	Report to Prevent Future Deaths **Regulation 28 of** **The Coroners (Investigations) Regulations 2013** **June TURNER (died 28.09.25)**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
2	**DATE OF REPORT** 8 July 2026
3	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
4	**THIS REPORT IS BEING SENT TO:** 1. The Chief Medical Officer Department of Health and Social Care 2. The President Resuscitation Council UK You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 September 2026. I, the coroner, may extend the period if an appropriate application is made.
5	**YOUR RESPONSE**

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe that you have the power to take such action.
7	**INVESTIGATION AND INQUEST** On 3 October 2025, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of June Turner, aged 77 years. I concluded the inquest on 7 May 2026. I apologise to you and to Ms Turner's family for the delay in making this report. I recorded the medical cause of death as: 1a hypoxic encephalopathy 1b anaphylaxis 1c injection allergy June Turner died from anaphylaxis caused by a steroid injection administered to her shoulder at her general practitioner surgery.
8	**CIRCUMSTANCES OF DEATH**

	Ms Turner had the injection at 11.42am on 12 September 2025, returned to the surgery complaining of shortness of breath at 11.52am, was seen by a doctor at 11.56am and became peri arrest at 11.57am, when an ambulance was called. She died in hospital 16 days later.
9	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: My understanding is that there is Department of Health guidance regarding the risk of severe life threatening reactions after immunisation, but no guidance regarding the risk following steroid injections. This seems an omission.
10	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every interested person who in my opinion should receive it. I may also send a copy of the report to any other person who I believe may find it useful or of interest. I have sent the report to: • the family of June Turner • the Lonsdale Medical Centre. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 5 above for additional information relating to the publication of reports and responses.
	SIGNATURE *ME Hassell*