Evidence Extraction Sheet

Source document: William McChesney NHSGGC.pdf | **Length:** 13 PDF pages | **Record type:** scanned hospital SAR response and attached clinical records

Applicant	William McChesney	**Date of birth**	26 July 1962
CHI number	2607623510 (pages 5 and 8)	**Address recorded**	101 Kilmaurs Road, Kilmarnock, Ayrshire, KA3 1NU (pages 5 and 8)
Hospital record source	Queen Elizabeth University Hospital records; QEUH is selected on the electronic patient records checklist (pages 1 and 3)	**Review limitation**	The SAR cover states that identifying or supplied third-party information was removed before disclosure (page 1)

Overall conclusion

No evidence was identified in this 13-page hospital bundle confirming a childhood care placement, an institutional address, abuse in care, neglect, a contemporaneous disclosure, trauma-related mental-health symptoms, psychiatric medication, counselling, self-harm, suicide, substance misuse or a long-term social consequence linked to childhood abuse.

The only potentially relevant physical-health material is an adult orthopaedic referral concerning a traumatic right elbow fracture approximately four years earlier. The injury was treated conservatively and was followed by right-elbow Tinel's sign and reduced right-hand function. The record does not state how the fracture occurred, identify any perpetrator or witness, or connect it with childhood care or abuse. Subsequent nerve-conduction testing was normal and found no significant entrapment at the elbow secondary to the fracture.

Important: absence of evidence in this limited hospital disclosure is not evidence that no placement or abuse occurred. It means only that these particular disclosed pages do not contain the requested material.

Category-by-category findings

No.	Category	Finding
1	**Evidence of placement in care**	Not identified. No care home, residential school, foster placement, assessment centre, institutional address, care admission/discharge date, social worker, residential employee, or wording such as “in care” or “looked after”.
2	**Physical abuse**	Not identified. Page 5 records a traumatic adult elbow fracture but gives no mechanism, alleged perpetrator, witness, safeguarding response or connection with care.
3	**Sexual abuse**	Not identified. No disclosure, allegation or medical indicator is connected by the record to sexual abuse.
4	**Emotional or psychological abuse**	Not identified. No humiliation, threats, fear of staff, institutional distress, absconding or related clinical description.
5	**Neglect**	Not identified. No childhood medical, physical, emotional or safeguarding neglect is documented.
6	**Contemporaneous disclosures**	Not identified. No statement that a staff member or resident harmed the patient, and no referral to police, social work or child protection.
7	**Mental-health conditions and symptoms**	Not identified in this bundle.

No.	Category	Finding
8	**Mental-health medication**	Not identified in this bundle.
9	**Counselling, therapy and psychiatric care**	Not identified in this bundle.
10	**Self-harm and suicide**	No positive or negative suicide/self-harm findings identified.
11	**Substance and alcohol use**	Not identified in this bundle.
12	**Physical consequences in adulthood**	Pages 5 and 8: traumatic right elbow fracture with reported Tinel's sign and reduced right-hand function; nerve studies later normal. No link to abuse or childhood care.
13	**Long-term personal and social impact**	Not identified. No work, housing, relationship, offending, education or social impact is linked to abuse or care.
14	**Third-party and attached records**	Pages 5-12 include an orthopaedic referral, coeliac serology result, EMG report and technical nerve-conduction data. Page 1 confirms third-party information was removed.
15	**Contradictory or neutral entries**	Page 6 contains normal coeliac serology. Page 8 records normal bilateral ulnar motor and sensory studies and no significant elbow entrapment. Pages 4, 7, 9, 11 and 13 are blank.

Detailed page-reference schedule

Entries are recorded even where they are neutral, negative or not linked to abuse. PDF page numbers correspond to the uploaded 13-page file.

PDF page	Internal page / date	Document / clinician	Category and exact evidence	Care setting / perpetrator	Impact / treatment	Link and evidential value	Follow-up / format
1	**None** 1 May 2026	**SAR cover letter** NHSGGC Subject Access Request Team / Health Records Department	**Identity; record provenance; disclosure limitation** Identifies William McChesney, DOB 26.07.1962. States that Queen Elizabeth University Hospital records are attached. States records were clinician-reviewed and identifying or supplied third-party information was removed.	**Setting:** Queen Elizabeth University Hospital (record source only) **Perpetrator:** None **Frequency:** Single administrative letter	**Impact:** None recorded **Treatment:** None	**Link:** No abuse/care link **Value:** Identity and provenance; limitation on completeness	**Follow-up:** None **Format:** Typed scanned letter
2	**None** 1 May 2026	**Continuation of SAR cover letter** NHSGGC Subject Access Request Team	**Administrative / neutral** Generic explanation of information sources, record retention and complaint routes. It does not identify a care placement or applicant-specific abuse information.	**Setting:** None **Perpetrator:** None **Frequency:** Single administrative page	**Impact:** None **Treatment:** None	**Link:** No link recorded **Value:** Context only	**Follow-up:** DPO/ICO routes stated **Format:** Typed scanned letter
3	**None** Undated checklist	**Electronic patient records checklist** NHSGGC Health Records	**Record provenance** Queen Elizabeth University Hospital is ticked. No other hospital or service box is visibly selected.	**Setting:** Queen Elizabeth University Hospital (healthcare setting, not a care placement) **Perpetrator:** None **Frequency:** Single checklist	**Impact:** None **Treatment:** None	**Link:** No abuse/care link **Value:** Confirms source of disclosed hospital records	**Follow-up:** None **Format:** Typed form with handwritten tick
5	**None** Clinic/dictation 21 Sep 2016; typed 4 Oct 2016; authorised 10 Oct 2016	**Orthopaedic referral letter** Lesley McKee, Orthopaedic Registrar / ST5, University Hospital Crosshouse	**Adult physical injury / possible long-term consequence** Requests right-arm ulnar nerve conduction studies. Records that the patient was four years after a traumatic elbow fracture treated conservatively, with strongly positive Tinel's at the right elbow and reduced right-hand function.	**Setting:** University Hospital Crosshouse; referral to QEUH Neurophysiology **Perpetrator:** Not recorded **Frequency:** Ongoing symptoms approximately four years after fracture	**Impact:** Right-elbow signs and reduced right-hand function **Treatment:** Conservative fracture treatment; nerve-conduction testing requested	**Link:** No link to childhood abuse or care **Value:** Adult injury/treatment evidence only	**Follow-up:** Neurophysiology study **Format:** Typed scanned clinical letter
6	**Page 1 of 1** Sample 24 Oct 2024; received 25 Oct 2024; report viewed 1 May 2026	**Coeliac serology result** Laboratory result / QEUH portal	**Neutral medical record** tTG IgA result 1.6 U/mL, within the stated reference range of 0.0-7.0.	**Setting:** Healthcare laboratory **Perpetrator:** None **Frequency:** Single test	**Impact:** No abnormality indicated **Treatment:** None stated	**Link:** No abuse/care link **Value:** No evidential value for placement or abuse	**Follow-up:** None stated **Format:** Typed scanned laboratory result
8	**EMG report page 1** 3 Feb 2017; typed 7 Feb 2017	**EMG / nerve-conduction report** Dr Cameron Mann, Consultant Clinical Neurophysiologist	**Adult physical consequence; neutral/contradictory finding** Bilateral ulnar motor measures, F waves, median sensory responses and ulnar sensory responses were normal. Opinion: no evidence of significant entrapment at elbow level secondary to the fracture.	**Setting:** Southern General Hospital Clinical Neurophysiology; referred by Crosshouse Hospital **Perpetrator:** None **Frequency:** Single investigation	**Impact:** No significant nerve entrapment identified **Treatment:** Diagnostic nerve-conduction studies	**Link:** No abuse/care link **Value:** Neutral clinical evidence; qualifies page 5 symptoms	**Follow-up:** No further action stated **Format:** Typed scanned clinical report
10 and 12	**EMG data pages 2 and 3** 3 Feb 2017	**Technical nerve-conduction tables and traces** Clinical Neurophysiology	**Attached diagnostic data** Sensory/motor nerve-conduction measurements and F-wave traces supporting the narrative report on page 8. No separate abuse, placement or care information.	**Setting:** Clinical Neurophysiology **Perpetrator:** None **Frequency:** Single investigation	**Impact:** Technical test data **Treatment:** Diagnostic testing	**Link:** No abuse/care link **Value:** Supporting technical data only	**Follow-up:** Refer to page 8 interpretation **Format:** Typed tables and graphs

PDF page	Internal page / date	Document / clinician	Category and exact evidence	Care setting / perpetrator	Impact / treatment	Link and evidential value	Follow-up / format
4, 7, 9, 11 and 13	**None** None	**Blank pages** None	**Neutral / no content** No substantive record content visible.	**Setting:** None **Perpetrator:** None **Frequency:** Five blank pages	**Impact:** None **Treatment:** None	**Link:** No link **Value:** None	**Follow-up:** None **Format:** Blank scanned pages

Highlighted copy

The highlighted source copy marks pages 1, 3, 5 and 8. Yellow overlays identify patient identity, record provenance, the adult elbow-fracture referral, the nerve-conduction findings and the neutral opinion that no significant entrapment was demonstrated.

No highlighting was added to blank pages or to records that had no meaningful connection with the requested evidential categories.