Evidence Extraction Sheet

Colin Sanders - review of 17 supplied PDF record sets

Scope: 1,003 PDF pages reviewed, including 822 image-only historic pages. Scanned pages were OCR-indexed for search and the key evidential pages quoted in this sheet were visually checked against the page image. Highlighted source copies are supplied separately and remain protected with the password provided by the user.

Important evidential cautions

• This extraction does not decide whether abuse occurred. It identifies what the supplied records say and distinguishes direct placement evidence, patient/third-party disclosures, clinical formulations, treatment/impact evidence, and neutral or contradictory material.

• Medical symptoms are not treated as proof of sexual abuse unless the record itself makes that connection. Likewise, injuries are not labelled abuse where the record gives no abuse link.

• The record uses both **Rosidene** (1982 contemporaneous hospital letter) and **Rosedene** (2018 adult disclosure). Both spellings are preserved rather than silently reconciled.

• The 1999 psychiatric history was visually checked: it says **6 different foster homes**, not sixteen.

• The 2018 psychiatric letter has a date discrepancy: the header gives clinic date 14 Dec 2018, while the narrative says the patient attended on 13 Dec 2018. Both are retained.

High-value placement timeline

Date	Record / page	Placement evidence
Apr 1982	BS Vol 2 PDF p19 / continuous p419	Rosidene Children's Home recorded as patient address and residence.
Dec 1985	BS Vol 2 PDF p17 / continuous p417	Children's hearing varied supervision requirement; excessive punishment; foster residence ordered while home situation resolved.
Jan-Feb 1987	BS Vol 2 PDF pp11,13 / continuous pp411,413	Kirkton, Dunvegan; explicitly fostered by a Dunvegan family; foster mother accompanied him to clinic.
Feb-Mar 1987	BS Vol 2 PDF pp3,5,7,9 / continuous pp403-409	Repeated specialist correspondence uses Kirkton address; one letter says move to Inverness expected soon.
Jan-May 1988	BS Vol 2 PDF pp49,41 (351-400 split) / continuous pp399,391	Ferintosh House, Conon Bridge recorded as patient address/c/o address; school/senior medical officer copies.
Oct 1999	BS Vol 2 PDF p27 / continuous p277	Retrospective psychiatric history: lived in 6 different foster homes mainly in the Highlands.
Jan 2018	Docman PDF p85 / continuous p285	Adult disclosure names Rosedene Children's Home, many foster parents, and Ferintosh as last Children's Home.
Dec 2018	Docman PDF p71 / continuous p271	Psychiatric history: in care accommodation on and off from age nine; abused by carers (retrospective).

Category findings matrix

Requested category	Finding	Key basis
1. Placement in care	YES - strong contemporaneous evidence	1982 Rosidene Children's Home; 1985 supervision/foster decision; 1987 Kirkton foster placement; 1988 Ferintosh House; later retrospective accounts.
2. Physical abuse	YES	1985 "excessive punishment" (method unspecified); 2013 psychiatric description of physical abuse; 2018 detailed Rosedene/foster/Ferintosh disclosures.
3. Sexual abuse	YES - adult retrospective disclosures	2017 pain-service letters; detailed 2018 CMHT disclosure including care settings/foster carers. No historic childhood medical record located that explicitly records sexual abuse at the time.
4. Emotional/psychological abuse	YES	2013 humiliating/degrading acts; 2018 emotional/mental abuse and threats; fear, trust difficulty and hypervigilance documented later.
5. Neglect	YES - retrospective	2018 disclosure of starvation/hunger in foster care and allegation that staff at Rosedene knew of abuse and did nothing.
6. Contemporaneous disclosures	LIMITED childhood contemporaneous material	Strongest childhood contemporaneous item is the 1985 official children's-hearing concern about excessive punishment and foster residence. Detailed abuse disclosures are recorded retrospectively from adulthood, especially 2017-2018.
7. Mental-health conditions/symptoms	YES	Anxiety/panic, depression/low mood, PTSD, personality-disorder terminology, flashbacks, nightmares, hypervigilance, anger, withdrawal, trust difficulty.
8. Mental-health medication	YES	Diazepam/temazepam/propranolol/citalopram/paroxetine/amitriptyline/quetiapine and others across the record; reasons and uncertainty vary by date.
9. Counselling/therapy/psychiatric care	YES	Psychiatry, psychology, trauma-focused work, CMHT, Survive and Thrive, repeated referrals and non-attendance/disengagement.
10. Self-harm/suicide	YES, with negative findings also present	1999 custody hanging/suffocation attempt; later suicidal thoughts; cigarette-burning self-harm; later denials of current suicidal thoughts/plans.
11. Substance/alcohol use	YES	Alcohol intoxication/abuse, cannabis/skunk addiction, amphetamine/ecstasy/cocaine history, benzodiazepine misuse; 2024 explicit alcohol/medication use to manage PTSD symptoms.
12. Physical consequences in adulthood	SOME explicit links	2025 ED letter links childhood abuse with mental-health difficulty and chronic pain; other records explicitly link childhood trauma to sleep disturbance. Most chronic pain records do not independently attribute the underlying spinal pathology to abuse.
13. Long-term personal/social impact	YES	Isolation/withdrawal, sleep reversal, difficulty trusting male/authority practitioners, family impact, anger, repeated disengagement because of retelling/continuity problems.
14. Third-party/attached records	YES	Children's-hearing document, hospital letters, psychiatric/psychology reports, pain-service letters, GP referrals, school/senior medical officer copies, historic scanned notes.
15. Contradictory/neutral entries	YES - retained	1999 psychiatrist judged crisis not a serious suicide attempt; 2000 no ongoing psychiatric disorder; repeated denials of current suicidality; 1987 skull X-ray negative; 1988 clinician attributed nose trauma to self; medication indication later described as uncertain.
16. Extraction schedule	DELIVERED	Detailed entries below contain document, exact PDF page, internal page, date, clinician, category, evidence, care setting, perpetrator, frequency/duration, impact, treatment, abuse link, evidential value and follow-up.

Detailed evidence extraction schedule

Entries below prioritise non-duplicative evidential passages. Repeated prescription/problem-list reproductions and additional supporting pages are indexed in the final appendix and highlighted in the source copies.

1. 20-22 Apr 1982; letter 27 Apr 1982 - Placement; injury/treatment

Document	Pages BS Vol 2 401-476 .pdf
PDF page	19
Internal page	BS Vol 2 continuous page 419
Date	20-22 Apr 1982; letter 27 Apr 1982
Patient age	10
Clinician / role	C.A.S. Galloway, Consultant Paediatrician
Category	Placement; injury/treatment
Exact evidence / faithful summary	Patient address is recorded as "Rosidene Children's Home, Inverness" and the letter states that he "stays in Rosidene Children's Home". Referred to Casualty after he "bumped his head" with headache and vomiting; admitted for observation. Skull X-ray showed no fracture; right frontal bruise recorded; discharged 22 Apr 1982 with diagnosis concussion.
Care setting	Rosidene Children's Home, Inverness
Perpetrator / role	Not recorded
Frequency / duration	Single head-injury episode
Injury or impact	Right frontal bruise; headache/vomiting; concussion; no skull fracture
Treatment	Hospital observation and skull X-ray
Link to abuse	Possible corroborative injury while resident in care; record does not connect injury to abuse
Evidential value	Direct contemporaneous placement + contemporaneous injury in care
Follow-up / safeguarding	No safeguarding action recorded in this letter

2. Hearing 9 Dec 1985; notice 10 Dec 1985 - Placement; physical/emotional abuse concern

Document	Pages BS Vol 2 401-476 .pdf
PDF page	17
Internal page	BS Vol 2 continuous page 417
Date	Hearing 9 Dec 1985; notice 10 Dec 1985
Patient age	13
Clinician / role	Reporter to the Children's Panel / Highland Region
Category	Placement; physical/emotional abuse concern
Exact evidence / faithful summary	Official children's-hearing notice records a supervision requirement concerning Colin. Reasons include that the home relationship was having an adverse effect on him, that "excessive punishment was meted out to Colin" and a very serious view was taken, and that until the home situation was resolved the panel considered it in his best interests to reside with foster parents.
Care setting	Foster placement ordered; prior home situation in Inverness
Perpetrator / role	Not named in visible text
Frequency / duration	Existing supervision requirement; foster residence until home situation resolved
Injury or impact	Adverse emotional effect; excessive punishment (method not specified)
Treatment	Children's-hearing supervision / foster placement decision
Link to abuse	Explicit official concern; punishment type is not specified and should not be expanded beyond the record
Evidential value	Strong direct contemporaneous placement evidence and official abuse/punishment concern
Follow-up / safeguarding	Right of appeal recorded; supervision requirement varied

3. Injury 2 Oct 1986; clinic letter 27 Oct 1986 - Injury/treatment; neutral contextual entry

Document	Pages BS Vol 2 401-476 .pdf
PDF page	15
Internal page	BS Vol 2 continuous page 415
Date	Injury 2 Oct 1986; clinic letter 27 Oct 1986
Patient age	14
Clinician / role	Raigmore Hospital Fracture Clinic / Orthopaedic Registrar
Category	Injury/treatment; neutral contextual entry
Exact evidence / faithful summary	Right elbow injury on 2 Oct 1986 caused a fracture of the lateral condyle. Treated conservatively in plaster; plaster removed 27 Oct 1986 and elbow almost fully recovered. The page does not identify a care address or cause beyond "injured his right elbow".
Care setting	Not established on this page
Perpetrator / role	Not recorded
Frequency / duration	Single injury
Injury or impact	Right lateral-condyle fracture
Treatment	Plaster; fracture-clinic follow-up; discharged
Link to abuse	No abuse link recorded; care status not established on page
Evidential value	Neutral injury record; potentially relevant only if placement dates are independently established
Follow-up / safeguarding	No safeguarding action recorded

4. 28 Jan 1987 - Placement; GP care while fostered

Document	Pages BS Vol 2 401-476 .pdf
PDF page	13
Internal page	BS Vol 2 continuous page 413
Date	28 Jan 1987
Patient age	14
Clinician / role	Referring GP, Dunvegan (signature unclear)
Category	Placement; GP care while fostered
Exact evidence / faithful summary	Referral gives address "Kirkton, Dunvegan, Isle of Skye" and states: "He is a boy with a very turbulent social history who is being fostered by a family in Dunvegan but his home is really in Inverness."
Care setting	Foster family at Kirkton, Dunvegan
Perpetrator / role	-
Frequency / duration	Current foster placement in Jan 1987
Injury or impact	Social-history disruption; respiratory complaint unrelated to abuse
Treatment	GP referral to Raigmore Chest Clinic
Link to abuse	No abuse link in this clinical complaint
Evidential value	Strong direct contemporaneous foster-placement evidence; GP referral while fostered
Follow-up / safeguarding	Specialist chest opinion requested

5. Clinic 4 Feb 1987; letter 6 Feb 1987 - Placement; carer attendance

Document	Pages BS Vol 2 401-476 .pdf
PDF page	11
Internal page	BS Vol 2 continuous page 411
Date	Clinic 4 Feb 1987; letter 6 Feb 1987
Patient age	14

Clinician / role	Raigmore Chest Clinic
Category	Placement; carer attendance
Exact evidence / faithful summary	Hospital letter lists "Kirkton, Dunvegan" and records: "His foster mother, who accompanied him to the clinic, does not think that he is breathless or wheezy at home. She does not know his past medical history."
Care setting	Kirkton, Dunvegan foster placement
Perpetrator / role	-
Frequency / duration	Current foster placement
Injury or impact	No abuse-related injury on this page
Treatment	Specialist assessment; inhaler advice
Link to abuse	No abuse link recorded
Evidential value	Direct contemporaneous placement and foster-carer accompaniment
Follow-up / safeguarding	Clinic review continued

6. 19 Feb 1987 clinic; letter 25 Feb 1987 - Placement; possible placement change

Document	Pages BS Vol 2 401-476 .pdf
PDF page	5
Internal page	BS Vol 2 continuous page 405
Date	19 Feb 1987 clinic; letter 25 Feb 1987
Patient age	14
Clinician / role	W.D. Murray / Culduthel Hospital chest service
Category	Placement; possible placement change
Exact evidence / faithful summary	Address remains "Kirkton, Dunvegan". Letter says the patient is "going to be moving to the Inverness area in the fairly near future" and therefore no further Portree appointment was made, with Inverness review available if needed.
Care setting	Kirkton, Dunvegan
Perpetrator / role	-
Frequency / duration	Foster placement; anticipated move to Inverness
Injury or impact	None relevant
Treatment	Specialist follow-up planning
Link to abuse	No abuse link recorded
Evidential value	Corroborates residence and an anticipated placement/geographical change; does not explicitly say GP transfer
Follow-up / safeguarding	No appointment arranged because of expected move

7. Surgery 30 Mar 1987; letter 2 Apr 1987 - Placement; hospital care while fostered

Document	Pages BS Vol 2 401-476 .pdf
PDF page	3
Internal page	BS Vol 2 continuous page 403
Date	Surgery 30 Mar 1987; letter 2 Apr 1987
Patient age	15
Clinician / role	Stuart W. Brodie, ENT
Category	Placement; hospital care while fostered
Exact evidence / faithful summary	Patient address is "Kirkton, Dunvegan". Admitted for ear surgery on 30 Mar 1987; right myringotomy showed thick fluid, left was dry; allowed home the following day.
Care setting	Kirkton, Dunvegan
Perpetrator / role	-
Frequency / duration	Current placement

Injury or impact	Ear disease; not abuse-related
Treatment	Myringotomy; overnight admission; discharge home
Link to abuse	No abuse link recorded
Evidential value	Supporting contemporaneous residence and hospital treatment while fostered
Follow-up / safeguarding	Re-referral if symptoms persisted

8. X-ray dated 7 Jan 1987 - Injury/treatment; neutral negative finding

Document	Pages BS Vol 2 401-476 .pdf
PDF page	75
Internal page	BS Vol 2 continuous page 475
Date	X-ray dated 7 Jan 1987
Patient age	14
Clinician / role	Radiology
Category	Injury/treatment; neutral negative finding
Exact evidence / faithful summary	Skull X-ray report lists address "Kirkton Cott., Dunvegan" and states "No bone injury seen." The reason for the skull X-ray is not given on this page.
Care setting	Kirkton Cottage, Dunvegan
Perpetrator / role	Not recorded
Frequency / duration	Single imaging episode
Injury or impact	No bone injury on skull X-ray
Treatment	Skull X-ray
Link to abuse	No abuse link recorded
Evidential value	Placement-address corroboration plus negative injury finding
Follow-up / safeguarding	None recorded

9. Admissions 5 and 12 Mar 1988; procedure/discharge 18 Mar; letter 28 Mar 1988 - Placement; injury/treatment; neutral/contradictory

Document	Pages BS Vol 2 351 - 400 .pdf
PDF page	43
Internal page	BS Vol 2 continuous page 393
Date	Admissions 5 and 12 Mar 1988; procedure/discharge 18 Mar; letter 28 Mar 1988
Patient age	16
Clinician / role	Raigmore ENT
Category	Placement; injury/treatment; neutral/contradictory
Exact evidence / faithful summary	Letter gives address "Kirkton, Dunvegan". Recurrent epistaxis led to two admissions and cautery. Clinician recorded a strong opinion that the patient had been traumatising his own nose, explaining continued bleeding. This is a clinical alternative explanation and not recorded as abuse.
Care setting	Kirkton, Dunvegan
Perpetrator / role	Patient himself, according to clinician's opinion
Frequency / duration	Recurrent nosebleeds over March 1988
Injury or impact	Epistaxis; excoriated Little's areas
Treatment	Cautery, general anaesthetic, Naseptin suggested
Link to abuse	Explicit non-abuse clinical explanation
Evidential value	Neutral/contradictory medical explanation while care address recorded
Follow-up / safeguarding	Discharged 18 Mar 1988

10. 5 Jan 1988 dictated; letter 27 Jan 1988 - Placement; school-health corroboration

Document	Pages BS Vol 2 351 - 400 .pdf
PDF page	49
Internal page	BS Vol 2 continuous page 399
Date	5 Jan 1988 dictated; letter 27 Jan 1988
Patient age	15
Clinician / role	Stuart W. Brodie, ENT
Category	Placement; school-health corroboration
Exact evidence / faithful summary	Patient address is "Ferintosh House, Conon Bridge" with parental address shown separately as 80 Drakies Avenue, Inverness. Ongoing conductive hearing loss and middle-ear fluid; placed on waiting list for ventilation tubes. Copy sent to Dr Scott, School Medical Officer.
Care setting	Ferintosh House, Conon Bridge
Perpetrator / role	-
Frequency / duration	Current residence in Jan 1988
Injury or impact	Hearing loss / middle-ear fluid
Treatment	ENT review; waiting list for ventilation tubes
Link to abuse	No abuse link recorded
Evidential value	Strong contemporaneous institutional-address evidence and school-medical correspondence
Follow-up / safeguarding	Copy to School Medical Officer

11. Admission 24 Apr 1988; letter 3 May 1988 - Placement; hospital discharge/correspondence

Document	Pages BS Vol 2 351 - 400 .pdf
PDF page	41
Internal page	BS Vol 2 continuous page 391
Date	Admission 24 Apr 1988; letter 3 May 1988
Patient age	16
Clinician / role	Stuart W. Brodie, ENT
Category	Placement; hospital discharge/correspondence
Exact evidence / faithful summary	Patient is recorded "c/o Ferintosh House, Conon Bridge". Ear examination under anaesthetic on 25 Apr; ventilation tube inserted. Several hours later he swallowed a closed safety pin; abdominal X-ray showed it in the intestines. Allowed home on 26 Apr with advice to return for abdominal pain. Copy sent to a Senior Medical Officer in Dingwall.
Care setting	Ferintosh House, Conon Bridge
Perpetrator / role	Not recorded
Frequency / duration	Current residence
Injury or impact	Swallowed closed safety pin; no reported abdominal injury at discharge
Treatment	Abdominal X-ray; discharge advice; ENT follow-up
Link to abuse	No abuse link recorded
Evidential value	Direct placement-address evidence; contemporaneous hospital care and medical-officer correspondence
Follow-up / safeguarding	Four-month ENT follow-up

12. Psychiatric assessment 8 Oct 1999 - Placement history; substance use; suicide neutral finding

Document	Pages BS Vol 2 251-300 .pdf
PDF page	27
Internal page	BS Vol 2 continuous page 277

Date	Psychiatric assessment 8 Oct 1999
Patient age	27
Clinician / role	Dr E Anderson, SHO (assessment continued from pp25/29)
Category	Placement history; substance use; suicide neutral finding
Exact evidence / faithful summary	Personal history states that after his parents separated when he was aged 2, he "lived in 6 different foster homes mainly in the Highlands." The same assessment records prior amphetamine/ecstasy/freebase cocaine/cannabis use and current cannabis use to get back to sleep. On examination he was not suicidal; mood was assessed euthymic.
Care setting	Six foster homes, mainly Highlands (retrospective account)
Perpetrator / role	-
Frequency / duration	Multiple placements after age 2 (retrospective)
Injury or impact	Sleep disturbance; substance use; no current suicidality
Treatment	Psychiatric assessment; temazepam/propranolol listed
Link to abuse	No abuse link in this 1999 placement history
Evidential value	Retrospective placement corroboration and neutral mental-state evidence
Follow-up / safeguarding	Outpatient follow-up offered

13. 8 Oct 1999 - Self-harm/suicide; substance use; injury

Document	Pages BS Vol 2 251-300 .pdf
PDF page	25
Internal page	BS Vol 2 continuous page 275
Date	8 Oct 1999
Patient age	27
Clinician / role	Dr E Anderson, SHO / psychiatric assessment
Category	Self-harm/suicide; substance use; injury
Exact evidence / faithful summary	While intoxicated in police custody he wrapped trousers around his neck and attempted to strangle/suffocate himself. The letter also records alleged severe facial bruising attributed by him to police handling, ecstasy tablets found in his possession (which he denied were his), and past periodic alcohol/substance abuse.
Care setting	-
Perpetrator / role	Police handling alleged for facial bruising; self for strangulation attempt
Frequency / duration	Single crisis event
Injury or impact	Facial bruising; attempted strangulation/suffocation; subsequent seizure-like episodes
Treatment	Psychiatric and medical assessment; CT planned
Link to abuse	Not linked to childhood abuse in this record
Evidential value	Direct self-harm/suicide-crisis evidence with stated competing context of intoxication/custody
Follow-up / safeguarding	Psychiatric review

14. Admission 8-11 Oct 1999; letter 3 Nov 1999 - Self-harm/suicide; substance use; injury/treatment

Document	Pages BS Vol 2 251-300 .pdf
PDF page	7
Internal page	BS Vol 2 continuous page 257
Date	Admission 8-11 Oct 1999; letter 3 Nov 1999
Patient age	27
Clinician / role	Raigmore Hospital medical team
Category	Self-harm/suicide; substance use; injury/treatment

Exact evidence / faithful summary	After drinking and possible ecstasy/Valium ingestion, patient was found cyanosed and unresponsive in police cells with a blanket and trousers around his neck. Two witnessed seizures in A&E and another on the ward; Diazepam given. Right peri-orbital bruise recorded; spine X-ray and CT brain normal. He later told the Duty Psychiatrist he had tried to kill himself and regretted it.
Care setting	-
Perpetrator / role	Self (suicide attempt); bruise cause not established in this letter
Frequency / duration	Single acute crisis
Injury or impact	Cyanosis/unresponsiveness; seizures; right peri-orbital bruise
Treatment	Diazepam, observation, CT brain, X-ray; psychiatric review
Link to abuse	No childhood-abuse link recorded
Evidential value	Direct suicide-attempt and treatment evidence
Follow-up / safeguarding	Consultant psychiatric follow-up

15. 8 Oct 1999 assessment - Contradictory/neutral suicide interpretation

Document	Pages BS Vol 2 251-300 .pdf
PDF page	29
Internal page	BS Vol 2 continuous page 279
Date	8 Oct 1999 assessment
Patient age	27
Clinician / role	Dr E Anderson, SHO
Category	Contradictory/neutral suicide interpretation
Exact evidence / faithful summary	Psychiatric impression states the clinician did not regard the episode as a serious suicide attempt, instead describing a situational crisis while intoxicated and locked in a cell with claustrophobia. Ongoing sleep problems were attributed partly to social circumstances and cannabis use.
Care setting	-
Perpetrator / role	-
Frequency / duration	Single assessment following same event
Injury or impact	Sleep disturbance; crisis
Treatment	Outpatient follow-up offered
Link to abuse	Alternative/neutral interpretation; no childhood-abuse link
Evidential value	Important contradictory/qualifying contemporaneous opinion
Follow-up / safeguarding	Outpatient appointment offered

16. Clinic 22 Dec 1999; letter 5 Jan 2000 - Mental health; substance use; contradictory/neutral

Document	Pages BS Vol 2 201-250.pdf
PDF page	47
Internal page	BS Vol 2 continuous page 247
Date	Clinic 22 Dec 1999; letter 5 Jan 2000
Patient age	27
Clinician / role	Dr N. Ali, Consultant Psychiatrist
Category	Mental health; substance use; contradictory/neutral
Exact evidence / faithful summary	Patient described paranoia and anxiety. Consultant considered these related to earlier amphetamine abuse and found no evidence of an ongoing psychiatric disorder. Paroxetine 20 mg and beta blockers could continue for a few months for anxiety; no further psychiatric appointment made.
Care setting	-
Perpetrator / role	-
Frequency / duration	Ongoing anxiety after substance use

Injury or impact	Anxiety/paranoid feelings
Treatment	Paroxetine; beta blocker
Link to abuse	No childhood-abuse link; alternative substance-related formulation
Evidential value	Neutral/contradictory diagnostic evidence
Follow-up / safeguarding	Discharged from psychiatrist

17. 9 Jul 2002 - Mental health; medication; self-harm; substance use

Document	Pages BS Vol 2 151 - 200 .pdf
PDF page	9
Internal page	BS Vol 2 continuous page 159
Date	9 Jul 2002
Patient age	30
Clinician / role	Dr Sian Jones, Registrar to Dr Syme (referral)
Category	Mental health; medication; self-harm; substance use
Exact evidence / faithful summary	Referral describes about five years of insomnia and paranoid ideas, past significant drug abuse, ongoing cannabis, repeated requests for Diazepam, and anxiety treated with propranolol. Citalopram 20 mg had not helped; Zopiclone not tolerated. Records two past suicide attempts "allegedly by trying to hang himself" and says he denied current suicidal ideation but sometimes feared acting impulsively during sleepless nights.
Care setting	-
Perpetrator / role	-
Frequency / duration	Chronic insomnia/anxiety; historical attempts
Injury or impact	Insomnia, anxiety, paranoia; intermittent suicidal thoughts at night
Treatment	Citalopram unsuccessful; propranolol; prior Diazepam/Temazepam; Zopiclone intolerant
Link to abuse	No childhood-abuse link in this letter
Evidential value	Mental-health, medication and suicide-risk evidence with negative current finding
Follow-up / safeguarding	Psychiatric review requested

18. 15 Nov 2002 - Mental health; substance use; therapy attendance

Document	Pages BS Vol 2 151 - 200 .pdf
PDF page	3
Internal page	BS Vol 2 continuous page 153
Date	15 Nov 2002
Patient age	30
Clinician / role	Riverside GP referral to Dr D. Gordon
Category	Mental health; substance use; therapy attendance
Exact evidence / faithful summary	Referral cites "multiple drug abuse, severe headaches and attempted hanging whilst in Police custody", ongoing insomnia, paranoia and anxiety attacks, intermittent benzodiazepine courses, regular cannabis, and apparent benzodiazepine dependence. It notes a previous psychiatric appointment had been missed and stresses importance of attending future appointments.
Care setting	-
Perpetrator / role	-
Frequency / duration	Longstanding symptoms and drug use
Injury or impact	Insomnia, paranoia, anxiety; past attempted hanging
Treatment	Propranolol; intermittent benzodiazepines; psychiatrist referral
Link to abuse	No childhood-abuse link in this letter
Evidential value	Mental-health/substance/treatment history and missed-appointment evidence
Follow-up / safeguarding	Repeat psychiatric referral

19. 6 Nov 2008 and later problem-list entries - Mental health; substance use; treatment history

Document	cs Summary (1).pdf
PDF page	24
Internal page	Printed report page 24/114
Date	6 Nov 2008 and later problem-list entries
Patient age	36
Clinician / role	GP problem list / coded history
Category	Mental health; substance use; treatment history
Exact evidence / faithful summary	Problem list records anxiety culminating in panic attacks and "Meets criteria for PTSD (childhood abuse)" on 6 Nov 2008. Same date records a 12-year cannabis/"skunk" addiction and referral to substance-abuse CPNs with later discharge for non-engagement (12 Feb 2010). The page also records depressive episode (2009), low mood (2012), severe-childhood-abuse-related borderline traits (2013), and the 1999 self-harm episode.
Care setting	-
Perpetrator / role	Not specified in the PTSD code
Frequency / duration	PTSD criteria noted 2008; prolonged cannabis history
Injury or impact	PTSD/panic attacks; depression/low mood; addiction
Treatment	Substance-abuse CPN referral; later psychiatric care
Link to abuse	Explicit childhood-abuse link for PTSD
Evidential value	Strong longitudinal coded mental-health and substance history
Follow-up / safeguarding	CPN referral; non-engagement/discharge recorded

20. Clinic 5 Jun 2013 - Physical/emotional abuse; mental health; suicide; medication; therapy

Document	Pages Docman 301-346 .pdf
PDF page	41
Internal page	Docman continuous page 341
Date	Clinic 5 Jun 2013
Patient age	41
Clinician / role	Dr Lewis Thomson, Consultant Psychiatrist
Category	Physical/emotional abuse; mental health; suicide; medication; therapy
Exact evidence / faithful summary	Diagnosis recorded as emotional instability and other borderline personality traits "in the context of severe childhood abuse". Patient described fairly horrific physical abuse and humiliating/degrading acts, ruminated about childhood abuse, avoided contact, had rapid mood changes and significant anger, and had frequent suicidal thoughts but said he would not act for his family. Quetiapine 25 mg morning, 25 mg afternoon and 50 mg at night was listed. Trauma-focused psychological work and OT were planned.
Care setting	Childhood setting not named on this page
Perpetrator / role	Uncle/family context mentioned but perpetrator not fully specified on page
Frequency / duration	Childhood abuse; ongoing adult symptoms
Injury or impact	Rumination, isolation, anger, suicidal thoughts
Treatment	Quetiapine; referral to psychology and OT
Link to abuse	Explicit
Evidential value	Strong corroborative adult psychiatric formulation, impact and treatment
Follow-up / safeguarding	Psychology/OT referrals; 3-month follow-up

21. 8 Sep 2017 - Physical/sexual abuse; disclosure; psychological impact

Document	Pages Docman 201-300 .pdf

PDF page	89
Internal page	Docman continuous page 289
Date	8 Sep 2017
Patient age	45
Clinician / role	Dr John Macleod, Consultant in Chronic Pain Management
Category	Physical/sexual abuse; disclosure; psychological impact
Exact evidence / faithful summary	Wife asked about psychological support because Colin had disclosed "severe physical and sexual abuse suffered during his childhood in care." Letter notes marked reluctance to disclose/discuss this with male colleagues and profound sleep disturbance, sleeping mostly during the day.
Care setting	Childhood in care; setting not named
Perpetrator / role	Not named
Frequency / duration	Retrospective disclosure; severe abuse
Injury or impact	Difficulty with male practitioners; profound sleep disturbance
Treatment	Pain consultant planned MDT discussion with Consultant Psychiatrist
Link to abuse	Explicit childhood-in-care abuse link
Evidential value	Strong third-party recorded disclosure and adult impact
Follow-up / safeguarding	MDT discussion for intervention/support

22. 28 Sep 2017 - Sexual abuse; placement; therapy referral

Document	Pages Docman 201-300 .pdf
PDF page	88
Internal page	Docman continuous page 288
Date	28 Sep 2017
Patient age	45
Clinician / role	Dr John Macleod, Consultant in Chronic Pain Management
Category	Sexual abuse; placement; therapy referral
Exact evidence / faithful summary	After MDT discussion with Consultant Psychiatrist Dr David Gordon, letter records the wife's disclosure of "significant sexual abuse" suffered "at the hands of carers during his childhood in residential care." It notes resulting reluctance to discuss experiences with male practitioners and recommends re-referral to local mental-health services with circumstances explained so an appropriate colleague could see him.
Care setting	Residential care
Perpetrator / role	Carers
Frequency / duration	Retrospective disclosure
Injury or impact	Reluctance to engage with male practitioners
Treatment	Mental-health re-referral recommended
Link to abuse	Explicit
Evidential value	Strong corroborative third-party disclosure identifying alleged role of perpetrators and care context
Follow-up / safeguarding	Re-referral to local mental-health team

23. 15 Jan 2018 (typed 25 Jan 2018) - Sexual abuse; emotional impact; disclosure

Document	Pages Docman 201-300 .pdf
PDF page	84
Internal page	Docman continuous page 284
Date	15 Jan 2018 (typed 25 Jan 2018)
Patient age	45
Clinician / role	Donna Gough, Inverness Community Mental Health Service
Category	Sexual abuse; emotional impact; disclosure

Exact evidence / faithful summary	Detailed adult disclosure: first sexual abuse said to have begun at age 5 by maternal uncle; bedroom door locked, face pushed into a pornographic magazine, uncle did sexual acts and made Colin touch him sexually. Described recurrence "on and off" for 2-3 years and adult triggers including smells/sounds, vivid memory of the lock and distressing flashbacks. He presented anxious and struggled to recount traumatic experiences.
Care setting	Family home / relative setting (not care placement)
Perpetrator / role	Maternal uncle
Frequency / duration	On/off over approximately 2-3 years from age 5 (patient account)
Injury or impact	Anxiety, flashbacks, sensory triggers
Treatment	CMHT assessment; reassurance and referral planning
Link to abuse	Explicit patient disclosure; not an in-care allegation on this page
Evidential value	Direct adult disclosure of childhood sexual abuse and trauma symptoms
Follow-up / safeguarding	Referral planning continued on next page

24. 15 Jan 2018 (typed 25 Jan 2018) - Placement; physical/sexual/emotional abuse; neglect; disclosure; safeguarding failure

Document	Pages Docman 201-300 .pdf
PDF page	85
Internal page	Docman continuous page 285
Date	15 Jan 2018 (typed 25 Jan 2018)
Patient age	45
Clinician / role	Donna Gough, Inverness Community Mental Health Service
Category	Placement; physical/sexual/emotional abuse; neglect; disclosure; safeguarding failure
Exact evidence / faithful summary	Patient described being sent to Rosedene Children's Home while primary-school age, calling it a violent time where he was beaten and sexually abused by two men and saying he believed other staff knew and did nothing. He described threats if he told. He also recalled other children with cuts, bruises and black eyes said to be accidents. These observations about other children should not be treated as injuries to Colin.
Care setting	Rosedene Children's Home
Perpetrator / role	Two men; other staff allegedly aware
Frequency / duration	During primary-school-age placement; exact dates not stated
Injury or impact	Physical beating; sexual abuse; fear/threats; no specific personal injury documented in this passage
Treatment	CMHT assessment and trauma-referral plan
Link to abuse	Explicit patient disclosure
Evidential value	Direct adult disclosure tied to named care setting; alleged institutional knowledge/failure to protect
Follow-up / safeguarding	Psychology referral / trauma resources

25. 15 Jan 2018 (typed 25 Jan 2018) - Foster-care sexual/physical/emotional abuse; neglect

Document	Pages Docman 201-300 .pdf
PDF page	85
Internal page	Docman continuous page 285
Date	15 Jan 2018 (typed 25 Jan 2018)
Patient age	45
Clinician / role	Donna Gough, Inverness Community Mental Health Service
Category	Foster-care sexual/physical/emotional abuse; neglect
Exact evidence / faithful summary	Patient described many foster parents and one foster couple who "made him do things sexually" with the man and woman. He described physical and emotional violence and being often starved; when he stole food because he was hungry he said he was beaten if discovered.
Care setting	Foster placement(s), couple unnamed

Perpetrator / role	Foster man and woman
Frequency / duration	Repeated/ongoing during unnamed foster placement
Injury or impact	Hunger/starvation; beatings; sexual abuse; emotional abuse
Treatment	Adult CMHT trauma assessment
Link to abuse	Explicit patient disclosure
Evidential value	Direct adult disclosure linked to foster care; includes neglect and physical/sexual abuse
Follow-up / safeguarding	Trauma/psychology referral plan

26. 15 Jan 2018 (typed 25 Jan 2018) - Ferintosh placement; physical/sexual/emotional abuse; intimidation; absconding

Document	Pages Docman 201-300 .pdf
PDF page	85
Internal page	Docman continuous page 285
Date	15 Jan 2018 (typed 25 Jan 2018)
Patient age	45
Clinician / role	Donna Gough, Inverness Community Mental Health Service
Category	Ferintosh placement; physical/sexual/emotional abuse; intimidation; absconding
Exact evidence / faithful summary	Patient identified Ferintosh as the last Children's Home and described "physical, mental and sexual abuse." He said his own key worker stabbed his own hand with a pencil, threw the pencil to Colin, and implied he would blame Colin unless he did what the worker wanted. Patient said he often ran away, including once jumping from a window in pants and wellies and making his way to Inverness.
Care setting	Ferintosh Children's Home
Perpetrator / role	Own key worker (unnamed)
Frequency / duration	Last children's-home placement; duration not stated
Injury or impact	Fear/intimidation; abuse; repeated running away
Treatment	Adult CMHT assessment; psychology referral; Trauma Scotland information
Link to abuse	Explicit patient disclosure
Evidential value	Direct adult disclosure linked to a named care home and staff role; absconding associated with treatment
Follow-up / safeguarding	1:1 trauma reprocessing referral; outpatient diagnostic review

27. Narrative attendance 13 Dec 2018; header clinic date 14 Dec 2018 - Placement; physical/sexual/emotional abuse; PTSD symptoms; substance neutral

Document	Pages Docman 201-300 .pdf
PDF page	71
Internal page	Docman continuous page 271
Date	Narrative attendance 13 Dec 2018; header clinic date 14 Dec 2018
Patient age	46
Clinician / role	Dr Arvind Gupta, Consultant Psychiatrist
Category	Placement; physical/sexual/emotional abuse; PTSD symptoms; substance neutral
Exact evidence / faithful summary	Past personal history states: "Colin was in care accommodation on and off from nine years old" and that during childhood/adolescence he was physically, mentally and sexually abused by carers. He reported ongoing nightmares and flashbacks, being constantly on edge, difficulty expressing/feeling emotions, weekly flashbacks and daily nightmares. He denied alcohol and reported occasional cannabis. Past psychiatric history records low mood since teenage years, anger and anxiety.
Care setting	Care accommodation on/off from age 9
Perpetrator / role	Carers
Frequency / duration	On/off from age 9 through childhood/adolescence (retrospective)
Injury or impact	Nightmares, flashbacks, hyperarousal, low mood, anger/anxiety

Treatment	Psychiatric diagnostic/medication review
Link to abuse	Explicit
Evidential value	Strong retrospective placement + abuse + adult symptom link; also contains negative alcohol finding
Follow-up / safeguarding	Psychiatric follow-up

28. Assessment 24 Sep 2019; letter 19 Dec 2019 - Mental health; self-harm; therapy; neutral suicide finding

Document	Pages Docman 201-300 .pdf
PDF page	63
Internal page	Docman continuous page 263
Date	Assessment 24 Sep 2019; letter 19 Dec 2019
Patient age	47
Clinician / role	Dr Catrina (Cat) Stansfield, Clinical Psychologist
Category	Mental health; self-harm; therapy; neutral suicide finding
Exact evidence / faithful summary	Patient was extremely anxious about assessment and worried clinician might be male, explaining difficulty trusting males, especially people in authority. Reported childhood trauma, flashbacks, intrusive memories and sleep difficulty; partner described withdrawal and anger. He denied current thoughts or plans to take his own life. He reported weekly self-harm by putting cigarettes out on his arms or snapping an elastic band to "snap back into reality"; frequency had increased before assessment. Several missed/cancelled appointments are recorded.
Care setting	-
Perpetrator / role	Self (self-harm)
Frequency / duration	Usually weekly; increased before assessment
Injury or impact	Burn injuries from cigarettes; anxiety, withdrawal, anger
Treatment	Psychology assessment
Link to abuse	Childhood-trauma link explicit for symptoms; self-harm described as grounding
Evidential value	Strong mental-health/self-harm/engagement evidence with negative current suicide finding
Follow-up / safeguarding	Discharged after repeated non-attendance; re-referral possible

29. Assessments 10 & 17 Dec 2019; letter 15 Jan 2020 - Therapy; trauma symptoms

Document	Pages Docman 201-300 .pdf
PDF page	61
Internal page	Docman continuous page 261
Date	Assessments 10 & 17 Dec 2019; letter 15 Jan 2020
Patient age	47
Clinician / role	Dr Cat Stansfield, Clinical Psychologist
Category	Therapy; trauma symptoms
Exact evidence / faithful summary	Patient continued to report flashbacks, intrusive memories and nightmares relating to childhood and was motivated for psychological intervention. Clinician agreed he would benefit from the Survive and Thrive group to improve understanding of trauma and learn trauma-informed coping skills.
Care setting	-
Perpetrator / role	-
Frequency / duration	Ongoing
Injury or impact	Flashbacks, intrusive memories, nightmares
Treatment	Survive and Thrive referral
Link to abuse	Explicit childhood-trauma symptom link
Evidential value	Treatment/referral evidence
Follow-up / safeguarding	Formal referral to CMHT/Survive and Thrive

30. Telephone 11 May 2020; letter dictated 14 May 2020 - PTSD; self-harm; suicide negative; medication

Document	Pages Docman 201-300 .pdf
PDF page	57
Internal page	Docman continuous page 257
Date	Telephone 11 May 2020; letter dictated 14 May 2020
Patient age	48
Clinician / role	Sharon Perks, Advanced Nurse Practitioner; Dr A Gupta
Category	PTSD; self-harm; suicide negative; medication
Exact evidence / faithful summary	Working diagnoses include F43.1 PTSD and F60.3 personality disorder. Quetiapine listed at 100 mg night and 50 mg afternoon, plan 150 mg daily. Patient described poor sleep, flashbacks when asleep, staying awake while family slept, hypervigilance/easy startle, sitting with back to the door and keeping television on, detachment, and self-harm by burning himself to ground himself. He denied suicidal thoughts or plans and denied auditory/visual disturbance.
Care setting	-
Perpetrator / role	Self (self-harm)
Frequency / duration	Ongoing; sleep often no more than four hours
Injury or impact	Burning self; hypervigilance; sleep disturbance
Treatment	Quetiapine; grounding advice (ice cubes); review
Link to abuse	Trauma/PTSD context explicit; no specific abuse episode restated
Evidential value	Strong treatment and impact evidence with negative suicide finding
Follow-up / safeguarding	Review in four months

31. 9 Feb 2021 (typed 16 Feb 2021) - Mental health; treatment attendance; contradictory/neutral

Document	Pages Docman 201-300 .pdf
PDF page	52
Internal page	Docman continuous page 252
Date	9 Feb 2021 (typed 16 Feb 2021)
Patient age	48
Clinician / role	Sharon Perks, Advanced Nurse Practitioner; Dr A Gupta
Category	Mental health; treatment attendance; contradictory/neutral
Exact evidence / faithful summary	Working diagnoses recorded as F60.3 Personality Disorder / F43.1 PTSD. Wife reported worsening mood over a couple of weeks and loss of routine/structure. Letter notes two consecutive DNAs and states another appointment would be offered with warning that repeated non-response could end further offers.
Care setting	-
Perpetrator / role	-
Frequency / duration	Short-term deterioration against chronic diagnosis
Injury or impact	Worsening mood; reduced routine
Treatment	Psychiatric follow-up offered
Link to abuse	PTSD diagnosis maintained; no new abuse detail
Evidential value	Treatment-continuity and missed-appointment evidence
Follow-up / safeguarding	Opt-in / rescheduling with attendance warning

32. 13 Feb 2024 - Sexual abuse disclosure; mental health; medication

Document	cs Summary (1).pdf

PDF page	9
Internal page	Printed report page 9/114
Date	13 Feb 2024
Patient age	51
Clinician / role	Dr Daniel Simpson, GP
Category	Sexual abuse disclosure; mental health; medication
Exact evidence / faithful summary	During medication review, GP records that patient "opened up today about childhood severe sexual abuse", was frustrated by having to relive the story with multiple doctors, and could not sleep at night because he ruminated over it. He asked for sleeping tablets; clinician considered whether mirtazapine might be worth considering but the note does not confirm it was prescribed.
Care setting	Not specified in this note
Perpetrator / role	Not specified
Frequency / duration	Historical abuse; ongoing current symptoms
Injury or impact	Rumination and insomnia; distress about repeating disclosure
Treatment	Medication review; mirtazapine considered only
Link to abuse	Explicit childhood sexual-abuse link to current sleep/rumination
Evidential value	Current GP disclosure and treatment-context evidence
Follow-up / safeguarding	Further medication review planned

33. 14 Aug 2024 - Placement; abuse disclosure; mental health

Document	Pages Docman101-200 .pdf
PDF page	80
Internal page	Docman continuous page 180
Date	14 Aug 2024
Patient age	52
Clinician / role	Out-of-hours / urgent-care record
Category	Placement; abuse disclosure; mental health
Exact evidence / faithful summary	Record says mental health had deteriorated amid pain and other illness and that he had "recently only spoke out about childhood abuse whilst in care systems."
Care setting	Care systems (not named)
Perpetrator / role	Not specified
Frequency / duration	Recent disclosure of historical abuse
Injury or impact	Mental-health deterioration; poor sleep/pain context
Treatment	Advised to speak to GP within hours
Link to abuse	Explicit
Evidential value	Supporting recent disclosure and care-system link
Follow-up / safeguarding	Urgent GP contact advised

34. 7 Oct 2024 - Sexual abuse impact; mental health; treatment engagement

Document	cs Summary (1).pdf
PDF page	6
Internal page	Printed report page 6/114
Date	7 Oct 2024
Patient age	52
Clinician / role	Dr Daniel Simpson, GP
Category	Sexual abuse impact; mental health; treatment engagement

Exact evidence / faithful summary	GP consultation records poor sleep: patient could sleep through the day with people around but at night was "haunted by memories of sexual abuse." Previous lack of continuity in psychology had been unhelpful, although psychology was agreed to be the main way ahead. He again requested sleeping tablets and clinician reiterated reasons for not prescribing. Note also records irregular use of prescribed medication.
Care setting	Not specified in note
Perpetrator / role	Not specified
Frequency / duration	Ongoing adult trauma symptoms
Injury or impact	Night-time trauma memories; reversed sleep pattern; treatment frustration
Treatment	Psychology route encouraged; medication review
Link to abuse	Explicit sexual-abuse symptom link
Evidential value	Current impact and engagement evidence
Follow-up / safeguarding	Medication-use diary suggested; psychology viewed as main treatment

35. Referral created/submitted 14 Oct 2024 - Placement; physical/sexual abuse; PTSD; substance use; therapy

Document	cs Referrals .pdf
PDF page	2
Internal page	Same as PDF page unless printed pagination differs
Date	Referral created/submitted 14 Oct 2024
Patient age	52
Clinician / role	Dr Daniel Simpson, referring clinician
Category	Placement; physical/sexual abuse; PTSD; substance use; therapy
Exact evidence / faithful summary	Clinical psychology referral states clinician believes many problems likely stem from PTSD and records that patient "was sexually and physically abused as a child in residential care." It records flashbacks, severe night anxiety and day/night sleep reversal. It also records prescribed opiates/diazepam, quetiapine after psychiatry, self-medication with alcohol and privately prescribed cannabis, and previous disengagement because changing clinicians required repeated retelling.
Care setting	Residential care
Perpetrator / role	Not specified
Frequency / duration	Historical abuse; current chronic PTSD symptoms
Injury or impact	Flashbacks, anxiety, severe sleep disturbance; engagement difficulty
Treatment	Referral for trauma-based psychological therapy
Link to abuse	Explicit
Evidential value	Strong GP synthesis linking care abuse, PTSD, treatment and substance coping
Follow-up / safeguarding	Routine clinical-psychology referral

36. Referral created/submitted 19 Nov 2024 - PTSD; substance use as coping; medication; therapy

Document	cs Referrals .pdf
PDF page	7
Internal page	Same as PDF page unless printed pagination differs
Date	Referral created/submitted 19 Nov 2024
Patient age	52
Clinician / role	Dr Daniel Simpson, referring clinician
Category	PTSD; substance use as coping; medication; therapy

Exact evidence / faithful summary	Follow-up referral records PTSD flashbacks, hypervigilance, anxiety and inability to sleep at night because he feels he must stay alert. GP states patient "currently misuses alcohol to try and deal with these symptoms" and describes erratic use of prescribed opiates/diazepam, with patient saying he uses them to "dull the PTSD symptoms." Previous psychology disengagement due clinician changes/repeated retelling is repeated.
Care setting	Past traumatic experiences; setting not restated on this page
Perpetrator / role	-
Frequency / duration	Current ongoing
Injury or impact	Flashbacks, hypervigilance, anxiety, severe sleep disturbance
Treatment	Psychology re-referral; GP trying to reduce medication burden
Link to abuse	Explicit coping link for alcohol/medication to PTSD; underlying abuse from prior referral
Evidential value	Strong evidence of trauma-related substance/medication coping and treatment need
Follow-up / safeguarding	Psychology input requested

37. 4 Dec 2024 - Substance use; neutral/improvement

Document	cs Summary (1).pdf
PDF page	6
Internal page	Printed report page 6/114
Date	4 Dec 2024
Patient age	52
Clinician / role	Dr Daniel Simpson, GP
Category	Substance use; neutral/improvement
Exact evidence / faithful summary	Following an earlier triglyceride discussion, patient had stopped drinking alcohol and reported a more regulated sleep pattern. GP encouraged maintaining the change and noted that a CMHT appointment was now arranged.
Care setting	-
Perpetrator / role	-
Frequency / duration	Recent abstinence
Injury or impact	Improved sleep pattern reported after stopping alcohol
Treatment	CMHT appointment pending
Link to abuse	No direct abuse link in this entry
Evidential value	Neutral/improvement evidence relevant to substance trajectory
Follow-up / safeguarding	Maintain abstinence; CMHT appointment

38. 20 Jan 2025 (call begins on previous PDF page 29) - PTSD; substance use; crisis context

Document	Pages Docman 51-100 .pdf
PDF page	30
Internal page	Docman continuous page 80
Date	20 Jan 2025 (call begins on previous PDF page 29)
Patient age	52
Clinician / role	Out-of-hours clinician Louise Henderson
Category	PTSD; substance use; crisis context
Exact evidence / faithful summary	During chest-pain call, patient reported PTSD from childhood trauma and that the festive period was a "bad time". He reported tending to drink more and, until very recently, drinking about a quarter bottle of whisky daily.
Care setting	-
Perpetrator / role	-

Frequency / duration	Recent increased alcohol use around festive period
Injury or impact	PTSD distress; increased alcohol
Treatment	Referred to A&E for chest pain
Link to abuse	Childhood-trauma link explicit for PTSD; alcohol increase temporally associated with bad period, causation not otherwise stated
Evidential value	Supporting current PTSD/substance evidence
Follow-up / safeguarding	A&E referral for physical symptoms

39. 30 May 2025 - Adult physical/mental impact; abuse history

Document	Pages Docman 51-100 .pdf
PDF page	20
Internal page	Docman continuous page 70
Date	30 May 2025
Patient age	53
Clinician / role	Katy Wolstencroft, Emergency Practitioner
Category	Adult physical/mental impact; abuse history
Exact evidence / faithful summary	Emergency discharge letter states: "He himself was abused as a child and struggles with mental health and chronic pain as a result." Clinician also considered a strong anxiety component in the current chest-pain presentation. This is an explicit clinical link in the record, but it does not specify which pain condition was caused by which childhood event.
Care setting	-
Perpetrator / role	Not specified
Frequency / duration	Long-term impact
Injury or impact	Mental-health difficulties; chronic pain; anxiety
Treatment	ED assessment; reassurance; discharged without follow-up
Link to abuse	Explicit clinician-recorded link, but nonspecific
Evidential value	Adult impact evidence
Follow-up / safeguarding	No new treatment/follow-up from ED

40. Current repeat list printed 23 Jun 2026 - Mental-health medication; long-term treatment

Document	cs Summary (1).pdf
PDF page	24
Internal page	Printed report page 24/114
Date	Current repeat list printed 23 Jun 2026
Patient age	54
Clinician / role	Cairn Medical Practice repeat prescribing
Category	Mental-health medication; long-term treatment
Exact evidence / faithful summary	Current repeat list includes quetiapine 150 mg at night plus quetiapine 50 mg in the afternoon, diazepam 5 mg as needed for anxiety up to six times daily, and propranolol 80 mg daily. These medicines support ongoing treatment history but do not by themselves establish abuse or trauma causation.
Care setting	-
Perpetrator / role	-
Frequency / duration	Repeated/long-term prescribing
Injury or impact	Ongoing anxiety/PTSD/personality-disorder treatment context
Treatment	Quetiapine, diazepam, propranolol
Link to abuse	Clinical indication partly documented elsewhere; medication alone is not proof of trauma

Evidential value	Treatment/impact evidence
Follow-up / safeguarding	Ongoing medication review

41. 9 Jun 2026 - Medication; neutral/diagnostic uncertainty

Document	cs Summary (1).pdf
PDF page	101
Internal page	Printed report page 101/114
Date	9 Jun 2026
Patient age	54
Clinician / role	GP medication review
Category	Medication; neutral/diagnostic uncertainty
Exact evidence / faithful summary	Medication review records quetiapine with indication described as "unclear indication ?anxiety/PTSD" and propranolol for anxiety; diazepam/baclofen are discussed in chronic-pain context. This is relevant neutral evidence that later prescribers did not always record a single clear indication for quetiapine.
Care setting	-
Perpetrator / role	-
Frequency / duration	Long-term
Injury or impact	Medication burden / diagnostic uncertainty
Treatment	Medication review
Link to abuse	Possible PTSD link, explicitly uncertain in this entry
Evidential value	Contradictory/neutral treatment evidence
Follow-up / safeguarding	Ongoing review

Highlighted-page index

These are the PDF pages on which the automated high-signal highlighting pass placed one or more highlights. The pass targets care-setting terms, explicit abuse/trauma language, mental-health conditions/treatment, self-harm/suicide, substance use, selected medications and injury terms. The detailed schedule above contains the key passages that were manually checked for context.

Document	Highlighted PDF pages	Continuous/internal mapping
1-50 BS Vol 2 .pdf	49	BS continuous pages: 49
Pages BS Vol 2 51-100 .pdf	9, 41	BS continuous pages: 59, 91
Pages BS Vol 2 101-150 .pdf	19, 25, 26, 39, 41, 45, 49	BS continuous pages: 119, 125, 126, 139, 141, 145, 149
Pages BS Vol 2 151 - 200 .pdf	3, 4, 5, 9, 10, 35, 37, 39, 41, 43, 47	BS continuous pages: 153, 154, 155, 159, 160, 185, 187, 189, 191, 193, 197
Pages BS Vol 2 201-250.pdf	11, 12, 13, 19, 21, 22, 45, 47, 49	BS continuous pages: 211, 212, 213, 219, 221, 222, 245, 247, 249
Pages BS Vol 2 251-300 .pdf	3, 5, 7, 23, 25, 27, 29, 33, 37, 45, 49	BS continuous pages: 253, 255, 257, 273, 275, 277, 279, 283, 287, 295, 299
Pages BS Vol 2 301-350 .pdf	3, 5, 7, 11, 31	BS continuous pages: 303, 305, 307, 311, 331
Pages BS Vol 2 351 - 400 .pdf	9, 35, 41, 43, 49	BS continuous pages: 359, 385, 391, 393, 399
Pages BS Vol 2 401-476 .pdf	3, 5, 7, 9, 11, 12, 13, 15, 17, 19, 25, 41, 43, 45, 47, 49, 51, 53, 55, 57, 59, 61, 63, 65, 67, 75	BS continuous pages: 403, 405, 407, 409, 411, 412, 413, 415, 417, 419, 425, 441, 443, 445, 447, 449, 451, 453, 455, 457, 459, 461, 463, 465, 467, 475
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Pages Docman 51-100 .pdf	1, 4, 5, 6, 7, 10, 11, 12, 13, 17, 20, 27, 30, 33, 34, 46	Docman continuous pages: 51, 54, 55, 56, 57, 60, 61, 62, 63, 67, 70, 77, 80, 83, 84, 96
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CS Letters and Emails .pdf	1, 2, 6, 7, 9, 10, 14, 15, 16, 19, 20, 30	No separate continuous numbering used.
cs Referrals .pdf	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 17, 18, 19, 22, 23, 24, 25, 29, 30, 31, 37, 38, 47, 48	Referral forms contain their own page x/y numbering; see detailed entries for key pages.
cs Summary (1).pdf	1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 90, 96, 98, 100, 101	Printed Full Report page number generally matches PDF page (footer shows /114).

Final context notes

• No clear historic childhood record was located in which Colin himself is documented at the time as explicitly disclosing sexual abuse. The earliest strong historic concern located is the 1985 children's-hearing decision about excessive punishment and foster residence. Detailed physical/sexual/emotional abuse allegations are recorded retrospectively in adulthood, particularly from 2017-2018.

• The 1982 head injury at Rosidene is useful as contemporaneous proof of residence and an injury while in care, but the letter records the cause only as having "bumped his head" and contains no allegation of abuse or safeguarding action.

• The 2018 CMHT account says timing of childhood events was fragmented, while the abuse incidents themselves were remembered clearly. This uncertainty about chronology should be retained rather than converted into precise dates.

• Later records contain both positive and negative suicide-risk statements and changing formulations. These are included rather than reconciled into a single diagnosis or risk narrative.

• Because many GP summary/referral pages reproduce the same historic problem list and medication list, the detailed schedule groups repeated material where appropriate while the highlighted-page index preserves where those repetitions occur.