IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Stephen LAWRENCE
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] and [redacted] Eastcroft Nursing Home 7 Woodmansterne Lane Banstead Surrey SM7 3EX
2	**CORONER** Miss Anna Crawford, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into Mr Lawrence's death was opened on 16 February 2023. The inquest was resumed on 9 June 2025 and concluded on 13 June 2025. The medical cause of Mr Lawrence's death was: 1a. Pneumonia and Haemopneumothorax 1b. Rib Fractures 1c. Fall (21 December 2022) 2. Dementia With respect to where, when and how Mr Lawrence came by his death it was recorded at Box 3 of the Record of Inquest as follows:

	Mr Lawrence was a 76 year old man with a diagnosis of vascular dementia and a history of falls. On 21 December 2022 Mr Lawrence sustained an unwitnessed fall at his nursing home. On 25 December 2022 he was admitted to St Helier's Hospital, where he remained an inpatient until his death on 5 January 2023. Mr Lawrence had sustained multiple rib fractures as a result of his fall on 21 December 2022, which in turn led to him developing a haemopneumothorax and pneumonia, which caused his death. The inquest concluded with a conclusion of 'Accident'
5	**CIRCUMSTANCES OF THE DEATH** Mr Lawrence was a resident at Eastcroft Nursing Home in Banstead, where he had lived since September 2020. He was independently mobile and had been assessed as being at high risk of falls. He had a falls alarm in his room to notify staff as to when he was moving around and it was planned that a member of staff would observe him and offer to assist him whilst he was moving around to minimise the risk of falls. Whilst Mr Lawrence was a resident at Eastcroft Nursing Home he was not recorded as having sustained any falls until 21 December 2022, when his falls alarm went off in his bedroom and he was found crawling around on the floor. It was recorded that he had new bruising to the left-hand side of his face. He also reported rib pain, albeit that was not recorded in the records. On 23 December 2022 he began to complain of abdominal pain and on 24 and 25 December 2022, he remained in bed all day. On the evening of 25 December 2022, an ambulance was called and Mr Lawrence was transferred to St. Helier Hospital. Thereafter, Mr Lawrence had a CT scan which found multiple left sided acute rib fractures, which had caused a haemopneumothorax. The CT scan also identified a number of other old fractures, including fractures to the spine, ribs and sternum. Despite treatment, Mr Lawrence's condition did not improve and he died at St. Helier's Hospital on 5 January 2023. The court made a number of findings of fact with respect to the care provided by Eastcroft Nursing Home to Mr Lawrence:

	- There was a delay from 22 to 25 December 2022 in obtaining medical advice in relation to Mr Lawrence's unwitnessed fall and report of rib pain. - The nursing home records were deficient in their recording of Mr Lawrences presentation in the period following the fall. - The nursing home was unable to explain how Mr Lawrence had sustained the numerous old fractures which had remained undiagnosed until his admission to hospital on 25 December 2022. The court expressed concern that nursing home manager had, - Provided conflicting accounts with regards to the attempts that had been made to seek medical attention for Mr Lawrence in the period from 22 December 2022 onwards; - Maintained that Mr Lawrence had not sustained the acute rib fractures whilst he was in the nursing home, suggesting that they had occurred after he had been transferred to hospital.
6	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: - Mr Lawrence sustained significant unexplained injuries whilst he was a resident at Eastcroft Nursing Home; - Nursing Home records were deficient in their recording of key events following his unwitnessed fall on 21 December 2022; - There was a delay in seeking medical advice following the unwitnessed fall on 21 December 2022; - The Nursing Home Manager providing conflicting evidence about efforts to obtain medical advice and did not accept that the acute fractures leading to Mr Lawrence's death occurred whilst he was at the nursing home. - In view of all of the above, the Coroner is concerned that there is an ongoing risk to current residents.

7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Lawrence's family 3. The Longcroft Clinic, Banstead 4. Care Quality Commission 5. Adult Social Care Team, Surrey County Council (Banstead)
10	**Signed:** **ANNA CRAWFORD** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 6 August 2025**