**Medical Assessment of Alleged or Suspected Child Abuse and Neglect**

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**Purpose of Medical Assessment**

Medical advice will often be sought as part of the investigative process of alleged or suspected child abuse/neglect.

The general purposeof a medical assessment is threefold:

* to assist with the inter-agency assessment as to whether abuse/neglect has occurred
* to ensure that any evidence which is collected and presented is of a high quality thus ensuring that the child/young person has the optimum level of protection and support
* to ensure that the wider healthcare needs of the child/young person are fully identified and arrangements made to meet these needs.

In cases where medical staff have concerns but are unsure if these amount to having a reasonable cause for suspecting child abuse or neglect (and therefore making a referral to police/social services) they should seek appropriate advice.

Staff should be aware of their local Trust pathways for such advice and should avoid sending children/young people to their local Emergency Department (unless there is a clinical need for assessment/treatment in the Emergency Department) or that is the route of referral in their local Trust pathway.

Sources of advice may involve consulting with a local Consultant Paediatrician, a Trust **Named Doctor for Child Protection** or the **Trust Named Nurse or Safeguarding Children’s Nurse Specialists.**

Royal College of Paediatrics and Child Health, et al (2014) [*Safeguarding children and young people: roles and competences for healthcare staff: intercollegiate report*](http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf) (pdf) London, Royal College of Paediatrics and Child Health.

Advice may also be sought from social services by contacting the appropriate Social Services Gateway Team.

In these discussions professionals should be explicit that they are requesting advice and consultation for a child safeguarding or child protection query and that they are not necessarily making a referral. It must be recognised, however, that the process of consultation may identify a degree of risk that warrants making a referral.

* **Referral Regarding Alleged or Suspected Cases of Child Abuse and Neglect**

Where there is an allegation or reasonable cause to suspect that a child/young person has been abused, a referral must be made to the police and/or social services. The timing of such referrals should reflect the level of perceived risk of harm, not longer than within one working day of identification or disclosure of harm or risk of harm. In urgent situations the referral should be made immediately via telephone and followed up in writing within 24 hours by the staffl who identifies the child protection concern in accordance with the **Referral Procedure** (click here).

In all cases, professionals should consult with the Child Protection Register to establish if the child/young person is currently subject to an inter-agency Child Protection Plan. This information may be accessed by contacting social services via the local Gateway Team. The absence of the child/young person’s name on the Child Protection Register, however, should not be used to reassure oneself that no further action is required.

The **Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland** sets out a framework for joint working between police and social services on receipt of a referral regarding alleged or suspected child abuse.

When a referral is made the nominated person from each agency will gather information for consultation and assessment which will be the basis for making a decision as to the need for a joint investigation. Consultation will then take place between social services and police to decide the way forward.

The outcome of the initial assessment and consultation between police and social services could be:-

* A single agency child protection investigation by social services for child protection and/or family support;
* A single agency criminal investigation will be undertaken by the police;
* A Joint Protocol Investigation involving police and social services;
* No further action.

If a Joint Protocol Investigation is initiated then an initial Strategy meeting/discussion must take place between police and social services.

Further Strategy discussions/meetings may be required depending on the complexity of the case and may also need to include other professionals such as a Forensic Medical Officer, GP, Paediatrician, other health or education professionals and/or a person with special knowledge in dealing with children/young people with disabilities.

In cases of alleged or suspected child sexual abuse in children/young people currently below 18 years of age consultation should also take place at this stage with a relevant medical professional at The Rowan ([www.therowan.net](http://www.therowan.net)) which is the regional Sexual Assault Referral Centre (SARC) for Northern Ireland.

**General Guidance in relation to Medical Assessment**

The General Medical Council guidance **Protecting children and young people: The responsibilities of all doctors** sets out the responsibilities of all doctors and includes advice on:

* Identifying children and young people at risk of, or suffering, abuse or neglect
* Meeting the communication needs of children, young people and parents
* Confidentiality and sharing information
* Child Protection examinations
* Giving evidence in Court

**GMC Protecting Children and Young People: The responsibility of all doctors**

[**www.gmc-uk.org/guidance/ethical\_guidance/13257.asp**](http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp)

In cases of alleged or suspected child abuse medical assessment of the child/young person will often be carried out as part of the joint protocol investigation.

The timing of any medical assessment will depend first and foremost on the urgency of the child/young person’s medical and welfare needs. It is critically important that all relevant agencies/professionals assist in the planning process. The opportunity for forensic recovery needs to be considered as part of any potential criminal investigation. The planning process should also take account of the venue of the examination, which medical professionals will carry out the assessment, consent issues and any other operational/investigative matters.

In the case of children who are under the age of 13 years, or young people over that age, but who have additional vulnerability factors, a joint Forensic Medical Officer/Paediatric medical assessment should where possible be conducted. A joint medical assessment should also be considered in cases of children/young people aged 13, 14 and 15 years as per the **Royal College of Paediatrics and Child Health and the Faculty of Forensic and Legal Medicine (2007) Guidelines on Paediatric Forensic Examinations** ([www.rcpch.ac.uk)](http://www.rcpch.ac.uk)).

All paediatric forensic medical assessments should take place in a clinical paediatric facility whether in a hospital or community setting unless there are reasonable grounds not to do so.

Where there is information available to indicate that the child/young person has a communication difficulty, or if English is not their first language, consideration should be given to the need for a Registered Intermediary or the use of an interpreter and, if appropriate, they should be present during part or all of the assessment.

The child/young person’s general practitioner should be notified of the assessment by the examining doctor(s).

The examining doctor(s) should make arrangements for treatment and follow-up of health care needs of the child/young person as necessary.

To avail of Forensic Medical Officer involvement in a medical assessment contact must be made with the Police [www.psni.police.uk/](http://www.psni.police.uk/)

To avail of Paediatric involvement in a joint Forensic Medical Officer/Paediatric forensic medical assessment contact should be made with the local HSC Trust Paediatric Team.

**Consent for Medical Assessment**

Consent must always be obtained for a medical assessment.

Specific guidance in relation to consent in children and young people has been published by the General Medical Council.

General Medical Council (2007) [*0–18 years: guidance for all doctors*](http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp) London, General Medical Council.

A paediatric forensic medical assessment may only be carried out with the consent of the child/young person (if the child has the capacity to give consent) or with the consent from a person with parental responsibility.

A child/young person under the age of 16 years can give consent if they are Fraser competent, i.e., they have ‘sufficient understanding and intelligence to enable him or her to understand what is fully proposed’ (Lord Gillick v West Norfolk and Wisbech AHA, 1985 & Fraser Guidelines).

[Gillick v West Norfolk and Wisbech AHA [1985] UKHL 7](http://www.bailii.org/uk/cases/UKHL/1985/7.html)

If the consent of the person with parental responsibility is refused and he/she is not thought by professionals to be acting in the child/young person’s best interests, or there is no one with parental responsibility available (either in person or contactable by phone), the Health and Social Care Trust should seek legal advice to consider an appropriate way forward, including an application to Court.

**Medical Assessment in Alleged or Suspected cases of Child Abuse and Neglect**

The importance of taking a holistic approach to any presentation of alleged or suspected cases of child abuse and neglect, even minor, cannot be overstated. Learning from Case Management Reviews, where children have died or have been seriously injured, have evidenced occasions where ‘minor’ injuries have been considered singularly.

**A** **comprehensive medical assessment** should include the following;

* A full history gathered from parents/carers. This should include; information from the antenatal, perinatal and post-natal period and previous medical history (including hospital attendances, admissions, any previous injuries and attendance at hospital and community clinics). Information in relation to social, educational and family history should also be included.
* A full physical examination should be carried out. Medical staff may record the assessment using the Safeguarding Children/Young People - Medical Assessment Proforma (Click here).
* Photo-documentation of any injuries identified on examination.
* A review of any hospital (including Emergency Department ) records and community paediatric medical records.

**Investigations** may be required dependent on the findings of physical examination. These may include:

* Laboratory (blood) investigations the nature of which will depend on the type of injury.
* Skeletal survey with follow up views of ribs in 11-14 days (routinely in any child <2 years presenting with a possible deliberate physical injury), or neuroimaging (routinely in infants < 1 year and considered in all those undergoing skeletal survey).
* Ophthalmology assessment, orthopaedic assessment, other expert professional opinion as required/indicated

In certain circumstances a detailed **chronology** of involvement with children health and social care services can be useful. This may have particular relevance in presentations where neglect, emotional abuse and Fabricated and Induced Illness are being considered.

**Medical records** relating to history, examinations and investigations should be clear, detailed and contemporaneous.

**A comprehensive child protection assessment will be inter-disciplinary and/or inter-agency.**

It should include:

* Liaison with other professionals e.g. Health Visitor, Allied Health Professionals, General Practitioner, Mental Health Team, School Nurse, Children’s Social Services
* Consideration of any previous Court Orders or Social Services involvement.

**Following Medical Assessment**

* Following a joint protocol medical assessment for alleged or suspected child abuse the Forensic Medical Officer and, if relevant, Paediatrician will brief the Investigating Officer and/or Social Worker as to their initial findings, which may include the use of body maps, and their opinion, using clear unambiguous language and followed up in written format within 72 hours.
* Any further detailed reports must be shared with social services and the police. For further guidance on information sharing refer to the SBNI’s ‘Northern Ireland Information Sharing Agreement for Safeguarding Children’ (Click Here).
* The examining Forensic Medical Officer and, if relevant, Paediatrician should aim to attend any Strategy Meeting and/or Child Protection Case Conference if requested. Where this is not possible a written report should be submitted to the chair 2 days prior to the meeting.

**Further Information on Medical Assessment in alleged or suspected cases of Child Abuse and Neglect**

Detailed guidance on child maltreatment and medical assessment is available from:

Child Maltreatment:when to suspect maltreatment in under 18s [www.nice.org.uk/Guidance/CG89](http://www.nice.org.uk/Guidance/CG89)

Royal College of Paediatrics and Child Health (2006) [*Child protection companion*](http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/ChildProtCompL.pdf) (pdf) London, Royal College of Paediatrics and Child Health.

Additional information on systemic reviews with regard to child abuse and neglect is available on [www.core-info.cardiff.ac.uk](http://www.core-info.cardiff.ac.uk)

**Specific Considerations**

* **Alleged or Suspected Cases of Physical Abuse**

The following would justify a paediatric forensic medical assessment and the involvement of social services and police (this list is not exhaustive):

* The child/young person has an injury suspicious of physical abuse for example a suspected adult human bite mark, cigarette burn or a specific pattern suggestive of abusive bruising.
* The child is the twin of an infant (or sibling less than 2 years) admitted with signs of physical abuse.
* Any injury in a pre-mobile baby is of significant concern –Please refer to the **SBNI Protocol- Bruising in Pre-mobile Babies- A Protocol for Assessment, Management and Referral.**
* **Alleged or Suspected Cases of Emotional Abuse, Neglect and Fabricated or Induced Illness (FII)**

Medical assessment is indicated if a child/young person is displaying impairment of their physical health and/or development which it is thought may be as a consequence of neglect or emotional abuse or there is a suspicion that a parent/carer has deliberately fabricated or induced illness in their child/young person.

The medical assessment of suspected cases of neglect, including nutritional neglect (faltering growth), emotional abuse and fabricated and induced illness is complex and should always be referred to a senior paediatrician for assessment and management.

**Medical Assessment in Alleged or Suspected Cases of Child Sexual Abuse/Child Sexual Exploitation**

All medical assessments in cases of alleged or suspected child sexual abuse take place at the regional Sexual Assault Referral Centre, The Rowan.

**The Rowan** ([www.therowan.net](http://www.therowan.net)) is located on the grounds of Antrim Area Hospital and provides an appointment only service offering 24 hour assistance to victims of sexual violence.

Referral to The Rowan service, in respect of children/young people, is made by the Police Service of Northern Ireland.

Telephone advice is available to professionals by contacting 0800 3894424.

In exceptional circumstances medical assessments for alleged or suspected sexual abuse can be carried out in other locations, for example, if the child/young person is hospitalised and it is not clinically appropriate to travel or if the examination needs to be carried out under general anaesthetic. In these rare instances staff from The Rowan will attend the particular location.

If child sexual abuse is alleged or suspected it is vitally important that the child/young person is offered a medical assessment, in order to;

* Examine for physical evidence of abuse,
* Screen for sexually transmitted infections,
* Consider the need for urgent treatment to prevent blood borne infections such as HIV and Hepatitis B if assessed as at risk
* Consider emergency contraception for older children/young people
* Provide reassurance for the child/young person and their parents/carers

A medical assessment may be particularly important in cases of suspected child sexual exploitation where children/young people may be unwilling to support a criminal investigation or disclose sexual activity to authorities but are willing to have their health needs addressed.

Specific guidance in relation to medical assessment of alleged or suspected cases of child sexual abuse is available from the Royal College of Paediatrics and Child Health in collaboration with the Royal College of Physicians of London and its Faculty of Forensic and Legal Medicine.

Royal College of Paediatrics and Child Health in collaboration with the Royal College of Physicians of London and its Faculty of Forensic and Legal Medicine (2008) [*The physical signs of child sexual abuse: an evidence-based review and guidance for best practice*](http://www.rcpch.ac.uk/csa) London, Royal College of Paediatrics and Child Health in collaboration with the Royal College of Physicians of London and its Faculty of Forensic and Legal Medicine

The forensic/medical assessment of a child under the age of 13 years will usually be carried out jointly by a Rowan FMO and Rowan Paediatrician. A joint medical assessment should also be considered in cases of children aged 13, 14 and 15 who have additional vulnerability factors (as per the ‘RCPCH/FFLM- Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse- Oct 2012 (Click Here). If, in exceptional circumstances, a joint assessment is not possible then a Rowan FMO may carry out the examination, if appropriately trained, as per The Rowan protocols.

The type of case will determine when the medical assessment should take place. As mentioned above, the timing of any assessment will depend first and foremost on the urgency of the child’s medical and welfare needs and, as well, any opportunity for forensic recovery to assist in the criminal investigation.

Particular urgency of assessment is required in children presenting with ano-genital bleeding.

A briefing will be supplied to the Rowan FMO and, if relevant, the Rowan Paediatrician, by the Investigating Police Officer and Social Worker (if available) prior to assessment.

Medical assessment may include the following (the list is not exhaustive):

* A full history being taken from carers, including enquires about social, family educational history, previous injuries, concerns or attendance at hospital or community clinics
* A review of any hospital (including Emergency Department ) records and community paediatric medical records
* Liaison with other professionals e.g. Health Visitor, Mental Health Team or School Nurse
* Full general examination- including assessment for physical evidence of other forms of abuse, growth and interaction with parent, carer and examining doctor(s).
* Photo-documentation of the ano-genital examination using a video-colopscope
* Screening for sexually transmitted infections. The significance of any infection detected requires careful interpretation.
* Risk assessment for HIV, Hepatitis B and administration of post-exposure prophylactic treatment if indicated.
* Consideration of the need for emergency contraception.

The conduct of the assessment and the continuity of evidence must be maintained at all times and stored in accordance with agencies safeguards and protocols. For further information refer to the Faculty of Forensic and Legal Medicine (Click Here). This document is available at [www.rcpch.ac.uk/chil-health/standards-care/child-protection/publications/child-protection-publications](http://www.rcpch.ac.uk/chil-health/standards-care/child-protection/publications/child-protection-publications)

The Forensic Medical Officer/Paediatrician will brief the Investigating Officer and/or Social Worker as to their initial findings following the medical assessment which may include the use of body maps, and their opinion, using clear unambiguous language and followed up in written format within 72 hours. The doctor (s) may use the proforma template “Summary and Preliminary Medical Opinion” (Click here).

Any further detailed reports must be shared with social services and the police. For further guidance on information sharing refer to the SBNI’s ‘Northern Ireland Information Sharing Agreement for Safeguarding Children’ (Click Here). The examining Forensic Medical Officer and, if relevant, Paediatrician should aim to attend any Strategy Meeting and/or Case Conference if requested. Where this is not possible a written report should be submitted to the chairperson 2 days prior to the meeting.

**Female Genital Mutilation**

Female Genital Mutilation (FGM) is the term used to refer to the removal of part or all of the female genitalia for stated “cultural” or other non-therapeutic reasons. (Please refer to Safeguarding Practice Guidance on FGM (Click here). This practice is extremely painful and traumatic for the victim and has serious consequences for physical, sexual and mental health. It also can result in death. FGM is usually practiced in the country of origin of the child/young person's family. FGM is reportedly practiced in 28 African countries and in parts of the Middle and Far East. It is typically performed on girls aged between 4 years and 13 years, but can also be performed on new-born infants or on young women prior to marriage or pregnancy. It is not a religious practice and all major religions have condemned the practice as unnecessary and harmful.

Any such procedure on a female of any age is illegal under the Female Genital Mutilation Act 2003. It is also an offence under the act for UK Nationals or permanent UK residents to be involved in any way in this being carried out in the UK or abroad.

Female genital mutilation (FGM) is a serious crime and a child protection issues. The Northern Ireland Executive has published [Multi-agency practice](https://www.dfpni.gov.uk/sites/default/files/publications/dfp/multi-agency-practice-guidelines-on-female-genital-mutilation.pdf) [guidelines on female genital mutilation](https://www.dfpni.gov.uk/sites/default/files/publications/dfp/multi-agency-practice-guidelines-on-female-genital-mutilation.pdf) (pdf) Safeguarding practice guidance re FGM.

Where a child/young person below 18 years is thought to have been subject to FGM (or is at risk of FGM) a Strategy Meeting should take place and this should include consultation with a relevant medical professional at The Rowan as to whether a medical assessment is required and if so the timing of this.

**Unexpected Death of a Child/Young Person under 18 years of age**

In this guidance an unexpected death is defined as the death of an infant or child/young person which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

The term Sudden Unexpected Death in Infancy (SUDI) refers to all unexpected deaths of infants up to one year of age.

Unexpected death during childhood may occur as a result of sudden illness, accidents, suicide, or through maltreatment.

Unexpected deaths may occur either at home, in hospital or other community settings including custodial or educational.

**Professionals and Organisations Involved in Unexpected Death of a Child/Young Person**

A number of individuals and organisations are involved when a child dies unexpectedly. Whilst each have specific roles, a shared understanding of professional and organisational responsibilities is important in ensuring a co-ordinated and thorough response.

The responses of all professionals within the first hours of an unexpected death can play a crucial role in ensuring that the death is properly investigated and the family adequately supported.

A number of organisations and professionals have significant roles in the initial response to unexpected death in childhood. These include; ambulance service, police, forensic medical officer, general practitioner, hospital paediatrician, coroner, paediatric pathologist, forensic pathologist, paediatric radiologist and child protection agencies

Under section 7 of the Coroner’s Act (NI) 1959, police officers, doctors, registrars and funeral directors are required by law to report to the Coroner all deaths that are unnatural, sudden or suspicious.

**Responding to** **Unexpected Death of a Child/Young Person**

If a child dies suddenly or unexpectedly at home or in the community, the child/young person should normally be taken to an Emergency Department rather than a mortuary. In some cases when a child/young person dies at home or in the community, the police may decide that it is not appropriate to move the child/young person’s body immediately, for example, because forensic examinations are needed.

As soon as possible after arrival at a hospital, the child/young person should be examined by a consultant paediatrician and a detailed history should be taken from the parents or carers. The purpose of obtaining this information is to understand the cause of death and identify anything suspicious about it. In all cases when a child/young person dies in hospital, or is taken to hospital after dying, the hospital should allocate a member of staff to remain with the parents and support them through the process.

When a child/young person dies suddenly and unexpectedly, the consultant paediatrician/clinician (in a hospital setting) or the professional confirming the fact of death (if the child/young person is not taken immediately to an Accident and Emergency Department) should inform the coroner and the police.

The police will begin an investigation into the sudden or unexpected death on behalf of the coroner.

The consultant paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and children’s social services) to decide what should happen next and who will do it. The joint responsibilities of the professionals involved with the child/young person include:

* responding quickly to the child's death in accordance with the locally agreed procedures;
* making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
* liaising with the coroner and the pathologist;
* undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations;
* collecting information about the death;
* providing support to the bereaved family, involving them in meetings as appropriate, referring to specialist bereavement services where necessary and keeping them up to date with information about the child’s death; and
* gaining consent early from the family for the examination of the child/young person’s medical notes.

The following cases will be dealt with as a Child Protection Referral, at least to begin with, in accordance with the Protocol for Joint Investigation:

* Sudden Unexpected Death in Infancy i.e. where the cause of death has not yet been established;
* Suicide, where abuse is suspected or there has been extensive agency involvement in that child’s life;
* Any other death of a child where abuse is suspected.

Every child/young person who dies deserves the right to have their sudden and unexplained death fully investigated so that homicide can be excluded and a cause of death identified.

The police have a key role in the investigation of infant and child deaths.

The coroner has the statutory role to investigate certain cases. The police act on their behalf. Early notification by police and full discussion with the coroner is therefore essential.

The coroner will give directions to the pathologists and police concerning the extent of the post-mortem examination and the following considerations:

* Whether a joint post-mortem is required involving a forensic pathologist and a paediatric pathologist;
* Directions on skeletal survey prior to post-mortem;
* Directions on biochemical, metabolic and microbiological investigation.

**Reviewing and Reporting Child Deaths in Northern Ireland**

All child deaths in Northern Ireland are subject to a review process.

This process includes a multidisciplinary review of all child deaths at Mortality and Morbidity (M&M) meetings as a prime method of scrutiny. Every child death should be reviewed at a multidisciplinary mortality and morbidity meeting within eight weeks of the death occurring.

Details in relation to this guidance are available in **HSS MDI 2016 Process for Reporting Child Deaths.**

From the 1st February 2016, the guidance should be used for all child deaths.

**Principles**

1. All Child\* Deaths must undergo a clinical peer review process e.g. M&M meeting.

2. All Child\* Deaths must have a **Child Death Notification Form** (CDNF) completed and forwarded to the Health & Social Care Board/Public Health Agency.

3. Where a Child Death has required an Serious Adverse Incident investigation, the report’s recommendations must be discussed at the next scheduled M&M meeting.

\*Child

This guidance applies to every child up to their eighteenth birthday. This includes babies at any gestational age who are born alive and subsequently die.

**The Death of a Child/Young Person in the Community**

The death of a child/young person in the community will require a similar process of clinical peer review to that occurring after a death in hospital. This can be achieved by reviewing the death during a hospital M&M meeting where either the Hospital Consultant (who had cared for the child/young person when in hospital) or the Community Paediatrician takes the lead. A robust liaison process between the hospital and community services in these circumstances is needed so that each are aware of the details entered onto the Medical Certificate or Cause of Death or given to the coroner and the exact circumstances of the death. This is to be certain that the hospital clinical peer review covers all aspects of the death, including those features that occurred in the community.

The clinical peer review could also occur in the community if there is a community based clinical peer review process which satisfies HSCB/PHA requirements.

Detailed guidance in relation to the Child Death Reporting Process is provided in **HSS MDI 2016 Process for Reporting Child Deaths.**

**Other Processes involved with Child Death**

**Serious Adverse Incidents (SAIs)** These are under the responsibility of the Health and Social Care Board. Any adverse incident which meets one or more criteria should be reported as a SAI to Health & Social Care Board.

(Please click here for further information <http://intranet.hscb.hscni.net/documents/Policies/Governance/Procedure%20for%20the%20reporting%20and%20followup%20of%20SAIs/Procedure%20for%20the%20reporting%20and%20follow%20up%20of%20SAIs.pdf>).

**Case Management Reviews**

Case Management Reviews are undertaken by the Safeguarding Board for Northern Ireland. (Please click here for further information <https://www.health-ni.gov.uk/publications/guidance-safeguarding-board-northern-ireland-0>)

**Notifications should be made to**: [cmr.notifysbni@hscni.net](mailto:cmr.notifysbni@hscni.net)