National Police Chiefs' Council
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HM Senior Coroner Dr Julian Morris
London Inner South
Southwark Coroners Court
1 Tennis Street
London
SE1 1YD

By email to John Thompson, Clerk to the Senior Coroner
(john.thompson@southwark.gov.uk)

27th July 2026

Dear Senior Coroner Morris,

I write on behalf of the National Police Chiefs Council (NPCC) in relation to paragraph 7, Schedule 5 of the Coroners and Justice Act 2009, and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, in relation to the prevention of future deaths report (dated 01.05.2026) sent via email for my attention as the NPCC Chair (dated 05.06.2026).

The notice sets out concerns that arose from the information received during the inquest into the death of Natasha Hill. I am very sorry to read of the circumstances of Natasha's death. My sympathies are with her family, friends and colleagues.

Matters of concern have been highlighted below:

- Anyone requiring / needing / suffering
  - Safeguarding
  - Domestic violence / abuse
  - Controlling/ coercive behaviour

  And incurring the consequential risks, as a teenager approaching 18 should be formally reviewed by an adult safeguarding team and the independent reviewing officer.

- Thought should be given to creating a young person's team covering the transition from under 18 (MACE) to adult safeguarding teams e.g. For the period 18-22.

- Thought should be given to the creation of a young person's protection by way of creation of an extension to the CAWN for the young person, against the adult creating that safeguarding risk e.g. young person's abuse warning notice.

- The creation of one single national policy for policing and child sexual exploitation following the groundwork laid down by Operation Hydrant and local Forces.

- Re safeguarding offender management, the use of VOO's and the creation of POETs/ DAPST and RMUs: Consideration should be given to the creation of one set of criteria with one name whose role it is to cover and create a central guidance.

- To consider the wider dissemination of existing local protocols nationally, for example the London Exploitation Protocol.

- The provision of guidance in respect of missing persons / runaways and the return to home interviews to assist the actions of the police and local councils.

In formulating this response, the NPCC Hydrant Programme, The Child Sexual Exploitation Taskforce, and National Centre for Violence Against Women & Girls and Public Protection have been extensively consulted.

Initially, I thought it would be beneficial to highlight the national Child Protection Framework at the time of Natasha's death, before covering more recent developments. During the relevant period, agencies were operating within the statutory framework established by *Working Together to Safeguard Children 2015*, which was subsequently revised in July 2018. These arrangements required effective multi-agency information sharing, coordinated safeguarding planning, child-centred decision making, and collaborative responses between children's social care, policing, health and education services where concerns about significant harm existed.

In parallel, the Department for Education's 2017 guidance on Child Sexual Exploitation reinforced that exploitation is a form of child sexual abuse and highlighted the need to recognise coercion, grooming, power imbalances and the reality that children may continue to associate with those who are exploiting them. The guidance also emphasised the importance of professional curiosity, offender disruption and coordinated multi-agency safeguarding responses.

The circumstances identified within the DHR demonstrate that many nationally recognised indicators of child sexual exploitation and abuse were present, including a substantial age disparity, repeated missing episodes, physical injuries, controlling behaviour, isolation from support networks and continued association with a known violent offender.

The review found that extensive safeguarding activity was undertaken and that agencies recognised both Natasha's vulnerability and the risk posed by the perpetrator. However, the evidence suggests that safeguarding arrangements were fragmented rather than integrated. While MACE, MARAC and MAPPA processes were all engaged, there was limited coordination between these forums and no single mechanism that retained oversight of the cumulative and escalating risk presented to Natasha. Viewed against the statutory expectations operating at the time, the principal issue therefore does not appear to be the absence of safeguarding structures, but rather the effectiveness with which those structures were connected. The review identifies missed opportunities to share intelligence, coordinate disruption activity, manage cumulative risk and maintain a unified safeguarding plan around both the victim and the perpetrator.

The findings also highlight challenges associated with cross-border safeguarding, as Natasha moved between local authority and policing areas. Existing guidance required cooperation between agencies where children crossed geographical boundaries, but the review found that these arrangements did not always operate effectively in practice.

Contextual Safeguarding

Although Contextual Safeguarding was not yet fully embedded within statutory guidance during much of the relevant period, it was already emerging as a significant framework for understanding adolescent risk. The 2018 revision of Working Together subsequently incorporated references to contextual safeguarding, recognising that harm may arise in relationships and environments beyond the family home.

Natasha's experience reflects many features now associated with extra-familial harm: exploitation by an older adult, abuse within an intimate relationship, repeated missing episodes linked to risk, movement across geographical locations and overlapping indicators of domestic abuse and child sexual exploitation. The review therefore provides a powerful example of the type of adolescent vulnerability that has subsequently informed developments in contextual safeguarding practice.

Transitional Safeguarding

Perhaps the most significant strategic learning from the review relates to transitional safeguarding. The DHR demonstrates that Natasha's vulnerability did not diminish when she turned 18. Her experiences of trauma, exploitation, coercive control and domestic abuse continued, yet key child-focused safeguarding mechanisms reduced or ceased at the point she became an adult. The Child Abduction Warning Notice expired, children's safeguarding arrangements diminished, and no equivalent safeguarding framework existed to provide continuity of oversight.

However, it is important to recognise that there was no established statutory framework for transitional safeguarding in 2017–2018. There was no national requirement for MACE arrangements to continue beyond 18, no expectation that children's safeguarding processes should automatically extend into adulthood, and no dedicated transitional safeguarding model for vulnerable young adults. During this period, transitional safeguarding was still an emerging concept rather than an embedded feature of policy and practice.

Reflection: If this happened today

If a case with the same horrific circumstances experienced by Natasha presented today, safeguarding partners would be expected to adopt a fundamentally different approach, recognising that vulnerability, exploitation and coercive control do not cease when a young person reaches adulthood. Although transitional safeguarding remains an area of practice development rather than a statutory framework, it is now widely recognised that safeguarding responses should be driven by vulnerability and risk, not solely by age.

From a strategic perspective, a young person experiencing child sexual exploitation, domestic abuse, trauma, repeated missing episodes and care experience would not be expected to simply "age out" of safeguarding arrangements at 18. Instead, there should be planned continuity of protection, with transition arrangements commencing well before adulthood and involving children's services, exploitation specialists, police, health, adult safeguarding and leaving care services. The focus should be on maintaining oversight of risk, preserving protective relationships and ensuring clear ownership of safeguarding concerns beyond the child's eighteenth birthday. However, whilst these arrangements are expected, there is limited direction within the current statutory guidance Working Together to Safeguard Children 2026. Transition is limited to "*Known transition points for the child should be*

planned for in advance. This includes where children are likely to transition between child and adult services". In short, there is no single statutory national transitional safeguarding framework for children who continue to experience exploitation into early adulthood.

Research in Practice, the Department of Health and Social Care, Social Care Institute for Excellence, ADASS (Directors of adult social services), Local Government Association and others have collectively advanced Transitional Safeguarding as an approach to safeguarding young people into adulthood. Importantly, these organisations describe Transitional Safeguarding as a whole-system approach rather than a specific service, panel or statutory process.

Current safeguarding practice would also place much greater emphasis on the management and disruption of perpetrators. Rather than focusing primarily on the behaviour of the victim, agencies would be expected to coordinate intelligence, utilise available disruption tactics, consider civil and criminal powers and ensure that offender management and safeguarding arrangements operate as part of a coherent strategy.

CSE Taskforce Response

Many of the themes identified in the DHR have subsequently informed national improvements in child exploitation policy and practice. In particular, there has been a sustained shift towards child-centred, trauma-informed and perpetrator-focused responses, stronger multi-agency coordination, and greater recognition of contextual safeguarding.

There exists the Tackling Child Exploitation Support Programme and Department for Education's Multi-Agency Practice Principles for responding to child exploitation and extra-familial risk and harm (2026) which promotes a shared partnership understanding of risk, improved information sharing, a welfare-led approach to children affected by exploitation, and recognition of the need for agencies to work across age-related boundaries when exploitation continues into adulthood.

Successive editions of Investigating Child Sexual Abuse and Exploitation (CSAE) Practice Advice (2020, 2023 and 2025) have strengthened national expectations around child-centred investigations, trauma-informed practice, contextual safeguarding, multi-agency working, victim engagement and perpetrator disruption. Collectively, these developments have reinforced that exploitation should be understood as abuse, that vulnerability may persist beyond childhood, and that safeguarding responses should be informed by cumulative risk rather than individual incidents in isolation.

Alongside this, national disruption guidance and learning produced through the CSE Taskforce, Hydrant Programme and partners has sought to address one of the key findings of the DHR: the need to move beyond managing victims alone and place greater emphasis on identifying, disrupting and managing perpetrators and exploitation networks. National learning has promoted disruption as a safeguarding intervention, strengthened multi-agency approaches to exploitation through MACE arrangements, and reinforced the importance of linking missing person activity, contextual safeguarding and perpetrator management to achieve earlier intervention and improved safeguarding outcomes. National self-assessment activity has also supported forces and safeguarding partners to evaluate their response to child sexual exploitation and identify areas for improvement.

Current national activity has also focused on strengthening the strategic management of exploitation and extra-familial harm through improved multi-agency disruption approaches. National disruption

conferences and learning events have promoted the use of disruption as a safeguarding intervention, encouraging agencies to move beyond reactive measures and develop coordinated, preventative responses to perpetrators and exploitation networks.

The CSE Taskforce and Hydrant Programme have supported forces through national self-assessment activity, enabling policing and safeguarding partners to evaluate their response to child sexual exploitation, identify areas for development and inform future national guidance. Learning from major inquiries, inspection findings and independent reviews has been incorporated into successive iterations of national practice advice and guidance products.

Alongside developments in contextual safeguarding, increasing attention has been given to Transitional Safeguarding, recognising that young people affected by exploitation, abuse and extra-familial harm often remain vulnerable beyond their eighteenth birthday. National partners across policing, safeguarding and health sectors continue to advance policy and practice in this area to support greater continuity of protection and risk management through the transition to adulthood.

National work has also highlighted the importance of effective Multi-Agency Child Exploitation (MACE) arrangements, stronger links between missing person activity and exploitation risk, and improved oversight of children who experience harm across geographical boundaries or are placed away from their home area. These developments reinforce the need for coordinated intelligence sharing, disruption activity and safeguarding responses that recognise cumulative vulnerability and exploitation risk. Emphasis has been placed on understanding repeated missing episodes as indicators of exploitation and harm. Work continues to ensure information gathered through missing person investigations informs both safeguarding planning and perpetrator disruption activity. National initiatives have also strengthened engagement with sectors such as hospitality, transport and accommodation providers in recognising and responding to indicators of child exploitation.

Taken together, these developments provide a more coherent framework for responding to the risks highlighted by the review, and the concerns raised, including exploitation, extra-familial harm, domestic abuse, cross-boundary offending and the continuing vulnerability of young people transitioning into adulthood. Whilst transitional safeguarding remains an area of developing practice rather than a statutory framework, there is now far greater recognition that safeguarding responses should be driven by vulnerability, harm and need, rather than ending at an arbitrary age threshold.

Child Abduction Warning Notice

Child Abduction Warning Notice (CAWN) is, by design, a child protection tool and ceases to apply once the young person reaches 18. The DHR demonstrates how this created a significant safeguarding gap: the risk posed by the perpetrator remained unchanged, but one of the key disruption mechanisms available to agencies fell away when Natasha became an adult.

The concern highlighted the absence of any equivalent protection despite ongoing exploitation, domestic abuse and coercive control risks. There is currently no direct equivalent of a CAWN for adults and no nationally adopted "young person's abuse warning notice" or similar mechanism. The legal framework remains largely divided between child safeguarding powers and adult safeguarding arrangements.

However, there is growing recognition within Transitional Safeguarding practice that care-experienced young adults and those affected by exploitation may continue to require targeted protection and disruption activity beyond their eighteenth birthday. This has contributed to wider discussions about how safeguarding systems, contextual disruption and civil powers can be adapted to better protect children and young people by being vulnerability led rather than age led.

Missing Persons and Transitional Safeguarding

Current policing guidance recognises that missing episodes are often indicators of vulnerability, exploitation and harm rather than standalone incidents. Police are expected to view repeated missing episodes as part of a wider safeguarding picture, assess cumulative risk, share information with partners and consider the role of perpetrators and exploiters. Missing episodes should not be managed in isolation but used to build an understanding of escalating risk and vulnerability.

For children, Return Home Interviews (RHIs) are a key safeguarding intervention. They provide an opportunity to understand why a child went missing, whether exploitation or abuse has occurred, what support is required and what action should be taken to prevent further harm. The information gathered should inform safeguarding planning, disruption activity and multi-agency risk management.

From a transitional safeguarding perspective, Natasha's case highlights a continuing challenge. Whilst there are well-established statutory arrangements for children who go missing, there is no equivalent statutory Return Home Interview requirement or exploitation framework that automatically continues into adulthood. As recognised within transitional safeguarding guidance, abuse and exploitation frequently continue beyond 18 even though statutory safeguarding systems change significantly at that point.

The key strategic learning is that where a young person has a history of exploitation, repeated missing episodes, domestic abuse, grooming or coercive control, agencies should ensure that intelligence from missing episodes continues to inform safeguarding and disruption activity beyond the age of 18. Risk management should be driven by vulnerability and harm rather than chronological age, with continuity of oversight through multi-agency partnership arrangements, care leaver support and exploitation risk management.

We have taken an urgent review of the Child Abuse Authorised Professional Practice that is currently out for consultation through the College of Policing. There is much within the draft APP that aligns with transitional safeguarding principles, particularly its emphasis on vulnerability, exploitation, coercion and control, trauma informed practice, professional curiosity, information sharing and avoiding victim blaming. However a gap has been identified relating to transition to adulthood, and we have requested that additional wording is included. You can find the consultation here until 4th August 2026: Child abuse APP – have your say | College of Policing.

Whilst guidance and statutory arrangements exist to support transition into adult services, not all young people meet the high eligibility thresholds for adult social care. As a result, agencies must remain alert to young adults who continue to experience vulnerability, exploitation, trauma, or harm and ensure they are not viewed solely through a crime or incident-based lens. A holistic assessment of risk, need and lived experience remains essential.

I hope the information provided will go some way to address your concerns. Please do not hesitate to contact me if you require further action or information in relation to my response.

Yours sincerely,

CC Gavin Stephens QPM
Chair
National Police Chiefs' Council