# DMHAS CRITICAL INCIDENT SUBMISSION FORM

- Mental Health PNP Affiliates: Submit this form to designated contact at your LMHA.
- PNP/State Operated LMHAs and Other Mental Health/Substance Use Providers: Use this form to guide data entry into the online Critical Incident Application.
- **Contact Information** for making verbal report

## The Incident

**Contact Person:** **Contact Phone:** **Incident Date:** **Incident Time:**

**Provider Reporting:** **Program Reporting:**

**Location of Incident (CT Town Name or Out of State):**

**Location Type (Check one):**

- ☐ Client's Residence
- ☐ Community *(public location, relative's home, etc.)*
- ☐ IP Unit, DMHAS-Operated
- ☐ IP Unit, DMHAS Funded
- ☐ Jail
- ☐ Nursing Home
- ☐ Program Premises: Non-Inpatient
- ☐ Other Location *(please specify)*:

**Incident Category/Subcategory** *(check only one box to indicate a category type for this incident. Description of each subcategory can be found here: ci-categories-and-descriptions-dec-2025.pdf).*

***Client Abuse Alleged***

- ☐ Physical Abuse
- ☐ Verbal Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Exploitation

***Patient Rights***

- ☐ Potential violation of patient rights with significant consequences
- ☐ Potential breach of confidentiality with significant consequences

***Death***

- ☐ Suicide
- ☐ Homicide
- ☐ Accident
- ☐ Accidental Overdose (resulting in death)
- ☐ Medical Error
- ☐ Illness, Age, or Medical Reason
- ☐ Info Pending / Insufficient Info

***Emergency Evacuation***

- ☐ Fire
- ☐ Bomb
- ☐ Other

***Escape (Forensic only)***

- ☐ PSRB
- ☐ DOC
- ☐ Competency Restoration

***Federal Notification***

- ☐ Secret Service
- ☐ FBI
- ☐ Other Federal Notice

***Medical Event***

- ☐ Accidental Injury
- ☐ Accidental Overdose (not resulting in death)
- ☐ Medication Error/Reaction
- ☐ Medical Event – Other

***Missing Client***

- ☐ Missing Inpatient, Risk to Self or Others
- ☐ Missing Outpatient, Risk to Self or Others
- ☐ Missing Person

***Property Damage***

- ☐ Property Damage – Safety Issue
- ☐ Property Damage

***Serious Assault/Crime Alleged***

- ☐ Physical Assault
- ☐ Sexual Assault
- ☐ Risk of Injury to Minor
- ☐ Arson
- ☐ Drug Sale / Distribution/Possession
- ☐ Homicide / Manslaughter
- ☐ Theft/Burglary
- ☐ Other Serious Crime (specify):

***Serious Suicide Attempt***

- ☐ Suicide Attempt while Active in Program
- ☐ Suicide Attempt within 30 days of Discharge

***Threats***

- ☐ Threats to Agency
- ☐ Threats to Person

***Other***

- ☐ Other Incident (specify):

**Does it appear that one or more of the following substances were a direct cause or contributory cause of the incident?**
☐ Alcohol ☐ Prescribed Medication ☐ Illicit Drug ☐ Over-the-counter Medication ☐ Unknown

**Is there any evidence that the incident may have been a result of an alcohol/drug/medication overdose?**
☐ Yes ☐ No

**Does it appear that the incident is related to restraint or seclusion?** ☐ Yes ☐ No

**Is there evidence that this incident involves domestic/relationship violence?** ☐ Yes ☐ No

**Media Coverage:** ☐ Reported ☐ Possible Report ☐ Unlikely

**Incident Description:**

**Is this an Agency incident?** ☐ Yes ☐ No If you choose YES, you do not need to fill out the **People** section below

Note: An Agency incident is generally not specific to a particular client, but involves action at the agency level. Example: Evacuation of a residence due to a fire is an Agency level CI (Emergency Evacuation – Fire). If the fire was intentionally set by a client, it would be more appropriate to categorize it as a Client level CI (Serious Crime – Arson), even if it still involved evacuating other clients.

## The People

**Please fill out a copy of this page for each client/staff/visitor involved in this CI (if more than 2 people please copy this page for any additional people)**

### PERSON #1

**Check one box and follow the instructions**

☐ I am reporting on a CLIENT, **complete questions 1-6**
☐ I am reporting on a STAFF, **complete questions 3, 5 & 6 only**
☐ I am reporting on a VISITOR/OTHER, **complete questions 5-6 only**

1. **Client SSN:**
2. **Client relationship to Agency:** ☐ client – active ☐ former client – non active
3. **Name:** 4. **DOB:**
5. **Role:** ☐ Victim ☐ Perpetrator ☐ NA
6. **Injuries:**

☐ No injury ☐ Minor injury
☐ Death ☐ Unknown
☐ Medical intervention and/or hospitalization required

**PERSON #2** ***(skip if incident only involved one person)***
**Check one box and follow the instructions**

☐ I am reporting on a CLIENT, **complete questions 1-6**
☐ I am reporting on a STAFF, **complete questions 3, 5 & 6 only**
☐ I am reporting on a VISITOR/OTHER, **complete questions 5-6 only**

1. **Client SSN:**
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3. **Name:** 4. **DOB:**
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6. **Injuries:**

☐ No injury
☐ Death
☐ Medical intervention and/or hospitalization required
☐ Minor injury
☐ Unknown

## The Closure

**Note: This form may be completed by a person responsible for DDaP reporting in collaboration with program management.**

**Date of Review:** **Date Closed:**

**Closed by:**

**Primary Review Method:**

☐ Administrative Review
☐ Case conference
☐ Critical Incident Review
☐ Human Resources Review
☐ Other
☐ Root Cause Analysis

**Review Chairperson (if applicable):**

**Review Findings:**

**Corrective Actions (proposed/completed):**

**Did the Incident result in a change of policy?** ☐ Yes ☐ No

**Did the Incident result in a change in clinical practice?** ☐ Yes ☐ No

**Did the Review find that the Incident was substantiated (i.e., was there evidence to support that the incident did occur)?**
☐ Yes ☐ No
* Required only for Client Abuse Alleged and Patient Rights categories

**Final Incident Category/Subcategory:** *(check only one box to indicate a category type for this incident – based on the review findings, it may be the same or different from the category selected when the incident was reported). Description of each subcategory can be found here: ci-categories-and-descriptions-july-2025.pdf).*

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- ☐ Other Serious Crime (specify):

***Serious Suicide Attempt***
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- ☐ Suicide Attempt within 30 days of Discharge

***Threats***
- ☐ Threats to Agency
- ☐ Threats to Person

***Other***
- ☐ Other Incident (specify):

** see last question on next page*

**If the Final Incident Category is DEATH (shaded above), please fill out the following information:**

**Cause of Death:** *(choose one)*

- ☐ Accident
- ☐ Alzheimer's Disease
- ☐ Blood Poisoning (Septicemia)
- ☐ Cancer
- ☐ Chronic Lung Disease
- ☐ Diabetes
- ☐ Drug Overdose
- ☐ Heart Disease
- ☐ Hypertension/Renal Disease
- ☐ Influenza/Pneumonia
- ☐ Liver Disease
- ☐ Nephritis/Kidney Disease
- ☐ Stroke
- ☐ Suicide
- ☐ Unknown
- ☐ Other (specify):

**Source of Information:** *(choose one)*

- ☐ Autopsy Report/Medical Examiner
- ☐ Death Certificate
- ☐ Evident from Circumstances
- ☐ Family Report
- ☐ Media Report
- ☐ Other (specify):
- ☐ Physician/Medical Personnel
- ☐ Police Report
- ☐ Provider Report

**Medical Conditions present at Death:** *(choose all that apply)*

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Congestive Heart Failure/Heart Disease/Problems
- ☐ Chronic Pain
- ☐ Cirrhosis/Liver Disease
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema/Lung Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Infectious Disease (eg, COVID)
- ☐ Obesity
- ☐ Other (specify):
- ☐ Pneumonia
- ☐ Renal Failure/Kidney Disease/Infection
- ☐ Seizure Disorder
- ☐ Stroke/Aneurism
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury (TBI)

***If the Final Subcategory is *Accidental Overdose (resulting in death) OR Accidental Overdose (not resulting in death)*, please fill out the following information:**

**Substances involved in overdose:** *(choose all that apply)*

- ☐ Alcohol
- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Cocaine
- ☐ Crack
- ☐ Hallucinogens: LSD, DMS, STP
- ☐ Heroin
- ☐ Inhalants
- ☐ Marijuana, Hashish, THC
- ☐ Methamphetamines
- ☐ Non-prescriptive Methadone
- ☐ Other (specify):
- ☐ Other Opiates and Synthetics
- ☐ Other Sedatives or Hypnotics
- ☐ Other Stimulants
- ☐ Over-The-Counter
- ☐ PCP
- ☐ Tranquilizers
- ☐ Unknown