Evidence Extraction Sheet - GP / Healthcare Records

Patient: Jacqueline Good **DOB:** 14 May 1961 **Source:** 392-page iGPR SAR supplied in three PDF parts

Review finding: No explicit evidence of childhood placement in care, physical abuse, sexual abuse, emotional abuse, neglect, contemporaneous disclosure, or an express clinical link between childhood abuse/care and later symptoms was identified in the reviewed material. The relevant evidence primarily concerns low mood, tearfulness, sleep disturbance, treatment, negative self-harm/suicide findings, and neutral alcohol/substance entries. A single "Residential Home Visit" label on Part 1 page 53 appears to be an encounter type and does not identify a childhood care placement.

Date	PDF page	Document	Category	Clinician	Exact evidence / faithful summary	Care setting / perpetrator	Evidential value / link	Follow-up
26-Aug-2013	Part 1 p.52	GP consultation	Mental health; self-harm negative	Dr Jennifer Elliot	"Mood remains low. Crying all the time... Lives alone... No thoughts of self harm. Not keen for therapy/counselling."	No care setting/perpetrator recorded	Impact/treatment; no link to abuse recorded	Antidepressant agreed; review 1-2 weeks
30-Aug-2013	Part 1 p.52	GP consultation	Mental-health medication; therapy	Dr Louise Hallam	Sertraline not tolerated due to marked nausea/vomiting; patient not able to contemplate talking therapy at that stage.	No care setting/perpetrator recorded	Treatment; no link to abuse recorded	Alternative SSRI discussed; review in 2 weeks
16-Oct-2013	Part 1 p.52	GP consultation	Mental health; medication; sleep	Dr Iwona Dygas	Low mood, tearfulness and broken sleep; fluoxetine caused severe heartburn; venlafaxine trial agreed; hydroxyzine for very bad nights.	No care setting/perpetrator recorded	Symptoms/treatment; no link to abuse recorded	Review in 3-4 weeks; blood tests
13-Nov-2019	Part 1 p.34	GP consultation	Mental health; self-harm negative; therapy	Dr Gabriella Samson	Low mood and irritability; working 6/7 days; "No suicidal thoughts/ideas/plans." Talking therapies and citalopram advised.	No care setting/perpetrator recorded	Impact/treatment; no link to abuse recorded	Signposted to Doing Well, Breathing Space/Samaritans
24-Jul-2019	Part 1 p.34	GP consultation	Mental health; sleep; medication	Dr Andrew Houston	Sweats affecting work and sleep; mood okay when busy but tearful when unoccupied; venlafaxine not tolerated due to nausea.	No care setting/perpetrator recorded	Impact/treatment; no link to abuse recorded	Trial clonidine; review
15-May-2019	Part 1 p.35	GP consultation	Mental health; medication	Dr Andrew Houston	Mood tearful with night sweats/flushes; managing at work by day; venlafaxine trial agreed.	No care setting/perpetrator recorded	Symptoms/treatment; no link to abuse recorded	Review in 2 weeks
17-Apr-2019	Part 1 p.35	GP consultation	Mental health; impact	Dr Andrew Houston	Struggling with flushing and moods and feeling tearful since stopping HRT.	No care setting/perpetrator recorded	Impact; clinician links symptoms to HRT change, not abuse	Medication/risk-management changes
17-Feb-2021	Part 1 p.28	Telephone consultation	Mental health; sleep; medication	Dr Brian Maybin	Trouble sleeping; mood dipped since furlough; citalopram increased to 30 mg.	No care setting/perpetrator recorded	Impact/treatment; no link to abuse recorded	Sleep hygiene/lifestyle advice
16-Feb-2021	Part 1 p.29	Nurse consultation	Mental health; sleep	Mrs Adele Blunt	Patient emotional, low mood, not sleeping and staying up for up to 48 hours.	No care setting/perpetrator recorded	Symptoms; no link to abuse recorded	GP callback advised
21-Dec-2020	Part 1 p.29	Telephone consultation	Mental health; medication	Dr Donna Edwards	Citalopram started for menopausal flushes and mood changes; tearfulness improved but no major mood improvement.	No care setting/perpetrator recorded	Treatment response; no link to abuse recorded	Continue and review
19-Jul-2013	Part 1 p.53	GP consultation	Mental health; self-harm negative; sleep/appetite	Dr Catherine Cormack	Still tearful; "No thoughts self harm"; poor sleep and not eating well; patient considered symptoms hormone-related.	No care setting/perpetrator recorded	Symptoms/negative risk finding; no link to abuse recorded	HRT changed; review and consider support/SSRI
08-Jul-2013	Part 1 p.53	GP consultation	Mental health	Dr Emma Douglas	Weepy for 2-3 weeks; no new stresses; work unchanged.	No care setting/perpetrator recorded	Symptoms; no link to abuse recorded	Symptom diary and review
17-Jul-2008	Part 1 p.57	GP consultation	Mental health	Dr Sarah Henry	Feeling down with flushes; no reason identified; life otherwise good.	No care setting/perpetrator recorded	Symptoms; no link to abuse recorded	Blood tests; consider HRT change

Date	PDF page	Document	Category	Clinician	Exact evidence / faithful summary	Care setting / perpetrator	Evidential value / link	Follow-up
05-Jun-2008	Part 1 p.57	GP consultation	Long-term social/functional impact	Dr Lorna Corfield	Stopping HRT caused symptoms to return with no quality of life and inability to do job; restarted.	No care setting/perpetrator recorded	Functional impact attributed to menopausal symptoms, not abuse	HRT restarted
Multiple dates 2013-2026	Part 1 pp.63-74; Part 2 pp.92,102,114-115,128,142,152-153	Prescription records / scanned medication lists	Mental-health medication	Various	Repeated citalopram prescribing; historic venlafaxine, fluoxetine and sertraline entries.	No care setting/perpetrator recorded	Treatment evidence only; medication does not establish trauma/abuse	See dated prescription lists
09-Jun-2026 and other reviews	Part 1 pp.2,9,20	GP review / screening	Substance and alcohol - neutral/negative	Practice clinicians	Alcohol screening score 0; alcohol recorded as rare or nil.	No care setting/perpetrator recorded	Neutral/negative finding; no abuse link	No addiction referral recorded
Various 2024-2026	Part 1 p.5	Medication review	Opioid use - neutral treatment record	Practice clinicians	Long-term opioid medication review and discussion of gradual opioid reduction; patient did not wish to start reduction at that time.	No care setting/perpetrator recorded	Treatment evidence; no abuse link	Ongoing review

Category Review Summary

1. Placement in care

No explicit childhood care setting, institutional address, admission/discharge, GP registration while in care, social worker/carer attendance, or care-related correspondence identified.

2-6. Abuse, neglect and disclosures

No explicit physical, sexual or emotional abuse; neglect; or contemporaneous disclosure identified. Injury records located were ordinary medical presentations and did not record staff/resident causation.

7-9. Mental health, medication and therapy

Relevant entries are listed in the table. They consistently relate symptoms to menopause/HRT changes, furlough or no identified trigger; none expressly links symptoms to childhood care or abuse.

10. Self-harm and suicide

Negative findings recorded on Part 1 pp.34, 52 and 53: no suicidal thoughts/ideas/plans and no thoughts of self-harm. These are presented as negative findings.

11. Substance/alcohol

Alcohol recorded as nil/rare with screening score 0. Long-term opioid prescribing/reduction discussions are present, but no record says substances were used to cope with abuse or care memories.

12-13. Adult physical/social consequences

Some functional impact from menopausal symptoms and low mood is recorded, including sleep/work effects. No clinician attributes an adult physical condition or social consequence to childhood abuse/neglect.

14. Attachments

Scanned hospital, laboratory and medication documents in Parts 2 and 3 were included in the review. The highlighted Part 2 pages are medication-list pages.

15. Neutral/contradictory entries

Neutral and negative findings are retained, including absence of suicidal ideation, life otherwise described as good, work functioning, and symptoms attributed to menopause/HRT rather than abuse.

Important limitation: OCR of scanned records may contain recognition errors. Page references and highlighted originals should be checked against the visible source before quotation in a formal application.