The Lighthouse

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

This was a focused inspection on elements of the safe and well-led key questions only. Therefore, we did not rate the service. The service has not previously been inspected. We found the following:

- There were no qualified nurses working at night. This meant that young people with complex needs might not have access to the professional support needed. There were no qualified nurses working in the hospital at night. This meant that children did not have immediate access to a qualified nurse.
- Staff restrained children and young people using training models that were not consistent. This meant there was a risk of restraint not being done safely. The provider acknowledged that all staff should be trained to use the same techniques and has taken steps to address this.
- Staff had not received the appropriate level of training to fulfil their roles. Staff lacked training in the Mental Capacity Act and Gillick competency and so did not always consider consent appropriately. Safeguarding children training was not completed to the required level of competence. There were plans for this training to be completed by the end of May 2020.

Summary of findings

- Our findings from the other key questions demonstrated that governance processes were in their infancy. Policies required improvements. There were plans to fully review policies and procedures and implement robust governance.
- There had been a failure to notify CQC of safeguarding concerns and police contacts.

However,

- The service managed patient safety incidents well. Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so.
- The service had enough support staff, who knew the children and young people well. Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff felt respected, supported and valued.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards		See overall summary

Summary of findings

Contents

The Lighthouse

Services we looked at:
Child and adolescent mental health wards

Summary of this inspection

Background to The Lighthouse

The Lighthouse is a four-bedded child and adolescent inpatient service based in Darwen, Lancashire. The service provides mental health care to children of either gender from aged eight to eighteen. The service model is based on providing step-down care for children who are ready to leave a tier four child and adolescent mental health ward but require extra support before returning to the community. The service also provides crisis admissions for children and young people who need extra support to avoid requiring a tier four bed.

There was a registered manager in post at the time of our inspection. The Lighthouse was registered for the following regulated activities:

- Treatment for disease, disorder or injury
- Accommodation for people who require nursing or personal care

The service was registered in December 2019 and therefore had not been previously inspected.

Our inspection team

The team that inspected the service comprised of one CQC inspector and one CQC children's services team leader.

Why we carried out this inspection

We conducted a focussed inspection of The Lighthouse in response to concerns that were raised to the CQC. The inspection took place during the Covid-19 pandemic and national lockdown conditions.

How we carried out this inspection

Due to the nature of the concerns raised we focussed on elements of the following questions:

- Is it safe?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the service and observed how staff were caring for children and young people
- spoke with two children who were using the service
- spoke with the registered manager and the clinical director
- spoke with two other staff members
- received feedback about the service from two local authorities
- looked at two care and treatment records of children and young people
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

Children and young people spoke very highly of staff. Children and young people described staff as always available for them and that they had developed trusting relationships.

Children and young people commented that due to the small size of the service, staff have more time to interact with children and young people.

Children and young people said the service felt safe and had a calm and relaxed atmosphere.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate safe as part of this inspection. We found the following:

- There were no qualified nurses working at night. This meant that young people with complex needs might not have access to the professional support needed.
- Staff restrained children and young people using training models that were not consistent. This meant that there was a risk of restraint not being done safely. The provider acknowledged that all staff should be trained to use the same techniques and had taken steps to address this.
- Staff had not received the appropriate level of training to fulfil their roles. Staff lacked training in the Mental Capacity Act and Gillick competency and so did not always consider consent appropriately. Safeguarding children training was not completed to the required level of competence. There were plans for this training to take place by the end of May 2020.

However:

- The service had enough support staff, who knew the children and young people.
- Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.
- The service managed patient safety incidents well. Staff recognised incidents and recorded them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Are services effective?

We did not inspect this domain.

Are services caring?

We did not inspect this domain.

Are services responsive?

We did not inspect this domain.

Summary of this inspection

Are services well-led?

We did not rate well-led as part of this inspection We found:

- Our findings from the other key questions demonstrated that governance processes were in their infancy. Policies required improvements. Systems and process to demonstrate safety and effectiveness needed development. There were gaps in staff training and development. The risk register was not completed correctly. The risk register we were given on inspection had the incorrect date on it.
- There had been a failure to notify CQC of safeguarding concerns and police contacts. However, these were submitted retrospectively and since our inspection have been submitted in a timely way.

However:

- Leaders were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and provided opportunities for career progression. They felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children and young people to make decisions about their care for themselves. Children and young people were presented with information and supported to make informed choices wherever possible. However, in one young person's care records staff had signed consent on behalf of a young person who had the capacity to consent for themselves in line with Gillick competency.

Staff had not received and kept up-to-date with training in the Mental Capacity Act. The service had a policy on the Mental Capacity Act 2005, but Mental Capacity Act training was not mandatory for staff. The service had recognised this as a gap in their service design and had been delivering in-house Mental Capacity Act training. Five staff member had received Mental Capacity Act training from their former employers and six staff members had received Mental Capacity Act training within their inhouse restraint training module. A training provider had also been sourced to provide Mental Capacity Act training to all staff by 22 May 2020.

The Mental Capacity Act policy was not always relevant to the service user group. The policy referred to Deprivation of Liberty Safeguards which are not applicable to children under 18 years of age. The policy was not specifically designed for children and young people and was unclear. This meant that staff did not have an appropriate policy to reference.

There was one patient subject to a Court of Protection order. This had been in place prior to admission.

Staff took advice on the Mental Capacity Act from senior managers.

Child and adolescent mental health wards

Safe	
Well-led	

Are child and adolescent mental health wards safe?

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people.

The service employed the following 13 staff members:

- Clinical directors/mental health nurses, two
- Senior support workers, three
- Support workers, four
- Consultant psychiatrist, one (sessional basis approx. four hours a week)
- Psychologist, one (sessional basis approx. four hours a week)
- Teacher, one
- Housekeeper, one

The service had reducing vacancy rates. The service had 12 bank support workers and two bank mental health nurses. The service planned to employ an assistant psychologist and another mental health nurse. Adverts for recruitment had been placed. There were plans to increase the permanent staff team and to be less reliant on bank staff. Bank staff usage for support workers was approximately 33% of all shifts over the last three months.

- 28% of support worker day shifts were covered by bank support worker staff over the last three months
- 38% of support worker night shifts were covered by bank support worker staff over the last three months
- 1% of nurse day shifts had been covered by a bank nurse over the last three months

Bank staff received the same induction, training and supervision as permanent staff.

There was always a registered nurse available during the day. At night there was only a senior support worker available to support children and young people and other staff. The Royal College of Psychiatrists quality network for inpatient child and adolescent's mental health service standards for services recommends that one qualified nurse should work during the night. This meant that children and young people did not have immediate access to suitably qualified staff to care for their mental and physical health needs. Children and young people who required urgent care and treatment did not have access to this from an appropriately trained and qualified person. There was an on call qualified mental health nurse available to attend within 10 minutes if required.

During the day there was an average of 2.7 support workers and one mental health nurse on duty. During the night there was an average of 2.5 support workers on duty and a mental health nurse available on-call.

There were enough staff to ensure children and young people had time to complete one to one sessions with their individual key workers. Children and young people's activities had never been cancelled due to staffing issues.

There were enough staff to conduct duties such as observations and physical interventions.

The service had not predicted the level of acuity for some children and young people initially admitted to the hospital. Some children and young people presented with high levels of violence and aggression.

Not all staff had been trained sufficiently in restraint. The service had accepted training completed within different organisations. This meant that staff had been taught different restraint techniques. This is unsafe as staff did not have a consistent approach to maintain a child or young person's safety.

- nine staff had completed The Lighthouse restraint training
- eight staff were using restraint techniques learnt in previous NHS posts, however this training was identical to that of The Lighthouse (where the training was still in date)
- four staff had completed team teach training in previous employment (where the training was still in date)
- one staff member had completed management of actual or potential aggression training with a previous employer (the training was still in date)

- seven staff did not have any training in restraint. Restraint training had been planned to take place prior to the inspection but this had been postponed due to Covid-19.

The service had planned to train all staff in the new British Institute of Learning Disability restraint standards that were due to be implemented in April 2020. However, due to the current worldwide Covid-19 pandemic and associated restrictions this had not been implemented. All staff were trained in breakaway techniques.

A psychiatrist was available for approximately four hours a week and available to give telephone advise on an ad-hoc basis. For medical cover the service had access to community facilities such as GP and local hospitals. All children and young people were registered at a local GP practice. There was no out of hours medical cover. Children and young people had access to local hospitals and community services to meet any emergency medical needs.

Not all staff had not completed their mandatory training. The overall mandatory training compliance rate was 76% over 15 modules. Training modules that fell below 75% were:

- handling violence and aggression 48%
- food hygiene 70%
- information governance 66%
- equality and diversity 67%
- moving and handling 66%

Staff had not received mandatory training in the Mental Capacity Act or consent. Five staff members had received Mental Capacity Act training from their former employers and six staff members had received Mental Capacity Act training within their inhouse restraint training module. The provider had agreed to ensure appropriate training was in place in the immediate future.

Some practical training modules were on hold due to pandemic restrictions on social distancing and other measures. These included, moving and handling, manual handling, conflict resolution, practical and basic life support or immediate life support, (practical element). There was evidence of managers addressing poor staff performance issues related to training directly with staff.

The service accepted mandatory training that had been previously completed within other organisations. Senior managers checked the training was of good quality and the training content. There was internal training available for staff who had not completed training previously or where their training was not compatible or to a good standard. Extra training that was specific to the service was delivered during the induction period; such as specific fire safety information and internal information governance policies. Basic life support training and immediate life support training included both adult and child emergency care.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each child or young person on admission and reviewed this regularly, including after any incident. Where possible staff were now completing their own risk assessments prior to the child or young person's admission.

We examined two care records of children and young people. We found that risk assessments contained detailed information including comprehensive risk management plans.

Management of patient risk

Staff knew about any risks to each child or young person and acted to prevent or reduce risks. It was evident staff knew each child well and plans were in place to prevent future risks.

Staff identified and responded to any changes in risks to, or posed by, children and young people. Individual risk management plans were updated following new risks being identified. Staff used restorative justice methods to address issues between children and young people.

Staff could observe children and young people in all areas.

Staff followed the provider's policies and procedures when they needed to search children and young peoples' bedrooms to keep them safe from harm. There was evidence of staff conducting room searches when it was suspected children and young people had cigarettes, alcohol or drugs in their possession. Each child had individual plans in place to manage these issues. Staff

attempted to engage the child or young person to voluntarily hand over any dangerous items before resorting other action. Most children and young people had longstanding histories of smoking and/or substance misuse and staff engaged children and young people in therapy to address these problems.

Blanket restrictions were limited and appropriate for the hospital. They included no weapons, no alcohol and no drugs.

No children and young people at the hospital were detained under the Mental Health Act, the hospital did not accept detained patients. All informal children and young people could leave the hospital if they wished. However, the front door was locked. The door was locked as the hospital was in a high crime area of Darwen and to prevent the public from entering. The hospital was also located on a busy main road and was a traffic risk for some children. Children knew they could leave at any time and that they needed to ask staff to open the door. This information was also highlighted within the child and young persons' guide to the hospital. The hospital accepted children and young people who were restricted under Court of Protection orders. These children and young people had individual restrictions on leaving the hospital.

Levels of restrictive interventions had been high but were reducing.

This service had 11 incidences of restraint (four different children and young people) between 1 February 2020 and 15 April 2020. There had been no instances of seclusion. The service did not have seclusion facilities.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child or others safe.

There were five incidences of prone restraint, which accounted for 45% of the restraint incidents. Three of the restraints were on one young person who required intensive support and was not suitable for the service. Since their discharge the number and severity of restraints had decreased.

There were no incidences of rapid tranquilisation being used since the service opened in January 2020.

There have been no instances of mechanical restraint over the reporting period.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training about how to recognise and report abuse and they knew how to apply it. The provider had a named worker who was the child safeguarding lead.

This was a recent appointment and the staff member was due to receive extra training to fulfil their role.

Staff had not received enough training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with safeguarding training but it was not to the required level. Safeguarding training for children level two was 87% compliant. Adult safeguarding level two training was 83% compliant. Due to the high level of child safeguarding matters it would be expected that staff should be trained to level three and managers to level four and five. The service was planning to implement these changes and increase safeguarding training. It was expected that the extra training to safeguarding level three would be completed by 22 May 2020.

The safeguarding policy lacked specific detail. There was a plan for an external governance consultant to review and update the safeguarding policy and governance framework. It was expected that this would be completed by mid-June 2020.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were aware of specific child protection concerns that child might be at risk of and what action to take.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The service had close working relationships with local authorities and the children's' social workers. There were regular multidisciplinary meetings with external agencies to plan for children's care.

Staff knew how to make a safeguarding referral. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police

to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made nine safeguarding referrals between 1 February 2020 and 15 April 2020, of which all concerned children.

The service failed to notify the CQC of the safeguarding incidents. At the time of the inspection and in response to CQC queries, the service had submitted all safeguarding notifications to the CQC retrospectively and regularly submitted safeguarding notifications in a timely manner.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and recorded them appropriately. Managers investigated incidents and shared lessons learned with staff. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. There was an electronic incident reporting system that staff had access to. Incidents that had been reported included restraint, self-harm and safeguarding incidents. Staff had been given training on incident reporting during the induction process.

Staff raised concerns and reported incidents and near misses in line with provider policy. The service had no never events.

Staff understood the duty of candour. They were open and transparent and gave children and young people and families (if appropriate) a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Staff received feedback from investigations. Staff met to discuss the feedback and look at improvements to children and young peoples' care. There was evidence that changes had been made as a result of feedback. Staff had implemented a more thorough assessment process to ensure future children admitted to the hospital were appropriate for the service.

Are child and adolescent mental health wards well-led?

Leadership

Leaders lacked experience and understanding about how to implement good governance and what was required to ensure a service was safe and effective.

Leaders were visible in the service and approachable for patients and staff. Leaders displayed in-depth knowledge about individual children and young people and how their care was delivered. There were opportunities for staff to develop into more senior roles. Extra training was provided to support staff to develop into other roles.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Senior managers had a strong vision of what the service was providing, and staff described feeling inspired and motivated by managers.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in their daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear. Staff told us they could raise any issues or concerns directly with managers and that their concerns were dealt with appropriately. Staff described having trust in their leadership and gave examples of actions managers had taken as a result of concerns raised.

Staff knew how to use the whistle-blowing process and there was a policy in place for staff to refer to.

Managers dealt with poor staff performance when needed. Managers had addressed performance issues with staff and had taken the appropriate action. Managers took advice from a specialist human resources team when needed.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Senior staff had been placed on shifts where it was felt difficulties had or may occur. Managers had introduced rotational shifts to avoid any poor work culture developing.

Governance

Our findings from the other key questions demonstrated that governance processes were in their infancy and to yet be developed fully. The risk register we were shown on inspection made reference to restraints being a low risk, despite the significant number of restraints and prone restraints. At factual accuracy, the provider stated the date was incorrect on the risk register we were given and provided the correct risk register with the correct date on it. There were several audits in place and close oversight from senior leaders to conclude that performance and risk were managed well.

There were some systems and procedures in place to monitor and improve the service. However, these were limited. There was oversight to ensure that there was enough staff during the day, but there was not the correct grade of staff on shift at night to meet the needs of the children and young people. There were processes in place that showed staff were trained and supervised and that children and young people were assessed and treated well. However, the training compliance system was not robust or consistent. Changes had been made to ensure that new admissions had clearer assessments and plans. Incidents were recorded, investigated and learnt from. Incidents were audited and reviewed for themes and trends. Improvements were made as a result of incident audits. A development and safety lead had been appointed one week prior to the inspection.

The governance arrangements were weak and underdeveloped. There were clear gaps in several areas that senior managers had not yet rectified. These included a lack of consistent training, poor policies and issues relating the restraint of children and young people. There was a plan for an external governance consultant to assess and review the current governance processes and provide an improvement plan. The service was aware that some policies and procedures were not clear and needed review and that performance indicators were to be developed. The timescale for the review to be completed was mid-June 2020. Areas to be reviewed included:

- policies and procedures
- care plans and clinical records
- training records
- risk assessments and incident reports
- operational policy
- business plan/operational plan/annual plan
- terms of reference, agendas and minutes of key meetings

There was a clear framework of what must be discussed at service level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff understood the arrangements for working with other teams external to the service, to meet the needs of the children and young people. There was a children's advocacy service appointed to deliver advocacy to the children and young people. This had yet to be fully embedded due to the pandemic outbreak and associated restrictions. The service was working with the advocacy service to consider alternative ways of communicating and supporting children and young people. Staff worked closely with each child's social worker and had regular multi-disciplinary team meetings to discuss progress with each child or young person. The service was establishing links with the local police and liaised with senior police staff when issues could not be resolved directly.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

A draft risk register was in place. Staff raised issues within meetings and items were added to the risk register accordingly at the senior management team meeting. The risk register did not include all pertinent issues relating to the service. The structure of the risk register was due to be updated as part of the wider governance review.

The service had plans for emergencies such as adverse weather or a flu outbreak. A separate coronavirus contingency plan had been developed to support the management of the current pandemic.

Child and adolescent mental health wards

Information management

Data collection and outcome performance was in the developmental stage. An external governance consultant was due to review the systems and processes of the service and implement outcome and performance targets. Local audits were being completed in relation to incidents, record keeping and restrictive interventions. More wider data analysis for quality assurance purposes was due to be introduced.

Staff had access to the equipment and information technology needed to do their work. Children and young people's care records were stored on both electronic and paper systems. There were plans to introduce a new full electronic care record system.

Notifications had not been submitted to the CQC in relation to safeguarding incidents and police contact. Prior to the inspection, and following CQC queries, the service submitted the notifications retrospectively.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are trained in the same restraint techniques. Staff restraining children and young people must have the appropriate skills to do so safely.
- The provider must ensure that suitably qualified staff are deployed to meet the care and treatment needs of children and young people.
- The provider must ensure that all staff receive the appropriate mandatory training for their roles. The provider must identify gaps in training provision and implement the recommended training. This must include safeguarding and Mental Capacity Act training designed for staff caring for children and young people.
- The provider must review all policies and procedures. This must include the safeguarding and Mental Capacity Act policies and procedures.
- The provider must ensure there are appropriate robust governance processes in place to identify areas for improvement for themselves.
- The provider must ensure that the risk register is reviewed and updated to reflect current risks within the service accurately.

Action the provider SHOULD take to improve

- The provider should ensure that notifications to the CQC are submitted in a timely way.
- The provider should continue to review any young person who may be inappropriately placed and subject to restraint. The provider should work with relevant authorities to promptly move the young person to a more suitable setting to meet their needs.

This section is primarily information for the provider

Requirement notices

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff were not trained in the Mental Capacity Act. The Mental Capacity Act policy was not suitable for the purpose of working with children and was unclear. The consent policy also lacked specific detail. Staff had signed for consent on behalf of a young person who was able to consent. This was a breach of regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Staff were not trained appropriately in restraint despite the service having high levels of restraint. Staff had received different models of restraint training. This meant that restraint practices were unsafe. This was a breach of regulation 12(2)(c)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Overall systems and processes were not robust. There were gaps in the mandatory training schedule that meant staff were not skilled to deliver safe care and treatment. The approach to training was inconsistent with previous training being accepted. Many policies were poor and required review. The risk register did not clearly identify risk associated with the service. Areas for improvement within the service had not been identified by governance measures. This was a breach of regulation 17(2)(a)
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Suitably qualified staff were not deployed to meet the needs of children and young people. There were no qualified nurses working at night. This was a breach of regulation 18 (1)