

**From:** Docherty, Matthew [Matthew.Docherty@cqc.org.uk](mailto:Matthew.Docherty@cqc.org.uk)  
**Subject:** RE: POCU 1516 0181 Dr Minh Alexander Autumn Grange the death of Ivy Atkin and CQCs role  
**Date:** 2 March 2016 at 11:10  
**To:** Minh Alexander [minhalexander@aol.com](mailto:minhalexander@aol.com)



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**Email sent on behalf of Rob Assall-Marsden, Head of Inspection, Adult Social Care Directorate, Care Quality Commission – Central Region**

Dear Dr Alexander,

Your email to David Behan of 18 February 2016 has been passed to me for response.

CQC has not undertaken an internal review relating to Autumn Grange of the type carried out in relation to Homerton. Nottingham City Council did conduct a review in early 2013 which CQC had involvement in. You should contact the council if you require more information about this.

The way CQC inspected services in 2012 is very different to how inspections are now carried out. We now have teams, including Experts by Experience, who inspect services, looking at five key areas; are they safe, caring, effective, responsive to their needs, and well-led? We also rate these services as Outstanding, Good, Requires Improvement and Inadequate. Our approach to monitoring and inspecting adult social care allows us to get under the skin of services better than ever before. We have more inspectors with greater expertise and we are working more closely with our local partners to respond to concerns.

A Serious Case Review is currently being undertaken by Nottingham City Council with regard to what happened at Autumn Grange and CQC is contributing to this. The results of the Serious Case Review will be made public in due course and if there are further lessons for CQC to learn as a result of this, we will ensure we do so. You should contact the council if you require information regarding the Serious Case review.

Yours sincerely,

**Rob Assall-Marsden,  
Head of Inspection,  
Adult Social Care Directorate,  
Care Quality Commission – Central Region**

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**From:** Minh Alexander [<mailto:minhalexander@aol.com>]  
**Sent:** 18 February 2016 12:46  
**To:** Behan, David  
**Cc:** [meghilliermp@parliament.uk](mailto:meghilliermp@parliament.uk); Bernard Jenkin; [sarah.wollaston.mp@parliament.uk](mailto:sarah.wollaston.mp@parliament.uk); [Info@compassionincare.com](mailto:Info@compassionincare.com); [katherine@patients-association.com](mailto:katherine@patients-association.com); Louis Appleby; [louis.appleby@cqc.org.uk](mailto:louis.appleby@cqc.org.uk)  
**Subject:** Re Autumn Grange, the death of Ivy Atkin and CQC's role

To Mr David Behan Chief Executive CQC 18 February 2016

Dear Mr Behan,

## **Re Autumn Grange, the death of Ivy Atkin and CQC's role**

I see that the latest Private Eye reports concerns that CQC did not detect (or act upon) very serious failings at Autumn Grange care home, and concerns that the death of Ivy Atkin, 86 in 2012 was related to this. I copy below the salient extracts from the Private Eye article.

As the CQC has undertaken an internal review into why it gave Homerton maternity services a "good" rating in 2014, when this followed by at least five subsequent maternal deaths and findings of service failings at inspection a year later, may I ask if CQC has undertaken a similar internal review of the matters at Autumn Grange?

If such an internal review has been undertaken, please could a copy of this be made available and published.

Whilst I understand that a serious case review regarding Autumn Grange is now underway, may I also ask if there has been any previous examination of why Ivy Atkin was reportedly not admitted to hospital in October 2012 when she was found to be in such serious medical condition, but reportedly only transferred to another care home where she died three weeks later, despite CQC and all agencies presumably being aware of the serious medical condition in which she had been found?

Yours sincerely,

Dr Minh Alexander

cc Compassion in Care

Meg Hillier MP

Bernard Jenkin MP

Sarah Wollaston MP

Professor Louis Appleby CQC NED

Katherine Murphy, Chief Executive Patients Association

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The Private Eye article:

Autumn's fall

**“Barely seven weeks before an elderly woman was found close to death in a Nottingham care home, lying in her own urine and with a huge rotting pressure sore on her back, inspectors from the Care Quality Commission (CQC) had given the home a clean bill of health, the *Eye* can reveal.**

Earlier this month Yousaf Khan became the first ever care home director to be jailed for corporate manslaughter. Retired dressmaker, Ivy Atkin 86, had been found in Autumn Grange care home weighing just 4 stone, having lost half her body weight in the 48 days she had been there. Khan, 47, was sentenced to three years and two months for “wanton and reckless neglect”.

Ivy, who had dementia, wasn't the only resident suffering gross neglect. After an anonymous carer blew the whistle, at least two residents were found to have pressure sores which were not treated properly; others were found lying in their own urine or waste; another had long, filthy nails digging into the skin, and yet another was found dehydrated and with cracked and bleeding lips. Others had “unexplained injuries and bruising”, including head wounds, bruised and swollen hands, and cuts to the knees and eyes of people who were immobile. Painting a horrific picture of staff “care”, one resident complained to inspectors about noisy nights. “Depends on which gang is on. They shout at the barmy ones,” he said. There was no hot water to wash those who were in a filthy state, and call bells were either not working or deactivated.

Social workers from Nottingham city council went in after a horrified careworker – only three days into a new job – contacted the council on 28 October 2012. They alerted the police, the CQC and others and called an emergency safeguarding meeting. The home shut down and 28 residents were moved out. Ivy died three weeks later in another care home. Despite her condition, for some unexplained reason, she was not taken to hospital.”

**“...The home had a history of poor care since 2010. In 2011 the council had put a temporary halt on new admissions, lifting it the following January. The CQC and other visited regularly in 2012 to “review compliance”. On 13 September 2012 – four days before Ivy went into Autumn Grange – inspectors decided the home was finally “meeting standards”. The only area flagged up as “needing action” was that there were not enough staff to cope when “behaviours deteriorated”.**

**It was a very different picture when the CQC returned on 2 November and found widespread squalor, neglect and abuse. While it is clear that some of the worst reported examples (though not all) took place between the two CQC visits, inspectors looked at far more records and found that at**

**least two other residents were at risk of malnutrition and dehydration. Their care records had not been updated for seven months, they were not weighed regularly and their food and liquid intake were not monitored. The home failed every single standard it had so recently passed, to the extent that the CQC cancelled the owner's registration.**

“Homes can deteriorate very quickly – but not to *that* extent” an expert in adult social care told the *Eye*. Meanwhile Eileen Chubb of Compassion in Care, who has just produced a report on other failing care homes, called for CQC to be held to account, having repeatedly failed to act on bad care homes”. “Ivy is one of the countless people who have paid for this,” she added.

The *Eye* asked Nottingham city council and the CQC how this could have happened. Nottingham, which is carrying out its own serious case review said the question was presumably a matter for the coroner to explore. But in a statement it added: “This was a home on our safeguarding radar where we had previously suspended our contract and, with partners, endeavoured to improve standards of care. Usually when we do this, owners work with us and flag safeguarding issues with us for improvement, but unfortunately this was not the case at Autumn Grange”.

CQC said it was contributing to the serious case review and added, “if there are further lessons to learn as a result we will ensure we do so”. It said it now had more inspectors with greater expertise and was working more closely with local partners”

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