The Regulation and Quality Improvement Authority

Analysis of Serious Adverse Incidents Reported to RQIA Where the diagnosis is Addictions / Substance Misuse

September 2025 (Updated April 2025)

This report sets out the key findings from an analysis of Serious Adverse Incidents reported and recorded onto the RQIA SAI database between 1 January 2019 and 19 December 2022, where the diagnosis was recorded as Addictions/Substance Misuse.

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1.0 Introduction

This analysis is conducted under Article 35 of *The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003* (The Order) through which RQIA has a duty to conduct reviews and report on arrangements by statutory bodies, to monitor and improve the quality services provided.

A serious adverse incident (SAI) is defined as any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage. The *Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016)* (regional SAI procedure)[1] sets out the regionally agreed approach in Northern Ireland to the reporting, management, follow-up and learning from SAIs.

RQIA's role in the management of SAIs is detailed in the regional SAI procedure. Outlined within the regional SAI procedure, there is a statutory requirement on HSC organisations to notify RQIA of:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAIs that occurs within a registered service that has been commissioned/funded by a HSC organisation.

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA works in conjunction with the Strategic Planning and Performance Group/Public Health Agency (SPPG/PHA) with regard to the review of certain categories of SAIs.

This report sets out the key findings from an analysis of SAIs reported to RQIA from 1 January 2019 to 19 December 2022 where the diagnosis was recorded as Addictions/Substance Misuse. This was the period of time from which information was available on RQIA's new information system. These SAIs fall into the category "All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986" and therefore SAIs which occurred in a service registered with RQIA have not been included.

This analysis has been limited to the Initial Notifications and Review Reports (See Section 4.0) received by RQIA in this time period. However, it must be noted that from the Initial Notifications received, material numbers of SAI Review Reports had not been received by RQIA in a timely manner and therefore the analysis could not consider all SAIs. This is important because the findings are therefore specific to

[1] Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

this group of SAIs that were considered and may not provide a comprehensive view of all SAIs that occurred in that period.

It is acknowledged that the period of analysis includes the Covid-19 pandemic and it is likely that this will have impacted on the number and outcomes of SAIs during and after that period. The *Substance misuse treatment statistics 2020 to 2021, November 2021* report produced by the Office for Health Improvement and Disparities states that:

> *"Like other services, drug and alcohol treatment services were affected by the need to protect their staff and service users in the pandemic, especially in the early stages. Most services had to restrict face-to-face contact, which affected the types of interventions that service users received…*
>
> *It's likely that a number of factors will have contributed to the increase in the number of service users who died while in treatment during 2020 to 2021. These include changes to alcohol and drug treatment, reduced access to other healthcare services, changes to lifestyle and social circumstances during lockdowns, and Covid-19 itself."*

It should be noted there are a significant number of other SAIs that refer to the use of alcohol and drugs within the body of the SAI report but these were not recorded as a main diagnosis and therefore these SAIs are not included.

At the time of writing this report, a review of regional Tier 4a and Tier 4b Substance Use/Addictions services is being completed. The review is one of a number of work-streams relating to the development of a Regional Health and Social Care Strategic Plan for Substance Use/Addiction Services as required by the Department of Health (DoH) Substance Use Strategy 'Making Life Better, Preventing Harm, Empowering Recovery'. It is hoped that the findings of this report will inform and contribute to the overarching review.

This report should also be read in conjunction with the *RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland, June 2022* which identified five key recommendations to support the delivery of a new regional policy/procedure for reporting, investigating and learning from adverse events.

2.0 Legislative Framework which informs RQIA's practice

The Mental Health (Northern Ireland) Order 1986 *Article 86*, places a duty on RQIA to:

> *"keep under review the care and treatment of patients and to make inquiry into any case where it appears there may be ill treatment, deficiency in care and treatment, or improper detention in hospital or reception in guardianship, or where the property of any patient by reason of his mental disorder be exposed to loss or damage"*

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (The Order) also places a duty on RQIA to register

and regulate those establishments and agencies set out in Part III of The Order. RQIA also regulates HSC bodies. The Order places a duty of quality on HSC bodies to put and keep in place arrangements for the purpose of monitoring and improving the quality of health and personal social services provided and the environment in which it provides them. HSC bodies are not required to notify RQIA about SAIs which do not occur in mental health and learning disability services or registered services.

3.0 Overview of Regional SAI Procedure

The system for reporting adverse incidents was first introduced in Northern Ireland in 2004 by the former Department of Health, Social Services and Public Safety (DHSSPS), now known as the DoH. Reporting arrangements were transferred to the Health and Social Care Board (HSCB), now the Strategic Planning and Performance Group (SPPG) within the DoH, in partnership with the Public Health Agency (PHA), in 2010. Updates to this regional SAI procedure were implemented in 2010, 2013 and 2016.

The current version of the regional SAI procedure[1] which was last updated in 2016, advises that SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

Incidents which meet the following criteria may be classified as an SAI.

- Serious injury to, or the unexpected/unexplained death of:
  - a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit);
  - a staff member in the course of their work; and
  - a member of the public whilst visiting a HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or member of the public.

- Unexpected or significant threat to provide service and/or maintain business continuity.

- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.

- Serious self-harm or serious assault (including homicide and sexual assaults)
  - on other service users;
  - on staff; or
  - on members of the public.

- By a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to

mental health and related services (including Children and Adolescent Mental Health Services (CAMHS), psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.

- Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.

- Serious incidents of public interest or concern relating to:
  - any of the criteria above;
  - theft, fraud, information breaches or data losses; and
  - a member of HSC staff or independent practitioner.

Three levels of review are described in the regional SAI procedure. The expectation in respect of each level is summarised below:

Level 1 Review: Significant Event Audit (SEA)

For Level 1 reviews, membership of the SEA review team should include all relevant professionals, yet be appropriate and proportionate to the type of incident and professional groups involved.

The review panel undertakes an SEA of the incident to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local or regional learning.

Level 2 Review: Root Cause Analysis (RCA)

For Level 2 reviews, the level of review undertaken will determine the degree of leadership, overview and strategic review required. A core review panel should be comprised of a minimum of three people of appropriate seniority and objectivity.

Review panels should be multidisciplinary and have no conflict of interest with the incident concerned. The review should have a chairperson who is independent of the service area involved, while possessing relevant experience of the service area in general and of chairing reviews.

The chairperson should also not have been directly involved in the care or treatment of the individual or be responsible for the service area under review.

The review panel undertakes a root cause analysis to a high level of detail, using appropriate analytical tools to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning.

Level 3 Review: Independent Review

For Level 3 reviews, the same principles as Level 2 reviews apply; however, team membership must be agreed upon between the reporting organisation and the HSCB/ PHA (PHA) Designated Review Officer (DRO) prior to the review commencing.

The 2016 regional SAI procedure states that: “The review panel undertakes an in-depth review of the incident, to a high level of detail, using appropriate analytical tools to assess: what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning.”

In 2016, the regional SAI procedure was updated to guide SAI review panels in relation to providing patients and families with an opportunity to contribute to the SAI review.

The guidance outlined that:

- The level of involvement depended on the nature of the SAI and the patient and family’s willingness to be involved.
- Teams involved in the review of SAIs should ensure sensitivity to the needs of the patient and family/carer involved.
- Teams should agree on appropriate communication arrangements with the patient and family/carer involved.

To support the involvement process, an SAI leaflet was designed by the HSCB and PHA for organisations to give to patients and families prior to their initial discussion regarding the SAI which had occurred.

4.0 Findings

This section considers the findings from analysis on two stages of the SAI process. Firstly, the Initial SAI Notifications received by RQIA within the period and secondly a comprehensive review of the Review Reports received within the same period. The Review Reports include incidents that were reported during this period but also include incidents which occurred prior to this period.

RQIA Internal SAI Process (for all mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986).

Stage One – Initial Notification

On receipt of an Initial SAI Notification, administrative staff will log this on RQIA's information system and send an email to the aligned RQIA inspector including a link to the Initial SAI Notification Report. The inspector will screen the Initial SAI Notification Report to check that it has been fully completed, determine if any early risks are identified or additional information needed or queries raised. The inspector will also review other intelligence held against the service. RQIA's information system subsequently pre-populates the date with which the Review Report is due. This date is aligned to timescales identified within the regional SAI procedure[1].

Stage Two – Review Report Received

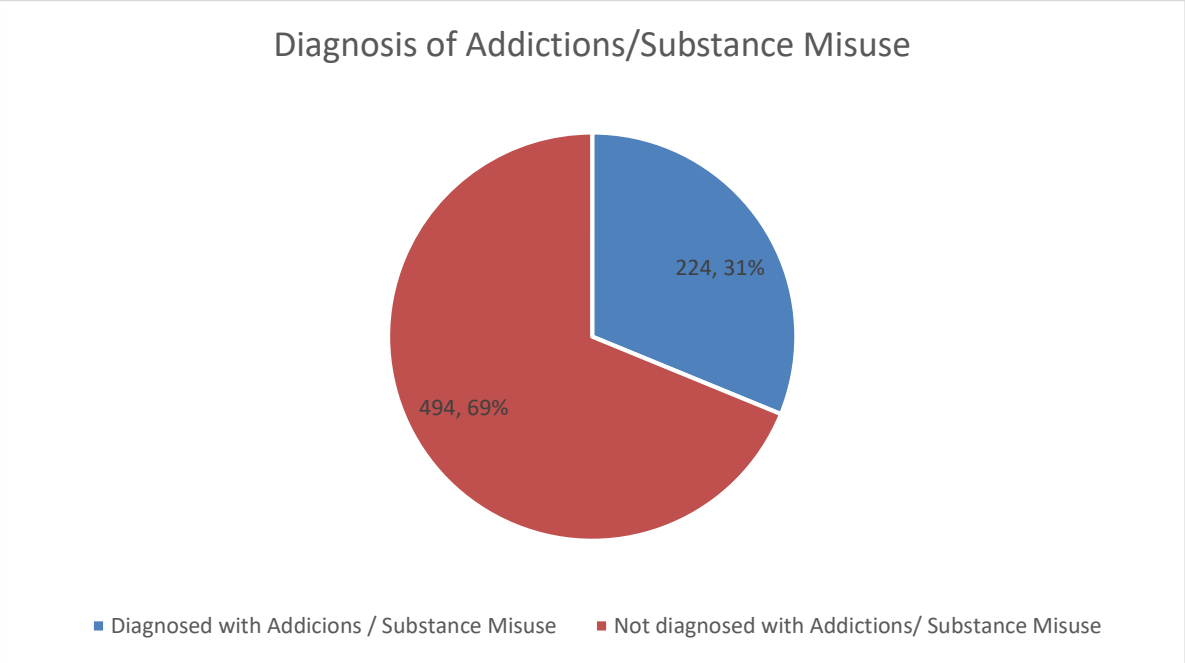
On receipt of the Review Report, the aligned inspector logs the recommendations made on RQIA's information system. The inspector reviews the report and determines if any regulatory response is required.

The analysis and risk assessment of intelligence at both stages of the process is critical. Information contained within SAIs is reviewed in terms of its value as regulatory intelligence and a determination is made regarding engagement with other relevant third party organisations and/or deciding whether a regulatory response is required. That could involve making further enquiries with the Trust/provider to seek assurances that patient safety risks have been addressed, whether any early learning has been identified and actions taken while the review is ongoing, through to deciding that an unannounced inspection is required.

4.1 Initial Notifications Received

Within the reporting period, RQIA received and logged Initial Notifications of 718 SAIs and of these 224 (31%) were attributed to incidents involving people with a diagnosis of Addiction/Substance Misuse.

Figure 1: Number of Notifications Received by RQIA by Diagnosis



Of the 224 Initial Notifications of SAIs involving people with a diagnosis of Addiction/Substance Misuse, 93% of the incidents occurred whilst the patient was in the community.

The majority (86%) were managed as Level 1 reviews, with 13% managed at Level 2, and 1% managed at Level 3.

65% of the SAIs were reported due to 'Suspected Suicide' and 26% were reported as a 'Death'. This means that 91.5% - 205 people - had died as a result of the incident.

4.2 Review Reports Received

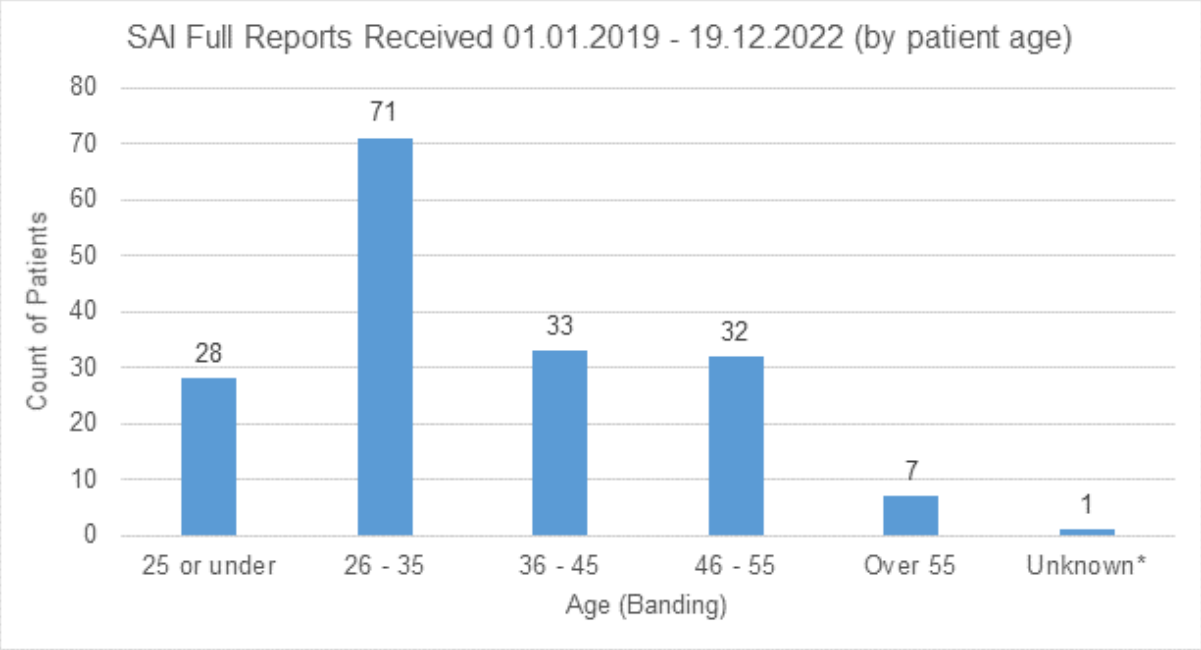
Review Reports were received within the reporting period (1 January 2019 to 19 December 2022) for 402 SAIs and 172 (43%) of these reports were attributed to people with Addiction/Substance Misuse.

The following section focuses on the 172 Review Reports received in relation to people with Addiction/Substance Misuse.

4.2.1 Number of SAI reports received by RQIA by age category

The vast majority of people (95%) with an Addiction/Substance Misuse involved in SAIs, were between the ages of 16 and 55.

Figure 2: Number of SAI Reports Received by RQIA by Age Category



*Patient DOB not recorded

The age group with the most SAIs were those patients between the age of 26 and 35 (71, 41%). This age group are thus considered particularly at risk.

It is well recognised that experimentation in a range of areas is a developmental component of young adulthood, but especially with regard to risk behaviours, such as using drugs and alcohol. This is demonstrated in the *Young people's substance misuse treatment statistics 2020 to 2021: report, 27 January 2022* produced by the Office for Health Improvement and Disparities.

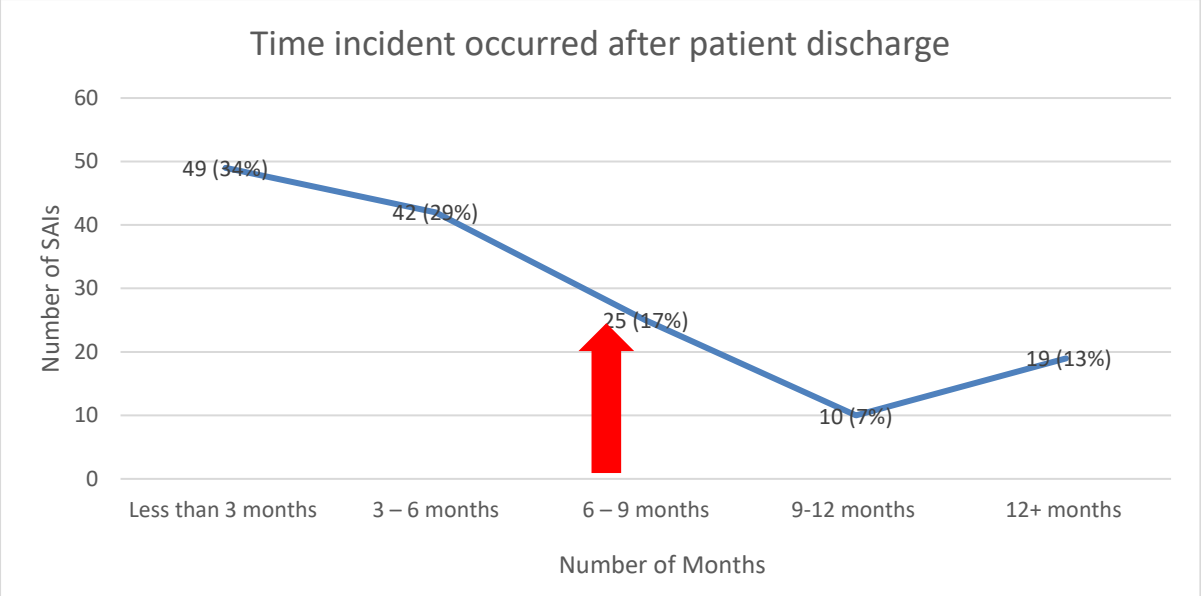
This data also correlates with the latest NISRA report *Finalised Suicide Statistics in Northern Ireland, 2015 – 2021 Published: 30th November 2022*

4.2.2 Time Period Between Patient Discharge and Incident

Of the 172 incidents included in the analysis, information on the time period within which the patient was discharged from inpatient Mental Health and Learning Disability (MHLD) services was available for 145.

This analysis does not have access to the total number of patients discharged from inpatient MHLD services in this period so it was not possible to conclude as to what extent patients discharged from an inpatient unit were later at the heart of a reported SAI. These findings relate only to the review of the SAIs received by RQIA.

Figure 3: Number of Months Between Patient Discharge and Incident



Red Arrow indicates 80%

As displayed above, 49 of 145 (34%) occurred within the three-month period following discharge, 91 of 145 (63%) occurred within the six-month period following discharge and 116 of 145 (80%) were within the nine-month period following discharge (displayed by the red arrow).

This indicates, from the information available, that patients are likely to be most vulnerable within the first nine months following discharge from an inpatient ward.

As such, it is of vital importance that robust systems are in place to ensure a safe discharge and appropriate follow on care in the community.

4.2.3 Programme of Care

The majority (165, 96%) of SAIs in which the service user had a diagnosis of Addictions/Substance Misuse, involved people who had a mental health condition.

There were no SAIs recorded with a diagnosis of Addictions/Substance Misuse for people with a learning disability (LD) within this time period.

Table 1: Number of SAI incidents notified to RQIA by category of care.

Programme of Care	Number	Percentage
Mental Health	165	96%
Learning Disability	0	0%
Unknown	7	4%
Grand Total	**172**	

Further consideration is required to determine why this might be the case. For example:

- Is there an element of under reporting in learning disability services?
- Are they categorised differently?
- Is there a lower rate of substance misuse?
- Is additional support provided to those with a LD that is not in place for those with MH difficulties?

Further research is required to determine the reason for no SAIs in this group.

4.2.4 Incident Type and Location

The tables below provide a breakdown of the 172 incident types and locations.

Table 2: Number of SAIs received by RQIA by Care Setting

Incident Type	Community	Prison	Hospital	(blank)	Grand Total
Grand Total	**160**	**8**	**3**	**1**	**172**

The majority of SAIs analysed related to people who had a diagnosis of Addictions/Substance Misuse occurred in community settings. These settings included the persons own home, out-patient departments, public places and day care facilities.

93% of SAIs occurred when the patient was in the community.

Fewer SAIs occurred within prison and hospitals and the reasons for this should be explored further.

The greatest percentage (68%) of Level 1 SAIs related to patients who were living in the community and completed suicide. Similarly, 61% of Level 2 SAIs involved patients who were living in the community and completed suicide. This is 113 people.

Table 3: Number of SAIs received by RQIA by Incident Type

Incident Type	Grand Total
01. Death	41
03. Serious Self Harm	6
07. Suspected Suicide	118
Other aggregated data[2]	7
Grand Total	**172**

[2] Data aggregated due to low numbers and potential to identify individual cases.

It is possible that a number of the incidents categorised as death may also have been suicides but not confirmed as such at the time the initial notification was received. However, the stark outcome is that 159 patients had died as a result of the incident.

Low levels of self-harm were noted in the data reviewed; six SAIs reported serious self-harm. Further review of the data is required to determine if this is a true representation of incidents occurring or if there is under-reporting of self-harm within services. If there is under-reporting, it could lead to missed opportunities to intervene to prevent suicide or death by ensuring that the learning from self-harm SAIs is fully implemented.

4.2.5 Time-frame within which Review Report was Received by RQIA

The time frame for completion of Review Reports is clearly set out in the regional SAI procedure[1]

- Level 1 SEA – 8 Weeks
- Level 2 – 12 weeks from notification
- Level 3 –Timeframe agreed by DRO

The table below sets out the timeframes within which Review Reports were received by RQIA for each of the three levels of review of the 172 SAIs.

Table 4: Number of Review Reports received by category and timeframe

Level of SAI	Number of associated Reports	Number received within 8 weeks	Number received within 12 weeks	Number received Within 6 months	Beyond 6 months
SEA (Level 1)	141	6	2	25	108
Level 2	28	1	0	3	24
Level 3	3	0	0	0	3
Grand Total	**172**	**7**	**2**	**28**	**135**

There was an extremely low level of compliance (4%) with the 8-week timeframe for Level 1 and the 12-week timeframe for Level 2 Review Reports (4%).

The *RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland, June 2022* made reference to these timescales in a number of areas. The report states that:

> *"The implementation of the regional SAI procedure focuses too heavily on process and non-attainable timescales instead of focusing on consistently delivering the practice of conducting high quality SAI reviews."*

And that staff:

> *"reported feeling constrained by an overly bureaucratic process, which they perceived placed completion of arbitrary timescales and narrow performance targets above the requirement for meaningful involvement."*

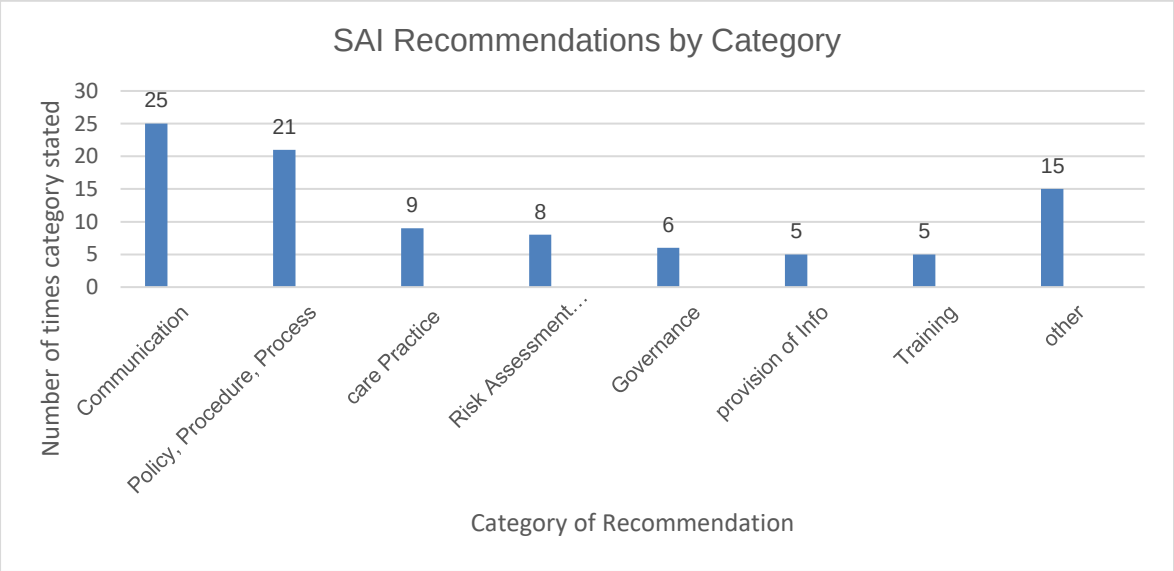
However, considering the levels of compliance above, it is clear that timescales are not routinely being achieved. As such, there is a significant risk that recommendations and learning identified through the SAI process may not be addressed in a timely way and may lead to similar incidents reoccurring.

The review stated five recommendations that, if implemented, would transform the current approach to learning from and preventing recurrence of harm within Health and Social Care in Northern Ireland.

4.2.6 Recommendations Made in SAI Review Reports

There were 388 recommendations linked to all SAIs received during this three-year period and 109 recommendations linked to SAIs with the diagnosis of Addiction/Substance Misuse.

Figure 4: Top Eight Categories of Recommendations Made in SAI Review Reports related to Addiction/Substance Misuse



Of the 109 SAI recommendations, the most frequently recorded recommendation categories were ‘Communication’ (23%) and ‘Policy, Procedure, Process’ (19%).

Some general themes emerged in the review of the recommendations made regarding these two categories.

<u>Communication</u>

- There were a large number of recommendations made about improved working with family and carers;
- Communication between the multi-disciplinary team and recording of decisions which were accessible to other members of the team were cited in several reports; and
- Email communication and the limitations and difficulties this posed was noted.

Policies, Procedures and Process

- A number of policies, procedures and guidance were identified that required update/review;
- A number of new policies, guidance and protocols were proposed;
- Deviations from established policies and procedures were identified; and
- Difficulties in adhering to expected practice was highlighted.

Additional observations:

There was variation in the recording of learning and recommendations made. In some incidents, learning that should lead to recommendations being made was recorded only in the body of the report or the Learning section but not in Recommendations section. It is considered that there is a risk of learning and subsequent improvements to safety being missed, as they are not set out as recommendations to be implemented and monitored through an action plan.

Some SAI Review Reports included unnecessary information that is not directly relevant to the incident. Some were lengthy with historical information and copious background that did not contribute meaningfully to the learning from the incident and may potentially be viewed as out with good practice in data protection and privacy guidance and legislation.

Some reports contained excerpts of information from patients records not always directly relevant and often not analysed.

Evidence of learning is not always apparent. It was not evident that practice has changed from previous recommendations.

4.2.7 Additional Points Noted in the Body of the Reports

A high number of the patients involved in the SAIs had multifactorial issues affecting their well-being. In addition to their mental health issues and their Addiction/Substance Misuse, common themes included:

- physical health problems;
- no permanent housing arrangement;
- strained family relationships;
- previous offending behaviour including theft, domestic violence and physical assault; and
- financial issues.

5.0 Conclusion

Effective regulation requires robust collection and analysis of data, information and intelligence that supports the core purpose of securing and improving the safety and quality of health and social care services in Northern Ireland. In making best use of regulatory intelligence RQIA will be able to confidently deploy its inspection and review resources to those areas where people may be most at risk and target its resources where it can leverage the greatest regulatory and quality improvement

impact. RQIA is committed to responsibly analysing all relevant information, including SAI information, to drive its regulatory and improvement actions.

In particular, RQIA's programme which regulates mental health services, holds a rich database of information regarding SAIs which can be analysed to identify important trends and themes related to Addiction/Substance Misuse. This learning derived from such analysis should be shared and used by services to reflect on any SAIs that have occurred and to direct improvement.

Some of the limitations identified in this report in relation to only having access to those SAIs received and recorded by RQIA, may be overcome if a review of all SAI cases that occurred during this period were assessed and contextualised by comparing with total patient discharges from inpatient facilities.

This analysis will be used to contribute to ongoing regional service reviews and to identify learning across a wide range of mental health services both acute and in the community. RQIA will share the findings of this analysis with the DoH, SPPG and relevant directors of the five Health and Social Care Trusts in Northern Ireland. The information contained in this report may also be used to inform and contribute to the outcomes from the review of regional Tier 4a and Tier 4b Substance Use/Addictions services.

This report has identified that improvements are required in the SAI process which aligns with the recommendations made in the *RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland, June 2022.*

The DoH has commenced its SAI redesign programme of work in July 2023, and therefore no further recommendations in this regard are stated in this report.

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