follow-up / caveat	Does not establish abuse or placement.

5. Self-harm / overdose	PDF page(s): **19, 21, 23**
Date	27/08/1985
Clinician / document	Historic problem list
Exact evidence / faithful summary	"[X]Deliberate drug overdose / other poisoning."
Care setting	N/A
Link to abuse	No precipitant or trauma link stated
Evidential value	Evidence of later deliberate overdose
Follow-up / caveat	No method/substance, risk assessment or follow-up contained in these referral summaries.

6. Self-harm / overdose	PDF page(s): **19, 21, 23**
Date	23/08/1987
Clinician / document	Historic problem list
Exact evidence / faithful summary	"[X]Deliberate drug overdose / other poisoning."
Care setting	N/A
Link to abuse	No precipitant or trauma link stated
Evidential value	Evidence of later deliberate overdose
Follow-up / caveat	No detail of intent, treatment or safeguarding response in this bundle.

7. Self-harm / overdose	PDF page(s): **19, 21, 23**
Date	18/04/1998
Clinician / document	Historic problem list
Exact evidence / faithful summary	"[X]Deliberate drug overdose / other poisoning."
Care setting	N/A
Link to abuse	No precipitant or trauma link stated
Evidential value	Evidence of later deliberate overdose
Follow-up / caveat	No detailed episode narrative in this bundle.

8. Mental-health medication	PDF page(s): **24**
Date	2011-2012 medication history
Clinician / document	NHS referral medication list
Exact evidence / faithful summary	Trazodone 50 mg at night; trazodone 100 mg two capsules at night; quetiapine modified-release 50 mg twice daily.
Care setting	N/A
Link to abuse	Indication not stated; no abuse link recorded
Evidential value	Treatment evidence only
Follow-up / caveat	Medication list does not state diagnosis or treatment response.

9. Mental-health medication	PDF page(s): **20**
Date	2014 medication history
Clinician / document	NHS referral medication list
Exact evidence / faithful summary	Sertraline 50 mg daily, sertraline 100 mg daily and citalopram 10 mg daily are listed among recent medication.
Care setting	N/A
Link to abuse	Indications not stated
Evidential value	Treatment evidence only
Follow-up / caveat	No abuse/trauma causation stated.

10. Mental-health medication	PDF page(s): **22**
Date	2014-2015 medication history
Clinician / document	NHS referral medication list
Exact evidence / faithful summary	Quetiapine 25 mg twice daily; citalopram 20 mg daily; diazepam 5 mg courses including twice-daily dosing.
Care setting	N/A
Link to abuse	Indications not stated
Evidential value	Treatment evidence only
Follow-up / caveat	No abuse/trauma causation stated.

11. Physical consequence / medical	PDF page(s): **6**
Date	26/08/2013 dictation
Clinician / document	Neurosurgery clinic letter - Mr A K Demetriades
Exact evidence / faithful summary	Reports back pain "since the age of 16", radiating right-leg pain, pins and needles/numbness, walking limited to about 100 metres, weakness and L4/5 stenosis compressing the right L5 root.
Care setting	N/A
Link to abuse	No assault, abuse or care link recorded
Evidential value	Long-term physical health evidence; not corroboration of abuse on its own
Follow-up / caveat	Surgical versus non-surgical treatment discussed; pre-admission planning.

12. Physical consequence / medical	PDF page(s): **23**
Date	05/10/2012 referral
Clinician / document	GP referral - Dr Alistair Wright
Exact evidence / faithful summary	Patient advised he had back problems "since the age of 16" with worsening pain/burning down the right leg; MRI showed annular tear/disc bulge at L4/5 contacting the L5 nerve root.
Care setting	N/A
Link to abuse	No assault, abuse or care link recorded
Evidential value	Earlier corroboration of longstanding back symptoms
Follow-up / caveat	Referral to neurosurgery.

13. Physical consequence / treatment	PDF page(s): **3**
Date	10-11/10/2013 episode
Clinician / document	Inpatient discharge summary
Exact evidence / faithful summary	Chronic low-back pain and right-leg radicular pain; L4/5 disc herniation compressing right L5 nerve root; right L4/5 microdiscectomy on 10/10/2013; codeine/tramadol analgesia.
Care setting	Hospital admission, not care placement
Link to abuse	No abuse link
Evidential value	Medical treatment evidence
Follow-up / caveat	Neurosurgical follow-up; GP to reduce analgesia as tolerated.

14. Neutral / treatment	PDF page(s): **4**
Date	10-11/10/2013
Clinician / document	Inpatient discharge summary
Exact evidence / faithful summary	Hospital admission 10/10/13 and discharge 11/10/13 after lumbar surgery; "recovered well" and "no perioperative complications"; discharged home.
Care setting	Hospital, not residential care
Link to abuse	No abuse link
Evidential value	Neutral medical outcome
Follow-up / caveat	Outpatient physiotherapy and clinic review.

15. Physical consequence / medical	PDF page(s): **7**
Date	31/03/2014 dictation
Clinician / document	Neurosurgery clinic letter - Mark White, SpR
Exact evidence / faithful summary	Persistent low-back/hip/buttock pain and altered sensation over the right foot six months after surgery.
Care setting	N/A
Link to abuse	No abuse link
Evidential value	Ongoing physical impact
Follow-up / caveat	Further imaging/follow-up considered.

16. Physical consequence / medical	PDF page(s): **8**
Date	03/11/2014 dictation
Clinician / document	Neurosurgery clinic letter - Mr A Demetriades
Exact evidence / faithful summary	Recurrent right L5 radiculopathy; persistent lateral-recess stenosis compromising the right L5 nerve root; tramadol and pregabalin recorded.
Care setting	N/A
Link to abuse	No abuse link
Evidential value	Ongoing physical impact and treatment
Follow-up / caveat	Plan for diagnostic/therapeutic nerve-root block.

17. Neutral / continuity of care	PDF page(s): **10-11**
Date	31/01/2015 and 14/09/2015
Clinician / document	Neurosurgery correspondence
Exact evidence / faithful summary	Planned nerve-root block not attended without notice; later outpatient appointment cancelled at short notice and patient discharged back to GP care after a second occurrence.
Care setting	N/A
Link to abuse	No trauma/abuse explanation recorded
Evidential value	Neutral attendance history
Follow-up / caveat	Care returned to GP; later re-referral occurred.

18. Physical consequence / medical	PDF page(s): **12**
Date	21/12/2015 dictation
Clinician / document	Neurosurgery clinic letter
Exact evidence / faithful summary	Persistent right-leg pain after surgery; previous L5 nerve-root block had not been attended; plan for hip X-ray and image-guided L5 nerve-root block.
Care setting	N/A
Link to abuse	No abuse link
Evidential value	Ongoing physical impact / treatment
Follow-up / caveat	Radiology referral and further treatment.

19. Physical consequence / imaging	PDF page(s): **15**
Date	04/10/2013
Clinician / document	Western General Hospital radiology report
Exact evidence / faithful summary	MRI: L4/5 disc protrusion with right L5 nerve-root compression; progression from prior imaging.
Care setting	N/A
Link to abuse	No assault or trauma mechanism stated
Evidential value	Objective medical imaging
Follow-up / caveat	Imaging used for planned microdiscectomy.

20. Physical consequence / imaging	PDF page(s): **16**
Date	21/12/2015
Clinician / document	Western General Hospital radiology report
Exact evidence / faithful summary	Right hip X-ray: minimal degenerative change of both hips; SI joints and remainder of pelvis normal.
Care setting	N/A
Link to abuse	No abuse link
Evidential value	Objective imaging / neutral finding
Follow-up / caveat	None stated.

21. Physical consequence / treatment	PDF page(s): **17**
Date	18/02/2016
Clinician / document	Western General Hospital radiology report
Exact evidence / faithful summary	CT-guided right L5 nerve-root injection with local anaesthetic, levobupivacaine and Kenalog; no immediate complication.
Care setting	N/A
Link to abuse	No abuse link
Evidential value	Treatment evidence
Follow-up / caveat	No immediate complication.

Category review - evidence not identified

Direct physical abuse

No entry describes Craig being hit, slapped, punched, kicked, beaten, restrained, force-fed, subjected to punitive cold bathing, or injured by care staff/residents. The spinal condition is extensively documented but no record attributes it to abuse.

Sexual abuse

No rape, sexual assault, inappropriate touching, sexualised behaviour, genital/anal injury, STI, grooming, forced nudity, intrusive bathing or later sexual-abuse disclosure appears in this 24-page hospital bundle.

Emotional / psychological abuse

No clinical entry describes humiliation, threats, intimidation, rejection, fear of staff, fear of returning to a placement, or emotional deterioration caused by a named care setting.

Neglect

No entry identifies untreated childhood injury/illness caused by a care setting, inadequate food/clothing/hygiene, failure to obtain healthcare, or failure to protect from staff/peer abuse.

Contemporaneous disclosure

No record in this bundle contains a childhood disclosure that a member of staff, resident, carer or foster carer harmed or sexually assaulted Craig.

Explicit causation

No clinician in these records links the documented mental-health history, overdoses, psychiatric medication or spinal disease to childhood abuse, trauma or being in care.

Third-party and attached material reviewed

The bundle includes inpatient discharge summaries (pages 3-4), neurosurgery clinic correspondence (pages 6-13), radiology reports (pages 15-17), and NHS Lothian referral letters carrying historic GP problem/procedure and medication summaries (pages 19-24). The repeated social-work-care entry appears within those referral summaries rather than as a standalone social-work record.

Evidential interpretation

Placement: The 12/08/1980 "in social work care" entry is useful supporting evidence that Craig was under social-work care, but it cannot by itself identify which eligible care setting he lived in or establish the full placement period. It should be read alongside social-work, Children's Hearing, school, residential or local-authority records if available.

Abuse: This bundle does not provide direct evidence of physical, sexual, emotional abuse or neglect in care. The mental-health, overdose and spinal records are therefore best treated as health history / possible impact evidence only unless another source expressly connects them to the alleged abuse.

Neutral material: Missed appointments, normal/positive post-operative findings and the absence of an abuse link have been retained rather than omitted, in accordance with the requested approach to contradictory or neutral evidence.