Mrs Angeline Gay and Mr John Gay

Bedrock Court - New Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Bedrock Court provides accommodation and personal care for up to six people aged 18 years and over. At the time of our inspection six people were using the service.

This inspection was unannounced and took place on 27, 28 and 29 September 2016.

People living at Bedrock Court attended another location (Bedrock Lodge) which is also a location registered with the CQC. The provider used this location for their day service. We visited that location on 27 and 28 September 2016. We visited Bedrock Court on 29 September 2016. In this report we have described the care received by people living at Bedrock Court. However, because of the arrangements for day care support and the fact that the staff worked across the providers locations it is inevitable that there will be some cross over of information. Therefore, our report of this inspection should be read in conjunction with the report for that location. You can read the reports from each of the provider's locations on our website at www.cqc.org.uk.

Our last full comprehensive of the service was on 22 and 23 December 2015. At that time we rated the service overall as 'Requires improvement'. This inspection was focussed and carried out in response to concerns shared with us. As this inspection was a focussed inspection and took place more than six months after the last comprehensive inspection, we were unable to alter the overall rating of the service.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager resigned from the provider's employment just over 12 months ago. An acting manager was in post and had submitted an application to register as manager with CQC.

We identified serious concerns during this inspection. We wrote to the provider outlining the most urgent of these and told them to provide us with a report of actions they would take to address these.

The provider and senior staff had failed to recognise where certain practices compromised people's dignity and respect. We found some of the terminology written in a people's care records was subjective in nature and reflected the personal opinion of staff. The tone of the accounts did not reflect a sense of compassion or sympathy and evidenced a lack of knowledge and understanding of people's needs. The service was, in many ways, demeaning to people and did not contribute towards them being viewed as valued individuals.

People did not receive a service that was safe. Risk assessments had not resulted in sufficiently detailed plans to keep people staff. Staff did not always know about the different types of abuse to look for and what action to take when abuse was suspected. Night time staffing levels had not been assessed by the provider to determine if people would be kept safe. Records regarding the administration of medicines were not

maintained correctly.

The service did not provide effective care and support. Staff had not received the training required to effectively meet people's needs. The provider and staff did not have a good understanding of the Mental Capacity Act 2005 (MCA). People were not encouraged to make choices and decisions. The involvement of other health and social care professionals was not sought and, as a consequence people's needs were not always met. The service was not built around people's needs. People were not involved in the planning of their care and support. People did not have access to hot drinks or snacks from the kitchen when they wanted them.

The service was not well-led. The culture of the service was not empowering and person centred. The service provided was institutional, dictated by routine, with a rigid hierarchy. People were expected to conform to the 'house rules'. Quality systems were not operated effectively. People's views were not used to make improvements. The provider and senior staff had not worked positively with other health and social care professionals. Records of the care and support provided and other records regarding the management of the service were not well maintained.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not kept safe by staff who knew what action to take if they suspected or witnessed abuse or ill treatment, or if this was alleged.

Risk assessments had not resulted in sufficiently detailed plans to keep people staff.

People did not always receive their medicines as prescribed. Records regarding the administration of medicines were not maintained correctly.

Night time staffing levels had not been assessed using a recognised staff dependency tool to ensure people would be kept safe.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training required to effectively meet people's needs.

The provider and staff did not have a good understanding of the Mental Capacity Act 2005 (MCA). People were not encouraged to make choices and decisions.

The involvement of other health and social care professionals was not sought and, as a consequence people's needs were not always met.

People did not have access to hot drinks or snacks from the kitchen when they wanted them.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager at the service

The culture of the service was not person centred. The service provided was institutional, dictated by routine, with a rigid hierarchy. People were expected to conform to the 'house rules'.

Records of the care and support provided and other records regarding the management of the service were not well maintained.

Quality systems were not operated effectively. People's views were not used to make improvements.

The provider and senior staff had not worked positively with other health and social care professionals.

Bedrock Court - New Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27, 28 and 29 September 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection was carried out by one adult social care inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of services for people with long-term mental health needs. A specialist advisor is a person who has professional experience of this type of service. The specialist advisor was a psychology professional with experience of services for people with learning disabilities, mental health needs and autistic conditions.

The last full inspection of the service was on 22 and 23 December 2015. At that time we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was as a result of people not being protected against the risks associated with medicine administration because, medical advice had not been sought when a person had received incorrect medicines. We rated the service overall as 'requires improvement'.

Following that inspection the provider sent us an action plan detailing the action they would take to improve these areas in order to comply with this regulation.

Prior to this inspection we looked at the information we had about the service. This included information of concern shared with us by health and social care professionals and information from 'whistle-blowers'. We also reviewed the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Due to the number of individual safeguarding concerns raised regarding the providers services. This location

(along with two others managed by the provider) was under a process of 'organisational safeguarding'. This is a process initiated by the local authority as a result of the number and/or severity of concerns raised with them. CQC had attended a meeting just prior to this inspection. This meant CQC had been closely involved with a number of health and social care professionals, social workers and commissioners regarding the service. We have referred to the intelligence reports we have received from those that visit the service and from multi-agency meetings.

Our analysis of the information received led us to the decision to carry out a focussed inspection of this service. This means we looked at three of our five key questions. These were; is it safe? Is it effective and is it well-led. We have reported on these three areas.

During the inspection we spoke with three people using the service and spent time with one person who was unable to communicate verbally with us.

We spoke with five care staff, two office based staff, three assistant managers and the provider. We spoke with the three assistant managers at Bedrock Court. The other staff we spoke with at Bedrock Lodge. Most of these staff worked across the providers three locations.

We looked at the care records of four people living at the service, training records for all staff, staff duty rotas and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We identified a number of concerns and breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were not always in place to keep people staff. Where they were, they lacked detail for staff to follow. Assessments did not result in clear plans to keep people safe. Guidance for staff was not clear. This was particularly concerning as people experienced complex behavioural needs. For example, one person had needs arising from a range of different behaviours including self-harm and aggression to others. This person did not have risk management plans for staff to keep them safe. Another person often became upset as a result of worrying about family members. As a result they would become verbally aggressive. This person did not have risk management plans for staff to follow in order to keep them safe.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

At our last inspection of this service in December 2015 we identified a breach of regulation regarding the safe management of medicines. At this inspection we identified further concerns with this.

The recording of the administration of medicines was not safe. As required ('prn') medicines had been administered with no clear recording or rationale of why. There were no clear records of how people presented before and after the administration of medicines for anxiety and distress. Guidance on the administration of these 'prn' medicines was unclear. Staff we spoke with were unable to tell us where guidance on the administration of these medicines was to be found. Following our visit, health and social care professionals identified further concerns regarding the administration of medicines. They reported that records showed one person had been receiving prn medicines of the wrong dose and at the wrong time. They further stated staff did not seem to see this as a concern. This was investigated further and, found to be recording errors on the medicine administration records.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

One staff member provided care at the service overnight. They were on rota for a sleep in shift. Staff slept on a put up bed in the lounge. Staff were expected to provide considerable levels of care and support during the night. Records showed staff sleeping in at the service, were actually awake providing care and support for considerable periods of the night. For example, on the night of 28 September the staff member was providing care from 03:00 hrs onwards and, on 25 September from 01:50 to 14:00 and then from 03:00 onwards.

People had varying levels of communication and would need assistance to evacuate the building if required. There was also a real risk of serious self-injurious behaviour from one person. When speaking to staff it was clear they had not considered the risks that could arise at night. When asked what they would do if they

required assistance, they all said they would ring the provider. They were not clear how they would summon further assistance if they were not available. Night time staffing levels at Bedrock Court had not been assessed using a recognised staff dependency tool.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Two staff were available to care for people during the day, Staffing levels during the day were sufficient to keep people safe.

People were not kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Newly appointed staff had not received training on safeguarding. Although we saw posters displayed giving the contact details for the local authority safeguarding team, staff we spoke with did not have a good understanding of how to report any concerns they had about a person's safety or welfare. Some said they would report concerns to the provider but did not say they would report concerns to the local authority, CQC or police. Across the providers three locations 13 individual safeguarding referrals had been made between the beginning of May and end of August 2016. The majority of these had come from third parties. When the provider had made referrals raising concerns about people's safety they had not always been raised in a timely manner. Health and social care professionals did not express confidence in the ability of the service to keep people safe from harm.

Staff did not have the necessary skills to keep people safe. They had received NAPPI (Non-abusive Physical and Psychological Intervention) training. However, other than breakaway techniques they lacked knowledge on how to avoid potential triggers, how to de-escalate people's mood and what they should and should not do with regards to physical interventions. The appropriateness of physical interventions had previously been raised (by a third party) as a safeguarding concern.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

Four 'apprentices' were employed across the providers three locations. These are staff that are supported to achieve a diploma qualification (formerly NVQ). Their contract of employment is usually time-limited and they are paid a reduced wage. They are usually new to the care profession and working as an 'apprentice' often provides a good route into care and allows the employer to fully assess whether they are suitable for the role. One had been employed on this basis for more than two years. We were told by senior staff that 'apprentices' were supervised by a more experienced staff member when providing care and support. However, people and care staff told us this wasn't the case and that they provided care and support unsupervised. Considering people's diverse and complex needs apprentices did not have the qualifications, competence, skills or experience for the work they were expected to perform.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed.

Bedrock Court was dank, dark and smelt in certain areas. One person's room was very bare and uninviting. This person damaged property and was prone to injuring themselves on furniture. Their room also needed to be thoroughly washed and cleaned each day. However, advice had not been sought on how to take these factors into account and still provide a room that was pleasant to be in.

Furnishings in communal areas looked tired with significant wear and tear. Visiting health and social care

professionals commented that, "The home is stark, cold and not a homely place to be". Relatives had also raised concerns regarding the physical environment. The condition of the home did not lend itself to safe and effective management of infection control risks. Staff had not received training on the control and prevention of infection.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We have reported on checks carried out on staff before they commence work in our report of our inspection of Bedrock Lodge.

Inadequate

Is the service effective?

Our findings

People did not receive a service that was effective in meeting their individual needs.

Staff had received basic training in areas such as; first aid, food hygiene and fire training. However, they had not all received specific training to meet people's individual needs.

For example, several people required assistance with their communication needs. We were told by other professionals that attempts had been made to organise communication workshops for staff. They reported it had not been possible to arrange these with the provider. It was clear through observations of staff interactions that people would benefit from staff having greater skills in verbal and non-verbal communication techniques.

Some people had serious mental health conditions. Staff had not all received training on these. Staff said they felt they needed training on these to better respond when people were anxious, upset or angry. Other people needed support to manage their behaviours. These behaviours were potentially very serious. One person self-harmed and had recently broken windows. They could also be aggressive towards others. Through observing and speaking with staff it was apparent they lacked knowledge in how to provide the support people required and, that they were ignorant of any guidance provided in people's care plans.

Concerns had been raised within the last 12 months regarding the ability of staff to respond to emergencies. This followed a sudden and unexpected death. Staff had rung the provider before seeking emergency assistance.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

A number of DoLS applications had been submitted for other people and returned by the authority(s) because the person had the capacity to make the decision themselves. A DoLS assessor employed by the local authority had attended a staff meeting to update staff. They had reported, 'Staff were hostile, reticent

and did not understand DoLS'. It was clear from this and discussions with the provider and staff there was no real understanding of the principles of the MCA. Staff were unable to explain their responsibilities to support people to make choices and decisions. This was further evidenced by the practice of locking doors, meaning people could not access parts of their home.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

The service provided was not person centred. People were required to fit into the service rather than the service being planned and delivered around their needs. People, or those acting on their behalf, were not involved in the planning of their care and support. Complaints had been received from families who were unhappy with not being informed about care review meetings and people's changing needs

Involvement from relevant health and social care professionals had not always been sought. People accessed their GP and attended hospital appointments with staff support. However, just two people were receiving input from the Community Learning Disabilities team. We saw little involvement from psychology professionals to assist in helping people, and their staff, manage their behaviour, speech and language therapists to assist people with their communication needs, or independent advocates to assist people to make choices and decisions.

Health and social care professionals told us they felt the service did not seek their assistance and was sometimes resistant to this. We were told how on occasions professionals who had made appointments found when they visited; the person and/or relevant staff were not available.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

People confirmed they did not have access to hot drinks or snacks when they wanted them and they were not happy about this. Kitchen doors were routinely kept locked. Only cold options were available for lunch on the days we inspected and, consisted mainly of sandwiches and a salad option. For example, on day one people had a choice of sandwiches or potato salad with tuna

We have reported on staff support and supervision in the report of our inspection of Bedrock Lodge.

Inadequate

Is the service well-led?

Our findings

Bedrock Court had been without a registered manager since July 2015. An acting manager was in post and had applied to CQC to become the registered manager. The arrangements in place to ensure the service was well led were unsatisfactory. This compromised essential aspects in service provision. Evidence of breaches in regulations we found throughout our inspection demonstrated that there had been serious failures to identify and manage risks for people across the service. A lack of planning meant that the risks were not minimised. This was particularly around providing prompt access to suitable training to equip staff with the right skills to provide safe, good quality care.

The provider did not always have people's best interests at the heart of their service. They had been resistant when offered support, guidance and advice from community and health and social care professionals. It was evident that they were reactive to improving the service they provided rather than being proactive. There was a lack of insight and vision as to how they intended to improve the service. The systems in place to monitor the quality of care were not robust and had failed to identify the serious failings of the service.

The provider sent out annual surveys to obtain the views of people using the service, relatives and other professionals. The provider/registered manager said the surveys that had been returned in 2016 were currently being collated and analysed by one of the assistant managers. We looked at the surveys returned in 2015 and saw these had not resulted in any identified actions to improve the service.

Some quality checks on standards within the service had been carried out. There were checks on the management of medicines, health and safety, staff training and supervision. However, these were not planned in a systematic way and had not resulted in identifying any shortfalls in these areas. Care plan audits had not been completed. Accidents, incidents and complaints were not audited. This meant any themes or trends were not identified or any action taken to keep to keep people safe or improve the quality of service they received.

Records of the care and support people received were not accurately maintained. Care plans were not sufficiently detailed or written in a person centred manner. Information was not always accurate or relevant. For example, one person's care plan contained an assessment for children with metabolic disorders and other information as much as 20 years out of date.

Daily records were often written in a negative and judgemental manner. Statements such as, 'Demanding cigarette' and, 'Refusing to go back to bed', were frequently used. These gave the impression of unequal relationships between people and staff and, a lack of respect for people.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Records of comments and complaints were not well maintained. These did not clearly identify how they had

been managed or, how feedback had been provided to the complainant. For example, one person had complained about changes to their day service. The record of this complaint stated, 'Activities changed'. But did not state in what way or, if the person was satisfied with the outcome of this.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

The provider had not published ratings on their website as required by CQC.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirements as to display of performance assessments.

The culture of the service did not promote dignity and respect. People had little choice over what they did during the day. They were expected to attend a day service at Bedrock Lodge. People were expected to conform to 'house rules'. These detailed when they were expected to go to bed and eat meals. Mr. Men characters were displayed on people's doors. These were childlike and potentially insulting.

The experience of people using the service was of a closed environment. They lived at the service, used the day care facilities at Bedrock Lodge and activities and holidays took place mainly in large groups. This raised the risk of people becoming further isolated from their family and friends and the wider community. This had not been recognised as a risk factor. Measures had not been taken to reduce this risk and help people to learn and develop. The overall impression of the service was that it was deskilling people rather than promoting their independence, value and worth.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

The provider and senior staff had not taken advantages of opportunities to keep themselves up to date with best practice or develop partnerships with key organisations. Feedback from health and social care professionals consistently spoke about the feeling they were 'kept at arms-length' from the service. In fact some felt, they were resistant to any advice given and gave off an attitude of knowing people best. This was concerning, as the varied and often complex needs of people using the service meant it was important for them to receive input from a range of professionals. This would also help staff to develop their knowledge, confidence and abilities in providing care and support to people.

The provider was financial appointee for most people. This was documented in people's care plans. An office based member of staff kept financial records of income and expenditure for each person. These were comprehensive. However, the provider/registered manager failed to follow best practice by ensuring arrangements were transparent and had not arranged for any independent audit of these records.

We recommend the provider reviews the systems for supporting people to access and manage their finances.

Staff were not always clear regarding their roles and the lines of accountability. When faced with any emergency situations staff were not clear what to do, in order to respond promptly. There was no formal on call system in place for staff. They told us the provider/registered manager lived close and could be contacted at any time. There were not clear what they would do if they were not available.

We recommend the provider reviews the systems in place to ensure staff are able to take the correct action

in emergency situations.

The provider and senior staff knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. There was a lack of confidence from other professionals that information required to keep people safe was consistently reported in a timely manner.

On the 29 September 2016 we spoke with the acting manager and two assistant managers. They showed an awareness of some of the concerns we had identified. When asked for their priorities for the service they said; "To introduce better care planning, link with other professionals more and focus on providing person centred care". These three senior staff had registered for their Level 5 Diploma for Leadership in Health and Social Care. This is a work based qualification that assesses knowledge and skills. We spoke with them about how they saw their roles and, whether they thought they would be allowed by the provider to implement and manage change. They recognised this as a major challenge but felt it could be achieved. However, we were aware the management team had worked together for some time and had not put any of these changes into effect.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care because; their needs and preferences were not assessed comprehensively, with the involvement of the person and appropriate others. 9 (3) (a). Care was not comprehensively planned to meet their needs. 9 (3) (b). Health and social care professionals with the required knowledge and expertise had not been involved in designing, delivering and reviewing their care. 9 (3) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. 10 (1). People's autonomy, independence and involvement in the community was not promoted. 10 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured care was provided in accordance with the requirements of the Mental Capacity Act 2005 (MCA). 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm because risks had not always been assessed. 12 (2) (a). People were not protected from harm because action had not been taken to mitigate against risks. 12 (2) (b). People were not protected from harm because appropriate measures for the prevention and control of infection were not in place. 12 (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured staff had been kept up to date to enable them to identify and report concerns regarding people's safety. 13 (2). People were not safeguarded from abuse or improper treatment because staff were unclear regarding the use of physical interventions. 13 (4) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not operated an effective system for receiving, recording and responding to complaints from service users and others. 16 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and

planned to improve the quality and safety of the service provided. 17 (2) (a).

The provider had not assessed, monitored and mitigated the risks relating to the health and safety of service users. 17 (2) (b).

The provider had not maintained clear records of the care and treatment people received with regards to medicines. 17 (2) (c).

The provider had not ensured records relating to the management of the service were maintained. 17 (2) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured all staff providing care had the qualifications, skills and experience for the work they were required to do. 19 (1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not ensured their website signposted the most recent rating by the Commission of their performance. 20A (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of staff to keep people safe. 18 (1). Staff had not received the training required to meet people's individual needs. 18 (2) (a).