



DR SHIRLEY RADCLIFFE  
HIS MAJESTY'S CORONER  
EAST LONDON

124 Queens Road Walthamstow, E17 8QP

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

	<b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b>  <b>THIS REPORT IS BEING SENT TO:</b>  [REDACTED] Secretary of State for the Home Department [REDACTED]
1	<b>CORONER</b>  I am Dr Shirley Radcliffe assistant coroner for the coroner area of East London
2	<b>CORONER'S LEGAL POWERS</b>  I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a>
3	<b>INVESTIGATION and INQUEST</b>  On 7 <sup>th</sup> May 2020 this Court commenced an investigation into the death of Georgia Jay Barter aged 32 years. The investigation concluded at the end of the inquest on 2 <sup>nd</sup> October 2025. The conclusion of the inquest was unlawful killing.  <b>Cause of death was:</b>  <b>1a multi organ failure</b> <b>1b liver toxicity</b> <b>1c paracetamol overdose</b>
4	<b>CIRCUMSTANCES OF THE DEATH</b>

	<p>Georgia Barter was in a long-term abusive relationship and during that time came to the attention of a number of police forces across southern England where there were allegations of domestic abuse.</p> <p>Following an assault by her partner on the 5<sup>th</sup> April 2020 she undertook an act of self-harm which resulted in her death on the 26<sup>th</sup> April 2020.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence revealed matters 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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>Georgia was a 32year old female who died as a result of domestic abuse and I recorded a conclusion of unlawful killing. She had come into contact with a number of police forces in southern England over the course of an abusive relationship.</p> <p>The concern I have is that there is difficulty for front line officers in police forces across the country to easily access the police national database to check on individuals who are suspected of domestic abuse. They are unable to easily identify if the individual has a history of reported domestic abuse in areas outside that forces' borders. This would allow police to be more proactive in their dealings with victims of domestic violence. I understand that some forces have implemented changes to facilitate better exchange of information and access to PND. However, I am concerned that there may be forces which continue to have limited access for front line police officers to the PND. This is on a background of rising numbers of domestic violence cases in this country. It accounts for 20% of all crime in Essex.</p> <p>I have been informed there is a plan to undertake a technological overhaul in the Home Office and I would consider this matter something that should be brought to your attention to prevent future deaths.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>27<sup>th</sup> November 2025</b>. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of Georgia Barter. [REDACTED] Commissioner of the Metropolis, I have also sent it to the local Director of Public Health who may find it useful or of interest.</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p>

	<p>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<b>[DATE] 2<sup>nd</sup> October 2025 [SIGNED BY CORONER]</b>