

Safeguarding Process Review

Safeguarding process reviews are designed to look at incident details, responses/actions taken and the outcomes achieved. Findings from safeguarding process reviews will highlight good practice and will act as a learning opportunity to support ongoing improvements to safeguarding processes, engagement and support. The review process may also identify areas for improvement and inform potential changes to practice, policy, procedure and training needs.

Below is a guide to the safeguarding process review, it will outline why a safeguarding process review maybe required, who the key people are in the process, what is recorded and how this could inform organisational development.

It is good practice to review safeguarding cases, the actions taken and the outcomes in order to understand how decisions were made and what impact they had, this can inform and improve future practice. A safeguarding process review takes place after a safeguarding concern/incident has been raised and has already been dealt with and focuses on the process of how this decision/outcome was reached. In most cases the lessons learned reviews will be in relation to **major** safeguarding incidents but can also be utilised in relation to any safeguarding concern/incident that has been logged.

The review will look into:

- Details of the concern/incident
- What initial actions were taken and the impact of these actions
- Is there an established documented procedure/policy that has been referred to
- Was this procedure/policy followed
- What the outcomes of these actions were
- Was there anything additional that could have been completed

The findings may feed into the following areas:

- Updates to current policy and procedures where required
- Additional training for coaches/Club Welfare Officers(CWO's)/Members where required
- Updates to training organisationally
- Greater insight and understanding of themes and trends
- Greater insight and understanding of the difficulties faced by coaches/CWO's/Members
- Creation of resources and briefings for coaches/CWO's/Members in relation to safeguarding procedures, themes, policy
- Review of and/or updates to risk assessments

*If it is found through a safeguarding lessons learned review that coaches/CWO's/Members have not followed procedure, this may be followed up by the CWO/Committee where appropriate, to look at additional support and training, or may lead to an investigation under the clubs Disciplinary Policy with potential disciplinary action being taken.

Who is involved?

Review Lead/s: Club Welfare Officer/s, Committee Member (for safeguarding where possible). Where appropriate, and in cases where the case handling is under scrutiny, a CWO and/or Committee member who was not involved in the handling of the case should carry out the review.



The review lead/s will liaise with all relevant parties involved in the incident (where required) and will ensure the below form is complete and stored securely. They will be responsible for communication and/or implementation of any required changes, which come about as a result of the lessons learned review, to relevant parties.

Relevant Parties could include:

- First Responder e.g., coaches/CWO's/Members
- Initial incident report writer
- Coaches/Team Leaders/Junior Leaders
- Paddlers
- Parents/Carer of children involved
- Any adults at risk involved in the case
- Club Committee

The following questions can be used to help guide you through the Safeguarding Process Review:

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Please describe the Safeguarding concern/incident details: (Where possible and appropriate include any incident report/s or supporting documents)	
What initial actions were taken? Please include any referrals, signposting made, support offered, etc:	
What processes, procedures and/or policies did you follow when responding to the concern/incident?	
Were the processes, procedures and/or policies useful when responding to this concern/incident? <i>Detail why they were/weren't:</i>	
Did you use any supporting documents, e.g. codes of conduct, disciplinary procedures, reporting guides, managing challenging behaviour, etc?	



Were the supporting documents useful when responding to this concern/incident? Detail why they were/weren't:		
What were the outcomes of the actions taken?		
What went well?		
Discuss what, if any additional steps could have been taken and what the impact of these actions may have been:		
Actions: (these could be training requirements, updates to procedures, implementation of risk assessments, creation of resources, etc.)	Details of Actions to be taken as a result of this lessons learnt process.	By who