	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**
1.	**CORONER** I am Dr Julian Morris, Senior, Coroner, for the coroner area of London Inner South.
2.	**DATE OF REPORT** 01.05.26
3.	**CORONER'S LEGAL POWERS** 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.
3.	**THIS REPORT IS BEING SENT TO** 1. Secretary of State for the Home Department 2. Chair of the National Police Chief's Council 3. Secretary of State for Education You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 23rd of June 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**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.

5.	**SUMMARY OF CORONER'S CONCERN** **See 9.** The concerns highlight gaps in safeguarding for vulnerable young people, particularly during the transition to adulthood. Key issues include the need for stronger transitional safeguarding arrangements (ages 18–22), improved protective measures for young people at risk from abusive adults, and greater national consistency in policing, child sexual exploitation policy, offender management, and responses to missing children. Overall, the emphasis is on clearer guidance, continuity of protection, and shared national standards.
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 each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 3.10.2022 the decision to resume an inquest into the death of Natasha Hill (aged 18) was made following her death on 15.4.2018 and the subsequent conviction of her killer. The investigation ended at the conclusion of the inquest on 2 February 2026. Medical cause of death: 1a Head Injury Conclusion of the jury as to the death: The conclusion was that Natasha Hill was unlawfully killed by her abuser while at his residence in South East London.
8.	**CIRCUMSTANCES OF DEATH** Natasha remained in care from a young age (as a looked after child) and then transitioned to being a former relevant child from the age of 18 until her death. In December 2016, having moved to semi-independent living she was struggling to cope; she self-harmed and misused alcohol and drugs. During this time she began to be groomed by an older man. In April 2017 she was set on a pathway for child sexual exploitation. A CAWN was issued against her abuser. She was assessed as at high risk. Over the following months Natasha went missing for periods of time, her abuser fell out of touch with his probation officer. She had signs of abuse across multiple police jurisdictions. Once she turned 18 (24.1.2018) the CAWN automatically lapsed and she was discharged from MACE but with no vulnerable adult action plan in place. Within a week of turning 18 she moved in with her abuser. Natasha had on-going, regular injuries; the level of violence increasing post Natasha turning 18, requiring hospital treatment. The police tried to locate her abuser. He could not be found. Natasha was pronounced dead at his home address in the early hours of 15.4.2018.

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:
	• Anyone requiring/ needing/suffering
	  ○ Safeguarding
	  ○ Domestic violence
	  ○ Controlling/ coercive behaviour
	And incurring the consequential risks, as a teenager approaching 18 should be formally reviewed by an adult safeguarding team ad 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.

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 also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Family/NOK 2. Counsel for Basildon Hospital – Mid and South Esses NHS Foundation Trust 3.NPS 4.Basildon Hospital 5. MET Police 6. Matthew Gold Solicitor for NOK 7. Essex Police 8. CRC 9. Essex County Council 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 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE **Dr Julian Morris Senior Coroner**