Secrets Spa Limited

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Inspection report

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Overall summary

We carried out this announced focused inspection on 12 October 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we asked the following three questions:

• Is it safe?

• Is it effective?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found this practice was providing effective care in accordance with the relevant regulations.

Are services well-led?

We found this practice was not providing well-led care in accordance with the relevant regulations.

Summary of findings

Background

Secrets Spa Limited is in Southport and provides private dental care and treatment for adults and children.

There is a ramp at the front entrance of the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available directly outside the practice with additional street parking nearby.

The dental team includes two dentists, two dental nurses, a practice manager, a physiotherapist and two receptionists. The practice has two dental treatment rooms and a third treatment room for the physiotherapist and aesthetic services. A visiting dentist attends as necessary to place dental implants.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Secrets Spa Limited is the practice manager.

During the inspection we spoke with the director, one dentist, one dental nurse, one receptionist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday 8.30 am to 5pm

Our key findings were:

- The practice appeared to be visibly clean, tidy and well-maintained.
- The provider had implemented standard operating procedures in line with national guidance on COVID-19. There was no evidence that face masks were appropriately fit tested.
- Improvements were needed to ensure the validation and auditing of infection control procedures to meet published guidance.
- The emergency medicines and life-saving equipment were not in line with nationally agreed standards and guidance.
- The provider did not have systems to help them identify and manage risk to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider's staff recruitment procedures did not reflect current legislation.
- The provider did not have a system to ensure staff were up to date with training.
- The clinical staff provided patients' care and treatment in line with current guidelines. There was no oversight of the dental implant service.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The provider did not have effective leadership and a culture of continuous improvement.
- The provider asked patients for feedback about the services they provided.

We identified regulations the provider was not complying with. They must:

Summary of findings

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

Full details of the regulations the provider is not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Take action to register the practice's use of dental X-ray equipment with the Health and Safety Executive in line with the Ionising Radiation Regulations 2017 (IRR17).

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services effective?	**No action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff had some systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. The provider could not demonstrate that staff had received sufficient and up to date safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. The provider had not asked clinical staff to provide evidence that they completed infection prevention and control training and received updates as required.

The provider had implemented standard operating procedures in line with national guidance on COVID-19. COVID-19 screening and triage processes were undertaken prior to patients attending the practice and immediately upon arrival. Entry and exit were controlled by the provider to protect staff and patients. The provider did not seek any evidence or assurance that protective face masks used during aerosol generating procedures had been appropriately fit tested by a competent person. They did not have a system to ensure that mask filters were replaced at appropriate times. After the inspection evidence was sent that action was in progress to address this.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The equipment used by staff for sterilising instruments had not been validated or serviced since it's installation date in 2017. Staff were not documenting daily tests of the steriliser in line with HTM 01-05. After the inspection, the provider arranged for service and validation to take place. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. The 2017 risk assessment was not up to date as changes had been made to the water systems after this date. Staff responsible for water testing had not received appropriate training and did not document the results of their tests. We saw dental unit water line management was maintained appropriately.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected, we saw the practice was visibly clean and tidy.

Are services safe?

The provider had policies in place to ensure clinical waste was segregated and stored appropriately in line with guidance. The practice manager told us that clinical waste was removed by a licensed waste contractor, but no evidence could be produced to support this. There were no waste consignment notes after 2020.

The provider carried out infection prevention and control audits upon opening in 2017 and in 2021. The latest audit was not available for us to review.

The practice manager confirmed there was a whistleblowing policy, but this could not be found during the inspection. Staff told us they felt confident they could raise concerns without fear of recrimination.

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

The provider had a recruitment policy to help them employ suitable staff. We looked at all the staff recruitment records. The provider did not carry out essential pre-employment checks on all staff members. In particular, references were not requested for three staff members and evidence of sufficient professional indemnity was not obtained for four clinical staff members.

A visiting dentist attended as required to place dental implants. The provider had not requested evidence of their training and competence, whether they had sufficient indemnity for these procedures, or any information about a dental nurse who had attended to support the implant dentist. The provider confirmed this service would not be provided again until the necessary information and assurances were obtained.

We observed that clinical staff were qualified and registered with the General Dental Council.

Equipment was not maintained according to manufacturers' instructions. Pressure vessel inspections which are required annually for this model had not been carried out on the autoclave or dental compressor since their installation in 2017. After the inspection, the provider arranged for these to be carried out. Satisfactory electrical wiring, portable appliance and gas appliance inspections had been carried out.

We were told that a fire risk assessment had been carried out in line with the legal requirements but evidence of this could not be produced. We saw the fire extinguishers were serviced annually and fire exits were kept clear. Fire detection systems including emergency lighting had been installed throughout the building in 2017. This had not been serviced since the installation date. A member of staff had been identified as the fire safety lead, but the provider had not ensured they had the training and competence for this role. A member of staff told us they carried out visual inspections of the emergency lighting, but this was not documented in the practice fire safety logbook and one emergency light had a red light which indicated it was not functioning. The provider also told us the fire alarm had been triggered recently for unknown reasons. No action had been taken to investigate why or arrange for servicing or maintenance. After the inspection, the provider arranged for this to be carried out.

The practice did not have arrangements to ensure the safety of the X-ray equipment and retain the required radiation protection information.

The clinicians used a handheld X-ray machine. We were told that this machine was not stored in a locked metal or theft-proof cabinet when not in use and the battery was not removed. Guidance from Public Health England on the safe use of hand-held dental X-ray equipment states that when the practice is closed the unit should be stored out of sight in a locked metal or theft-proof cabinet and the battery should also be removed from the main unit if possible and stored separately from it.

The provider had not registered their practice's use of dental X-ray equipment with the Health and Safety Executive in line with the Ionising Radiation Regulations 2017 (IRR17); or sought the advice of a radiation protection adviser about the

testing, use or quality assurance for the handheld X-ray machine. A critical examination was not in place to evaluate the risks of using this in the surgeries and up to date employer's duties and training on the use of the equipment were not provided to operators of this device. A dentist showed how they had researched the device of their own accord to ensure they used it safely and monitored the results.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The provider did not carry out radiography audits every six months following current guidance and legislation.

The provider did not ask the clinicians to provide evidence of continuing professional development in respect of dental radiography.

Risks to patients

The provider had not effectively implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments had not been kept up to date. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. A sharps risk assessment had not been undertaken by the provider. The staff followed the relevant safety regulation when using needles and other sharp dental items. There were procedures to follow in the event of a sharps injury.

The provider did not have a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. Evidence of the effectiveness was not obtained for seven clinical staff members and individual risk assessments were not in place. After the inspection, evidence was sent that action was being taken to obtain results from staff.

Staff had not completed sepsis awareness training to ensure staff triaged appointments effectively to manage patients who present with dental infection. The dentist had knowledge of the recognition, diagnosis and early management of sepsis. The practice manager confirmed team training would be arranged.

Staff knew how to respond to a medical emergency and some had completed training in emergency resuscitation and basic life support every year, although evidence of up to date training was not obtained for six staff members.

Emergency equipment and medicines were not available as described in recognised guidance. An Automated External Defibrillator (AED) was not available and this had not been risk assessed. We found the practice did not have the correct sizes of oxygen masks or self-inflating oxygen bags and masks, and the expiry date of unrefrigerated Glucagon had not been adjusted in line with manufacturer's instructions. The practice manager confirmed this would be addressed. Staff kept records to make sure emergency medical oxygen and medicines were available, within their expiry date, and in working order. The checking processes were not fully effective as they had not highlighted the issues identified during the inspection.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had some risk assessments to minimise the risk that can be caused from substances that are hazardous to health, but these had not been updated since 2017. We observed that staff stored hazardous substances appropriately and in their original containers which had clear instructions for use.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Are services safe?

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety, and lessons learned and improvements

The provider did not have effective systems for reviewing and investigating when things went wrong. There was an accident policy dated October 2017, but this did not include any processes to support staff to investigate incidents appropriately.

In the previous 12 months there had been no safety incidents. The practice manager told us that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider did not have a current system for receiving and acting on safety alerts. We saw the most recent alerts received and reviewed by the practice were from February 2019.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

The dental professionals kept up to date with current evidence-based practice. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice offered dental implants. These were placed by a visiting clinician, the practice did not obtain evidence the dentist had undergone appropriate post-graduate training in the provision of dental implants. We saw the provision of dental implants was in accordance with national guidance.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The dentists created and showed patients mock-ups of expected results and gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The dentist understood their responsibilities under the act when treating adults who might not be able to make informed decisions. They were also aware of Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

Are services effective?

(for example, treatment is effective)

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

The provider did not have quality assurance processes to encourage learning and continuous improvement.

Effective staffing

Improvements were needed to the systems to ensure staff had the skills, knowledge and experience to carry out their roles.

Some new staff members received a structured induction programme. This did not include the dentists.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. There was no system to track referrals to ensure these were received and acted on in a timely way.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

Leaders were open to discussion and feedback during the inspection. During the inspection process they demonstrated a lack of knowledgeable about issues and priorities relating to the monitoring of the quality and future of the service. Immediately after the inspection, they took action to seek advice from external companies to address the concerns highlighted by the inspection process. They sent evidence that they were addressing them.

The provider had a strategy for delivering the service which was in line with health and social priorities across the region. Staff planned the services to meet the needs of the practice population.

Culture

Staff at the practice had all recently been employed. They stated they felt respected, supported and valued. They were proud to work in the practice.

Not all staff had received an induction prior to commencing work or had their training needs evaluated. There were plans to carry out annual appraisals to discuss learning needs, general wellbeing and aims for future professional development.

We saw the provider did not have systems in place to identify staff poor performance.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management. Staff in lead roles including fire safety and Legionella, did not have the appropriate training and knowledge.

The registered manager had overall responsibility for the management and day to day running of the service. We saw no evidence of active clinical leadership or clinical governance knowledge and oversight.

The provider had implemented a system of clinical governance in 2017 which included policies, protocols and procedures. These had not been reviewed or updated since their implementation.

We saw there were ineffective processes for identifying and managing risks, issues and performance. In particular, the inspection highlighted significant risk and lack of systems and processes in relation to equipment maintenance, infection prevention and control, fire safety, Legionella, medical emergencies, radiation protection, staff recruitment and training.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff involved patients, the public, staff and external partners to support the service.

The provider used patient surveys and encouraged verbal comments to obtain staff and patients' views about the service. We saw letters and cards thanking staff for their care.

Are services well-led?

The provider gathered feedback from staff through informal discussions. There were plans to hold staff meetings once the team was more established.

Continuous improvement and innovation

The provider did not have systems and processes for learning, continuous improvement and innovation.

The provider did not have quality assurance processes to encourage learning and continuous improvement. Audits of dental care records or radiographs were not in place to monitor the quality of these. Audits of infection prevention and control were not carried out at the required six-monthly intervals.

We saw evidence that staff completed some 'highly recommended' training as per General Dental Council professional standards. The provider did not have a system to support and encourage staff to complete continuing professional development and for some members of staff, this evidence was not requested. In particular, evidence of up to date medical emergency, safeguarding vulnerable adults and children, radiography and infection prevention and control training.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Medical emergency equipment was not available in line with current guidance from the Resuscitation Council UK and General Dental Council standards that all clinical areas should have immediate access to an automated external defibrillator (AED). There was not timely access to an Automated External Defibrillator and insufficient sixes of oxygen masks and self-inflating bags available. • Equipment used for the sterilisation of dental instruments was not subject to the required validation processes as described in Health Technical Memorandum 01-05: Decontamination in primary care dental practices. • Pressure vessels had not had the required inspections at intervals in order to comply with Pressure Systems Safety Regulations (PSSR) 2000 and Provision and Use of Work Equipment Regulations (PUWER) 1992. • There was no system to receive relevant Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS). • Fire safety equipment had not been serviced since its installation. Staff using the equipment did not have the training, competency and skills needed. There were known faults with the fire safety system that had not been risk assessed or acted on. In particular, the fire alarm being triggered for unknown reasons.

This section is primarily information for the provider

Enforcement actions

- The Legionella risk assessment was not up to date with the current water systems of the practice. Monthly water testing could not be evidenced. Staff carrying out water testing did not have the training, competency and skills needed.
- The dental team had not received training or information to make them sufficiently aware of the signs and symptoms of sepsis and how it should be managed.
- X-ray equipment was not stored securely, used and maintained in line with nationally agreed guidance PHE-CRCE-023: guidance on the safe use of hand-held dental X-ray equipment and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017.
- There was no evidence to show that during 2021 clinical waste was removed and disposed of by a licensed contractor as required by Health Technical Memorandum 07-01: Safe management of healthcare waste. Furthermore, there was no up to date contract for disposal or pre-acceptance assessment available.

Regulation 12(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The registered person did not have an effective governance system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities. • The registered person did not ensure that clinical staff were appropriately fit tested for PPE when undertaking Aerosol Generating Procedures (AGPs) in line with

This section is primarily information for the provider

Enforcement actions

current nationally agreed guidance or decisions on sound reasoning and risk assessments. There were no systems to ensure that filters were changed appropriately.

- The registered person did not make sufficient arrangements to take appropriate action in the event of a clinical or medical emergency. The system in place to ensure the appropriate emergency medical equipment was present and risk assessed in line with current standards and guidance was not effective.

- The registered person did not have adequate systems in place to ensure all staff members received a sufficient role-specific induction, and that appropriate training was in place for staff to carry out the duties they are employed to perform. In particular, staff were not consistently asked to provide evidence of up to date training in basic life support, safeguarding for children and vulnerable adults, infection prevention and control and training for operators of handheld X-ray equipment in use at the practice.

- There was no risk management system in place to ensure the fire safety of the practice had been assessed by a competent person.

- The registered person did not have an effective risk management system in place to ensure Legionella risks were assessed at appropriate intervals in line with the Approved Code of Practice and Guidance L8, Health and Safety Executive (ALCOP L8), and Safe water in healthcare premises (HTM 04-01) and to ensure water quality of the practice.

- There was not an effective system in place to ensure sharps procedures were adequately risk assessed and in line with a practice policy and current regulations. The practice policy referred to the need to have an up to date risk assessment of sharps in use and the measures taken to ensure their safe handling in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. This had not been actioned.

This section is primarily information for the provider

Enforcement actions

- The registered manager was not able to provide evidence that clinical waste was collected by a licensed waste contractor or evidence of a contract. Accordingly, there was no clear oversight of clinical waste management.

- There were no systems in place to establish or risk assess the Hepatitis B status of clinical staff members. The registered person had not obtained the results of the effectiveness of Hepatitis B vaccinations for seven staff members who were performing clinical duties. They did not have any processes regarding the checks required of staff, preventing them from mitigating role related tasks where necessary.

- The registered person did not hold important information relating to staff employed, which was relevant to their role including information required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular, references for three staff members, or establish whether four staff members held sufficient indemnity for their role.

- The registered person did not assess the risk from, or put in place oversight of the systems to provide dental implants. Evidence of the qualifications and level of indemnity of the individuals were not obtained. There was no oversight of equipment brought and used to place dental implants. Processes for its maintenance and decontamination were not risk assessed and assurances were not obtained.

- The registered person had no system in place to risk assess current in-use substances that are hazardous to health in line with The Control of Substances Hazardous to Health Regulations 2002.

- The registered person did not have an effective system in place to ensure infection prevention and control processes were operating in line with current guidance. In particular, ensuring the validation of equipment and auditing of infection prevention and control at the required intervals in line with HTM 01-05: Decontamination in primary care dental practices.

This section is primarily information for the provider

Enforcement actions

- The registered person did not ensure that the practice had appropriate radiation protection arrangements, and ongoing quality assurance in place, and in line with The Ionising Radiation (Medical Exposure) Regulations 2017.
- The registered person had no quality assurance audit systems or processes to encourage learning and to ensure the practice was meeting the required standards in line with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 for X-rays.
- There was no system in place to ensure referrals to external healthcare providers were monitored and recorded so none were missing or lost.

Regulation 17(1)