



State of New Hampshire
Department of Health and Human Services
Bureau Program Quality

SENTINEL EVENT REPORTING FORM

Original Effective Date: September 2010
Revision Date: September 23, 2021

Individual's Name [Individual on whose behalf the Sentinel Event Report is being completed.]

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. <i>Note: Does not include homicide or suicide; and, is not related to the natural course of an illness or underlying condition.</i>	☐ 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 <u>physical</u> injury, or risk thereof to or by a client (jeopardizing a person's health).	☐ Serious <u>psychological</u> 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.	
2. Location of Sentinel Event:		
☐ Primary Residence ☐ Other Residence ☐ Business ☐ Other:		
Street Address:		City/Town:
3. DHHS Agencies/Programs Serving the Client:		
☐ Adult Protective Services ☐ Child Protective Services ☐ Drug and Alcohol Services ☐ New Hampshire Hospital ☐ Glenclyff Home ☐ Child Development and Head Start Collaboration	☐ Mental Health Services ☐ Juvenile Probation and Parole ☐ Elderly and Adult Services ☐ Housing Supports ☐ Transitional Housing ☐ Developmental Services	☐ Choices for Independence Waiver ☐ Sununu Youth Services Center ☐ Family Assistance ☐ Employment Supports ☐ Laconia BDS DRF ☐ Other (specify):



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4. 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:		
5. 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		
☐ Glenciff Home for the Elderly		
☐ Sununu Youth Services Center		
☐ Laconia BDS DRF		
☐ Other (specify):		
6. Person Completing the Sentinel Event Reporting Form:		
Last Name:	First Name:	
Work Phone:	Mobile Phone:	
Work Email:	Relationship to Individual:	
7. Person to Contact for Additional Information:		
Last Name:	First Name:	
Work Phone:	Mobile Phone:	



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II – INDIVIDUAL'S DETAILS <i>[Individual on whose behalf the Sentinel Event Report is being completed.]</i>						
8. Demographics: ☐ Male ☐ Female ☐ Other (specify):		Date of Birth: Click or tap to enter a date. Age:				
Street Address:	City/Town:	Zip:				
9. 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						
10. Legal Factors [Identify any legal factors(s) the individual may have]: <table border="0"><tr><td>Child Protection [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)</td><td>Community Care [check all that apply]: ☐ 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</td></tr><tr><td>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</td><td>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):</td></tr></table>			Child Protection [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)	Community Care [check all that apply]: ☐ 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):
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11. All Current Diagnosis(es):		
Psychiatric	Medical	
12. Individual's Services [List all services the individual is or was receiving if case was recently closed]:		
a.	b.	
c.	d.	
e.	f.	
g.	h.	
III - SENTINEL EVENT DETAILS		
13. Description of Event Details:		
a. What happened?		
b. If known, what were the precipitating factors?		
c. When did it happen?		
d. Where did it happen?		
e. How did it happen?		
f. Were there any witness(es)? ☐ Unknown ☐ No ☐ Yes (answer 13.g)		
g. Provide any relevant details about witness(es) (name, contact information, etc.):		
h. Other relevant information:		
14. Use of Restraints:		
☐ None Used ☐ Physical ☐ Mechanical ☐ Chemical		
If known, minutes in restraints:		



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15. 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]: <table border="0"><tr><td>☐ Adult family care</td><td>☐ Prison/jail</td></tr><tr><td>☐ Acute Psychiatric Residential Treatment Program (APRTP)</td><td>☐ Residential care/assisted living</td></tr><tr><td>☐ Community residence-certified (group home, shelter)</td><td>☐ Respite <i>(type of facility)</i>:</td></tr><tr><td>☐ Group home</td><td>☐ Residential treatment facility</td></tr><tr><td>☐ Psychiatric hospital or Designated Receiving Facility (DRF)</td><td>☐ Shelter</td></tr><tr><td>☐ Medical/general hospital</td><td>☐ Substance use disorder treatment facility</td></tr><tr><td>☐ Mid-level care facility</td><td>☐ Sununu Youth Services Center</td></tr><tr><td>☐ Skilled nursing facility</td><td></td></tr><tr><td>☐ Other (describe):</td><td></td></tr></table>			☐ Adult family care	☐ Prison/jail	☐ Acute Psychiatric Residential Treatment Program (APRTP)	☐ Residential care/assisted living	☐ Community residence-certified (group home, shelter)	☐ Respite <i>(type of facility)</i> :	☐ 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):	
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☐ 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: <i>PHI_SE_FIRSTNAME_LASTINITIAL_document description_YYYY-MM_DD</i>																				