| **Individual’s Name** *[Individual on whose behalf the Sentinel Event Report is being completed.]* | | | | | | | | | | | |
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| **Last Name:** | **First Name:** | | | | | | | | | | **Middle Initial:** |
| **Date of Sentinel Event:** Click or tap to enter a date. | | | | | | **Report Date:** Click or tap to enter a date. | | | | | |
| **I - BACKGROUND** | | | | | | | | | | | |
| 1. **Type of Sentinel Event [check all that apply]:** | | | | | | | | | | | |
| Unanticipated death is a sudden or accidental death.  *Note: Does not include homicide or suicide; and, is not related to the natural course of an illness or underlying condition*. | | | | | Permanent loss of function, resulting from such causes including but not limited to:   * medication error; * unauthorized departure or abduction from a facility providing care; or, * delay or failure to provide requested and/or medically necessary services due to waitlists, availability, insurance coverage or resource limitations. | | | | | | |
| Homicide victim  Homicide perpetrator | | | | | Suicide | | | | | | |
| Serious physical injury, or risk thereof to or by a client (jeopardizing a person’s health). | | | | | Serious psychological injury that jeopardizes the person’s health that is associated with the planning and delivery of care. | | | | | | |
| Victim of rape or any other sexual assault  Perpetrator of rape or any other sexual assault | | | | | Injury due to physical or mechanical restraints. | | | | | | |
| Suicide attempt that has explicit or implicit evidence that the individual intended to die and medical intervention was needed. | | | | | High profile event such as media coverage, police involvement, etc. | | | | | | |
| 1. **Location of Sentinel Event:**   Primary Residence Other Residence Business Other: | | | | | | | | | | | |
| Street Address: | | | | | | | City/Town: | | | | |
| 1. **DHHS Agencies/Programs Serving the Client:** | | | | | | | | | | | |
| Adult Protective Services | | Mental Health Services | | | | | | | Choices for Independence Waiver | | |
| Child Protective Services | | Juvenile Probation and Parole | | | | | | | Sununu Youth Services Center | | |
| Drug and Alcohol Services | | Elderly and Adult Services | | | | | | | Family Assistance | | |
| New Hampshire Hospital | | Housing Supports | | | | | | | Employment Supports | | |
| Glencliff Home | | Transitional Housing | | | | | | | Laconia BDS DRF | | |
| Child Development and Head Start Collaboration | | Developmental Services | | | | | | | Other (specify): | | |
| 1. **Individual’s DHHS Case Status [check all that apply]:** | | | | | | | | | | | |
| Currently receiving DHHS-funded services.  Has received DHHS-funded services within the preceding 30 days. | | | | | | | | | | | |
| Has received services through Emergency Services provided by a Community Mental Health Center.  Has received psychiatric hospitalization within the past year of the suicide death. | | | | | | | | | | | |
| Is receiving services from Child or Adult Protective Services.  Other: | | | | | | | | | | | |
| 1. **Reported by [check applicable box and complete the name or location if applicable]:** | | | | | | | | | | | |
| Adult Protective Services | | | District Office: | | | | | | | | |
| Mental Health Services | | | Community Mental Health Center: | | | | | | | | |
| DCYF – Child Protection | | | District Office: | | | | | | | | |
| DCYF – Juvenile Justice | | | District Office: | | | | | | | | |
| Choices for Independence (CFI) | | | Case Management Agency: | | | | | | | | |
| Designated Receiving Facility (DRF) | | | Name: | | | | | | | | |
| Developmental Services | | | Area Agency: | | | | | | | | |
| Drug and Alcohol Service | | | Agency: | | | | | | | | |
| Bureau of Housing Supports | | | Agency: | | | | | | | | |
| Division of Economic Housing Stability (DEHS) Other | | | Bureau: Click or tap here to enter text. | | | | | | | | |
| Managed Care Organization (MCO): | | | AmeriHealth Caritas NH NH Healthy Families Well Sense | | | | | | | | |
| New Hampshire Hospital (NHH) | | | | |  | | | | | | |
| Harbor Homes | | | | |  | | | | | | |
| Glencliff Home for the Elderly | | | | |  | | | | | | |
| Sununu Youth Services Center | | | | |  | | | | | | |
| Laconia BDS DRF | | | | |  | | | | | | |
| Other (specify): | | | | | | | | | | | |
| 1. **Person Completing the Sentinel Event Reporting Form:** | | | | | | | | | | | |
| Last Name: | | | | | | | First Name: | | | | |
| Work Phone: | | | | | | | Mobile Phone: | | | | |
| Work Email: | | | | | | | Relationship to Individual: | | | | |
| 1. **Person to Contact for Additional Information:** | | | | | | | | | | | |
| Last Name: | | | | | | | First Name: | | | | |
| Work Phone: | | | | | | | Mobile Phone: | | | | |
| Work Email: | | | | | | | Relationship to Individual: | | | | |
| **II – INDIVIDUAL’S DETAILS**  [Individual on whose behalf the Sentinel Event Report is being completed.] | | | | | | | | | | | |
| 1. **Demographics:**   Male Female Other (specify): | | | | | | Date of Birth: Click or tap to enter a date. | | | | | Age: |
| Street Address: | | | | City/Town: | | | | | | Zip: | |
| 1. **NH Medicaid Status:**   Is the individual receiving Medicaid benefits? No Yes with Member ID#: | | | | | | | | | | | |
| Date MCO Notified: Click or tap to enter a date. | | | AmeriHealth Caritas NH Healthy Families Well Sense | | | | | | | | |
| 1. **Legal Factors [Identify any legal factors(s) the individual may have.]:** | | | | | | | | | | | |
| ***Child Protection [check all that apply]:*** | | | | | ***Community Care [check all that apply]:*** | | | | | | |
| Abused  Neglected  Guardianship  Co-Guardianship  Out-of-home care / physical custody  Foster family care  Relative/kinship care  Residential/congregate living  Individual Service Option (ISO) | | | | | Authorized Representative (Individual has identified someone to act on his/her behalf for a specific purpose)  Conditional Discharge (Adult or child)  Court Involved Adult Protection Open Case  Durable Power of Attorney (DPOA)  DPOA for Health Care  Guardian of Estate  Guardian of Person | | | | | | |
| ***Juvenile Justice Services [check all that apply]:***  Child in Need of Services (CHINS)  Delinquent  Detained  Committed to Sununu Youth Services Center  Furlough  Medical furlough  Administrative furlough  Administrative release  Detained pending revocation  Parole | | | | | ***Psychiatric hospitalization: New Hampshire Hospital, Designated Receiving Facility (DRF), or a behavioral/psychiatric unit in a general hospital [check all that apply]:***  Involuntary Emergency Admission (IEA) up to 10 days  Involuntary commitment by probate (admission beyond 10 days)  Revocation of Conditional Discharge (CD)  Voluntary psychiatric admission   **Other (specify):** | | | | | | |
| 1. **All Current Diagnosis(es):** | | | | | | | | | | | |
| **Psychiatric** | | | | | **Medical** | | | | | | |
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| 1. **Individual’s Services [List all services the individual is or was receiving if case was recently closed]:** | | | | | | | | | | | |
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| **III - SENTINEL EVENT DETAILS** | | | | | | | | | | | |
| 1. **Description of Event Details:** | | | | | | | | | | | |
| 1. What happened? | | | | | | | | | | | |
| 1. If known, what were the precipitating factors? | | | | | | | | | | | |
| 1. When did it happen? | | | | | | | | | | | |
| 1. Where did it happen? | | | | | | | | | | | |
| 1. How did it happen? | | | | | | | | | | | |
| 1. Were there any witness(es)? Unknown No Yes (answer 13.g) | | | | | | | | | | | |
| 1. Provide any relevant details about witness(es) *(name, contact information, etc.):* | | | | | | | | | | | |
| 1. Other relevant information: | | | | | | | | | | | |
| 1. **Use of Restraints:** | | | | | | | | | | | |
| None Used Physical Mechanical Chemical  If known, minutes in restraints: | | | | | | | | | | | |
| 1. **Individual’s Housing:**   Was the individual in a 24-hour residential facility, community residence, shelter, or institution within 30 days preceding the sentinel event? No Unknown Homeless  Yes, then complete the next sections | | | | | | | | | | | |
| Facility Name: | | | | | Facility Location: | | | | | | |
| **Facility Type [check the applicable box]:** | | | | | | | | | | | |
| Adult family care | | | | | | | | Prison/jail | | | |
| Acute Psychiatric Residential Treatment Program (APRTP) | | | | | | | | Residential care/assisted living | | | |
| Community residence-certified (group home, shelter) | | | | | | | | Respite *(type of facility):* | | | |
| Group home | | | | | | | | Residential treatment facility | | | |
| Psychiatric hospital or Designated Receiving Facility (DRF) | | | | | | | | Shelter | | | |
| Medical/general hospital | | | | | | | | Substance use disorder treatment facility | | | |
| Mid-level care facility | | | | | | | | Sununu Youth Services Center | | | |
| Skilled nursing facility | | | | | | | |  | | | |
| Other (describe): | | | | | | | | | | | |
| **IV - INITIAL NOTIFICATION** | | | | | | | | | | | |
| DHHS Division / Bureau: | | | | | | | | | | | |
| DHHS Director / Administrator: | | | | | | | | | | | |
| Date Notified: Click or tap to enter a date.  Method of Notification: Telephone Voice Mail (VM) Other (specify): | | | | | | | | | | | |
| **V – ADDITIONAL INFORMATION** | | | | | | | | | | | |
| * Additional information regarding the sentinel event shall be reported as it becomes available, and upon the Department’s request. * As they are learned, additional details may include a change in status of the situation, links to relevant newspaper articles, etc.   + To submit Additional Information for a previously reported Sentinel Event, upload a separate document to the eStudio application.   + Use the following naming convention so that the Additional Information document remains part of the report history. For example:   *PHI\_SE\_FIRSTNAME\_LASTINITIAL\_document description\_YYYY-MM\_DD* | | | | | | | | | | | |