

# SAFEGUARDING ADULTS REVIEW REFERRAL FORM

For information on safeguarding adults reviews please refer to the [HSAB Safeguarding Adult Review](https://www.hertfordshire.gov.uk/media-library/documents/adult-social-services/herts-safeguarding-adults-board/hsab-information-for-professionals/safeguarding-adults-reviews-a-guide-for-practioners-april-2019.pdf) [Guidance](https://www.hertfordshire.gov.uk/media-library/documents/adult-social-services/herts-safeguarding-adults-board/hsab-information-for-professionals/safeguarding-adults-reviews-a-guide-for-practioners-april-2019.pdf) at [HSAB website](https://www.hertfordshire.gov.uk/services/adult-social-services/report-a-concern-about-an-adult/hertfordshire-safeguarding-adults-board/hertfordshire-safeguarding-adults-board.aspx)

Please complete and return via secure email to: jean.banks@hertfordshire.gov.uk and mary.moroney@hertfordshire.gov.uk

This information will be collated and used by the Safeguarding Adults Review sub-group to inform the decision about whether or not any form of review should be undertaken by Hertfordshire Safeguarding Adults Board.

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| **PART 1 – to be completed by the person making the referral** |
| **Referrer:** |  |
| **Date of Referral:** |  |
| **Identified person(s) at Risk Name:****D.o.B.:****D.o.D.:****Address:****NHS number (if known):** |  |
| **Sex:****Does the person identify with the sex they were assigned at birth:** **Ethnicity:****Race:** **Religion or Belief:** **Long term health condition/Disability (if known):****Preferred Language:****Sexual Orientation:** **Is the person married or in a civil partnership:****Is the person pregnant or undertaking maternity:**  |  |
| **Does the person at risk require support with communication?****If yes, please give details:** |  |
| **Known person(s) / Organisation(s) having had contact with the person:** |  |
| **Other relevant family / friends:** |  |
| **Has the person got/had care and support needs – please specify** | **YES / NO (please delete as appropriate) –Please specify** |
| **Has their death resulted from abuse or neglect – please specify****OR****If they are alive have they experienced serious abuse or neglect – please specify** | **YES / NO (please delete as appropriate) –Please specify** |
| **Is there concern that partner agencies could have worked more effectively to protect the person – please specify** | **YES / NO (please delete as appropriate) –Please specify** |
| **Is this person subject to a DoLS?** | Yes  No  |

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| **Question** | **Response** |
| **Reason for referral for consideration of SAR** |  |
| **Period under consideration :** |  |
| **Did your agency have any contact with the person concerned?** |  |
| **If so, in what capacity? (Please detail all services)** |  |
| **Has your agency identified any safeguarding concerns in relation to or any other family member / significant other? (please detail)** |  |
| **Has your agency identified any areas of learning in the way in which services were provided to?** |  |
| **Has your agency undertaken any form of learning / incident review in relation to this case? (If so, please detail, including recommendations and actual / anticipated impact).** |  |
| **Is your agency of the view that any form of multi-agency review should be undertaken? (Please explain your response)** |  |
| **Please detail any other information / comment that you consider would assist the sub-committee in deciding how to****respond to this referral.** |  |

# PLEASE MAKE SURE THIS REFERRAL IS SIGNED BY YOUR AGENCY’S HSAB MEMBER. THE REFERRAL WILL BE RETURNED IF SIGN OFF IS NOT COMPLETED

**Name of person completing this form**: **Job title**:

**Contact details**: **Executive Officer Name:**

**Job Title:**

**Signature:**

**Responding agency**:

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| **PART 2 – to be completed by the chair of the SAR subgroup** |
| **It is recommended/not recommended that this case be subject to a Safeguarding Adult Review for the following reasons:** |
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| **When a case does not meet the criteria for a Safeguarding Adult Review, other options may be considered – in this case the following is recommended:** |
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| **Legal advice has been sought Yes****No** |
| **Signed** |
| **Print Name** |
| **Date** |

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| **PART 3 – to be completed by the chair of the HSAB** |
| **Does this case meet the requirements of a SAR?** |
| **Yes/No** |
| **Does this case meet the requirements of a PCR?** |
| **Yes/No** |
| **Reason for decision:** |
| **Shared with HSP members Yes/No** |
| **Raised at HSAB meeting under confidential section? Yes/No** |
| **Date:** |
| **Signed:** |
| **Print name:** |
| **Date:** |