Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

Enfield Safeguarding Adults Board (ESAB) Safeguarding Adult Review (SAR) report in respect of Trey

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1. A Picture of Trey

This Safeguarding Adult Review (SAR) relates to a young adult, Trey, who died as the result of suicide in January 2025 aged 20 years.

Trey was a much-loved son and brother and his mother described how “his little brother really looked up to him”.

Trey lived with his mother and younger brother and had two older sisters. His father died in 2019, whilst Trey was in his teenage years.

Trey was of mixed heritage, his father being Nigerian/British and his mother Nigerian. He was born in UK and never had the opportunity to visit Nigeria.

Trey’s mother spoke about religion not being of particular importance to Trey.

Trey was described as “a sweet boy who would do anything for his brother”

Trey was diagnosed with autism at the age of 6 years, which presented him with a number of challenges, especially in terms of his exposure to new environments, building relationships and his perception of risk.

Trey’s mother described how during the time in primary and secondary schools Trey was “doing well” and received some “1:1 support to promote independence”.

Upon completing his GCSEs without achieving the necessary grade in English, Trey was unable to progress to the school's sixth form. He was subsequently accepted into a local college; Trey, at the time of his death, was enrolled at the same local college.

Trey’s mother described how, at the point Trey transferred from school to college, his situation and presentation began to decline.

“All fell down”

“He lost all his friends and didn’t know how to make new friends again”

Trey was very sporty and loved football, he supported Arsenal and streamed all their matches. Because his mother couldn’t afford to pay for him to join a club, he changed his sport activity to athletics.

In 2019 Trey experienced the death of his father.

He would often go running in the middle of the night; although the exposure to potential risks of this activity worried his mother, Trey did not share her concerns.

His mother spoke about times when “He just couldn’t be reached, despite having so much potential”.

He had the ambition to go to university and his mother described how “he had everything there” but just needed someone as he “didn’t have anyone around him, encouraging him in what he wanted to do”

2. Summary of circumstances leading to the review

Trey, a 20-year-old male, came to the attention of various services after his college raised concerns regarding his online activities, which included participation in Incel and Black Pill discussions and the expression of suicidal ideation

In January 2025, following a disagreement between Trey and his mother, Trey left the family home. When Trey failed to return, he was reported missing. He was initially observed on CCTV entering the River Thames and a body was later found and identified as that of Trey.

Following Trey's death, a Safeguarding Adults Review (SAR) referral was submitted, due to concerns about agency responses as it was believed there was an opportunity for learning from Trey's death across the multiagency system.

The referral was initially discussed at an Enfield Safeguarding Adults Board (ESAB) SAR referral meeting on 28 January 2025 and there was agreement that further information would be sought. It was agreed that the SAR would not progress until formal processes within the Police force had concluded. The case was subsequently discussed at a meeting on 6th October 2025, when a recommendation was made to commission a statutory, discretionary SAR, under section 44 (4) of the Care Act (2014).

The Independent Chair of the Enfield Safeguarding Adult Board(ESAB) agreed with the recommendation and approved the commissioning of a SAR.

The purpose of a SAR is to:

"Promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring."

Independent Reviewer

Dr Amanda Boodhoo authored this review and was selected by ESAB as suitably qualified and experienced. Dr Boodhoo is an experienced health and safeguarding professional and holds a PhD, having completed research which focused on collaborative working within safeguarding practice, and has worked within a multi-agency environment for over thirty years. She is independent from all agencies involved in this review.

3.The methodology used and contributing Agencies

ESAB agreed that the SAR would cover the period from January 2024 to January 2025, the year preceding Trey's death.

The review was conducted using a blended approach, informed by the SAR In Rapid Time model (SARiRT) principles.

The aims of the (SARiRT) approach are:

- To allow learning to be turned around swiftly
- To place limited demand on participants' time
- To produces practical learning, Illuminating barriers and enablers to timely, effective, personalised safeguarding
- To support the identification of social and organisational factors that make it harder or easier to do a good job?

The methodology included:

- Analysis of agency chronologies and reports
- Engagement with family members
- Conversations with individual practitioners/managers/experts identified as necessary from initial analysis of agency information
- Review of relevant policies, processes, SARs and research both local and national and triangulate to develop an initial appraisal of practice
- Produce an Early Analysis Report and timeline
- A structured multiagency workshop with practitioners

3.1 Agencies who contributed to the review:

Agency
The GP (General Practitioner)
LAS (London Ambulance Service)
The Police
London Borough of Enfield (LBE) Adult Social Care
LBE Children's Services
LBE Prevent Lead
North Middlesex University Hospital, *now merged with Royal Free London NHS Foundation Trust
North London Foundation Mental Health Trust
Southgate College
One to One

3.2 Panel members:

Agency	Role of panel member
AJB Care and Safeguarding Ltd	Independent Author
London Borough of Enfield (LBE)	Head of Safeguarding Adults & Quality Assurance
LBE	Team Manager, Strategic Safeguarding
NHS Integrated Care Board (ICB)	Safeguarding Adult Lead
North London Foundation Mental Health Trust	Named Professional for Adult Safeguarding,
North Middlesex Hospital, Royal Free London NHS Foundation Trust	Head of Safeguarding
London Ambulance Service	Social Worker and Safeguarding Specialist
Police (Enfield & Haringey)	DCI, Public Protection
LBE	Operational Support Officer
LBE	Public Health Professional

4. Family Involvement

At the outset of the review, careful consideration was given to both the timing and the most effective method for engaging Trey's family. It was decided to postpone initial contact to avoid dates that might hold particular significance for the family. As the family liaison officer remained the primary point of communication between Trey's family and the police team, after discussion, it was agreed that they would make the first contact to inform them of the ESAB's decision to commission the SAR, explain its purpose and approach, and request their consent to be approached by the independent author. Upon receiving agreement from Trey's mother, the independent author subsequently established contact with her.

Trey's mother indicated that she welcomed the fact the review was taking place and was willing to share her experiences.

The author wishes to acknowledge Trey's mother for her valuable contributions, which have enhanced the depth and quality of the information provided in this report. Insights shared by Trey's mother are integrated throughout this report.

4.1 Equality, Diversity and inclusion:

In order to attempt an understanding of the world through Trey's eyes, the panel first considered Trey's protected characteristics, as set out in the Equalities Act 2010.

Consideration was given to how Trey's experiences as a young male of mixed heritage, with a diagnosis of autism and presenting mental health challenges may have influenced both his worldview and how he was perceived by others.

5. The Key areas as the focus of the SAR

The author was requested, by ESAB to concentrate on six principal areas during the course of this review.

- To consider the extent to which professionals understood and responded to Trey, to ensure he received appropriate care and support up to the time of his death in response to areas of vulnerability. Including his diagnosis of autism
- To review the effectiveness of multi-agency communications and information sharing across the agencies involved in his care.
- To evaluate the approaches and responses of professionals when interacting with individuals exposed to potentially harmful online content.
- To assess whether the responses of professionals and services to Trey's expressions of suicidal ideation were personalised, trauma-informed, and aligned with best practice standards.
- To assess the extent to which Trey's voice, as a young adult, was acknowledged and addressed by professionals when he sought their support.
- To identify areas of best practice, including the way agencies worked together

6. Significant episodes in the life of Trey

Given the review's focus on the period from January 2024 to January 2025—the year preceding Trey's death—the reviewer has elected to provide a summary of significant agency contacts through two main practice episodes. The first covers key events and interactions occurring outside the specified timeframe that provide relevant context, while the second details the principal information within the defined period.

Significant episode 1: Period prior to January 2024

2004: Trey was born

2009 onwards: Trey attended school and is described by his mother as "doing well"

2010: Trey received a formal diagnosis of ASD (Autism Spectrum Disorder) following assessment by the community paediatric service.

2010 to 2022: Trey was reported to be a healthy child, remaining generally well, experiencing only minor health ailments.

2018 to 2021: the family were open to Children's social care. Concerns include the parent's experiencing challenges with their own mental health and financial pressures resulting in insufficient food in the house. Food vouchers were provided and mental health services offered to the parents.

2019: Trey experienced the death of his father.

2021: Trey left school to start college in September 2021 where he commences a level 2 course in sports and an English GCSE course. In transferring from school to college, there was a self-declaration of mild autism. The college were not aware that Trey had experienced the death of his father.

In October 2021, the college requested information from Trey's school. The school only shared exam access arrangements and no information was provided to confirm the diagnosis of autism.

In February 2022, there was an incident where Trey was noted to have cheated in an exam. The meeting to discuss this had to be postponed to ensure his mother was in attendance and did not take place until March 2022. This period onwards saw a decline in his college attendance. The delay in him knowing the outcome of the meeting would have resulted in some feelings of anxiety. At the meeting it was discussed how Trey would have benefitted from an Education, Health and Care Plan (EHCP). Following this meeting, the college requested an assessment from an education psychologist.

In April 2023, Trey was taken to North Middlesex hospital by ambulance from college after disclosing suicidal thoughts, bereavement, and gambling losses. Trey reported he had been experiencing suicidal thoughts since December 2022 but had not shared his thoughts, he stated he "did not have an active plan". Trey had been searching the web for suicide techniques which were flagged to the College Safeguarding Officer. It is further documented that Trey was autistic. Trey was given the mental health crisis telephone number and advised to self-refer to IAPT.

In May 2023, the college staff had frequent "check ins" with Trey and referred him to the college counsellor.

In September 2023, the GP sent a text to Trey asking him to attend for a mental health review in view of the April hospital attendance. The review was scheduled for November 2023. There was a delay in the GP receiving the letter detailing the April hospital attendance. The letter arrived late July 2023 and, although letters are coded immediately, GP reviews take 6-8 weeks (unless the letter is marked urgent or 2 week wait etc). Reminder texts were sent to encourage attendance.

In November 2023 at the scheduled GP appointment, Trey stated his mood was better, he was starting a new job in retail, reported his family to be supportive and

that he had had some counselling in the summer and didn't want any more. The GP noted no safeguarding concerns or mental health issues.

In November 2023 and December 2023, Trey had an assessment undertaken by the education psychologist. In contrast to the picture presented in the consultation with the GP, Trey reported low mood, stating he was struggling with learning and was frequently distracted by his mobile phone. He was wanting to develop friendships.

Significant episode 2: Period January 2024 to the time of Trey's death in January 2025

In February 2024, Trey attended a review meeting with the educational psychologist, and the college received the psychologist's report and learning support plan.

At that stage, the following concerns were identified:

- There were emerging concerns about his behaviour in the classroom.
- Discussions indicated that he was struggling to make friends and was displaying behaviour aimed at trying to fit in.
- He was also finding his college work difficult.

In March 2024, Trey was searching for suicide content online. The college met with him and explored this in depth and (with his consent) contacted Trey's mother, who confirmed if she was worried she would dial 999.

In April 2024 the college closely monitored Trey's online activity. There was another suicide alert flagged up from his online activity.

In May 2024 there was an escalation in Trey's online searching of suicide, resulting in the college making a safeguarding referral to adult social care (ASC). Concerns about his online activities related to suicide, Bitchute (a far-right video hosting site) and antisemitism sites. The referral stated that his mother was aware and supportive of the safeguarding referral and this searching is happening on a regular basis. Trey had said (to staff at the college) that he is just curious. At this stage his mother had made a GP appointment for June.

Following the referral the college followed up with a telephone call to Enfield Multi-Agency Safeguarding Hub (MASH) Operational Support emailing screenshots of a Reddit post for a group around suicide where Trey had been noted to speak about just wanting to sleep all the time and engage in escapism like video gaming. Staff from the college confirmed they were speaking to Trey each time and their belief was that it was getting too much for his mother. The college provided the telephone number of Trey's mother's.

In June 2024 a staff member from the MASH Team undertook a visit to Trey in the family home. Trey was spoken to in a separate room to his mother. Trey talked of his curiosity about the afterlife and spirituality and mentioned having online friends through gaming. Trey had reassured staff that he had no immediate plans to harm himself. He said he did have friends to talk about things with – though he corrected that these were online friends he played games with. The member of staff asked what they talked about and Trey said US politics and current events.

He said that he had no active plan to harm himself and, if he was struggling, he would talk to a teacher. He talked about a previous talk he had with a psychiatrist who explored the same questions and hadn't been concerned.

Trey's mother raised that Trey had 'mild' autism and therefore approached things differently. She said that he was a loner but attributed this to his autism. She said that she had taken him to the GP recently who hadn't felt a Mental Health referral was necessary. She described him as 'just curious' and doing searches on the afterlife etc. Trey had described himself as interested in spirituality.

Three days after the home visit, an email was sent to the referrer summarising the visit and Trey's views that he didn't want intervention and had no intention of harming himself. Advice was given to contact MASH again if there were further concerns and also to refer to Prevent.

In June 2024 Trey made an appointment to attend the GP with his mother after the college had raised their concerns. At the appointment Trey admitted to looking at Reddit and other websites about suicide. It was noted that he had no friends or social support. The GP made a referral to mental health services. During the GP appointment the GP spoke to the college staff.

In late June 2024, the Mental Health Single Point of Access screened Trey's GP referral, which included comprehensive background information.

July 2024 Trey was seen by the mental health team with his mother at a single point of access crisis centre. Records indicate his presentation did not give cause for concern.

When he was asked what he was expecting from this assessment he responded "nothing. The GP asked me to see you, and I am here". He was offered a range of leaflets and information on self-help websites. He was informed that he would be offered 2 follow-on phone calls and would then be discharged back to the GP.

In September and October 2024 Trey's college attendance was only 59%.

In late October 2024 Trey was referred to Prevent by the College due to concerns about suicidal ideations and potential danger to himself and others. Concerns leading to the referral included the college becoming aware of Trey searching online areas around suicide, Black pill and 'Looksmaxxing'. There were concerns that Trey was aligning his thoughts to the INCEL movement.

In late November 2024, Trey was reviewed by the Channel Panel. While Trey was accepted onto Channel, the panel noted concerns regarding his broader vulnerability. At the request of the Channel Panel, an Intervention Provider (IP) was identified and appointed to mentor Trey and discuss suicide ideology. A MASH professional was in attendance at the meeting.

In November 2024 the mental health practitioner attempted one of the agreed calls to Trey's phone which was answered by his mother. She stated Trey was doing well

and she had no concerns about his wellbeing. Information was given regarding contacts for any emergency and the plan was to close the case.

In December 2024, Trey was reviewed at the Channel panel. College had reported that his attendance was low. The Intervention Provider (IP) had met with him as requested. The police officer provided an update, noting that the IP meeting primarily served as an introduction and that "Trey engaged well during the first session, with the IP anticipating further progress." An additional session had been scheduled for January 2025. An action from the panel was to contact his GP to seek further mental health support.

In December 2024 the mental health practitioner made the second planned follow up call to Trey and again his mother answered. As Trey was on holiday from college the practitioner agreed to send leaflets outlining activities available to him.

In early January 2025 the mental health professional sent a letter to the GP to advise Trey would be closed to their services.

In early January 2025, Trey was reported missing. An urgent Channel Panel meeting was convened, during which all partners were notified and contact information for Trey was shared. Shortly thereafter, CCTV footage recorded Trey entering the Thames, and he was subsequently located in the river, deceased.

7. Thematic analysis of Trey's story – Summary and Findings

The findings are presented below aligned to the six key areas of focus.

Theme 1 *The extent to which professionals understood and responded to Trey to ensure he received appropriate care and support up to the time of his death in response to areas of vulnerability. Including his diagnosis of autism*

An analysis of the findings

In considering Trey's presentation and the information shared by Trey's mother, Trey appeared to feel supported throughout his childhood, receiving some one-to-one support in school and experiencing good health.

Accessing support can be challenging for parents and carers of children on the autism spectrum. In England, one important mechanism for securing appropriate support is the Education, Health and Care Plan (EHCP).

Although Trey had a diagnosis of autism, as part of this review, it was confirmed that he did not have a recent or historic EHCP. There is record of a reference to a school referral made in July 2014 but the needs listed in the application did not meet the legal assessment criteria.

The period surrounding 2019 was notable due to the death of Trey's father. The extent to which professionals acknowledged and responded to this event remains unclear. This is particularly relevant in light of Trey's neurodiversity. Individuals on the autism spectrum may respond to bereavement in unique ways, such as experiencing delayed or intensified emotions and expressing grief through non-

traditional behaviours, including focusing on practical matters, displaying limited immediate effect, or seeking detailed information. Effective coping strategies often include, maintaining established routines, implementing sensory regulation methods, and utilising visual aids or personal interests to support the grieving process. Considering that individuals with autism spectrum disorder frequently encounter challenges in expressing emotions, it is possible that professionals involved with the family may not have assessed Trey's response to his father's death within the context of his diagnosis.

There is no evidence that Trey was offered appropriate services to explore and support him address his feelings.

In triangulating the agencies' information, it is apparent that Trey's father was registered with a different GP to Trey and his mother, resulting in Trey's GP having no knowledge at that time of the death of Trey's father and the circumstances leading to his death.

Sharing information and data across departments and teams is critical for accurately assessing and addressing the needs of children and young people with additional requirements. Identifying specific needs, particularly during periods of significant transition when educational settings may lack familiarity with the individual, is essential for eliminating gaps in knowledge that any single service or area may possess. This collaborative approach facilitates a comprehensive understanding of how best to support children in meeting their unique needs.

At the point Trey moved from school to college although Trey had been diagnosed with autism at an early age, it is unclear as to why the college were not made aware by the school. Additionally, the college was not aware Trey had experienced the death of his father. This is a significant concern as it clearly impacted upon the ability of the college to fully understand Trey's presentation, including isolation and in turn, respond to his needs

In hearing the voice of Trey's mother, her view of Trey's lived experience aligned to the reports of professionals, where Trey presented as a young adult who had not been able to make friends during his college years, resulting in significant isolation.

In April 2023, Trey attended the hospital with notable concerns relating to his mental health and online activity that may be considered potentially harmful. He was given the contact information for the mental health crisis helpline and advised to self-refer to Improving Access to Psychological Therapies (IAPT) services. Given Trey's history of trauma and significant life events, ongoing bereavement following the death of his father, social isolation stemming from the transition between school and college, and the possible influence of autism on his capacity to articulate emotions, there is reason to believe that a recommendation to self-refer may have limited effectiveness.

As part of this review the author met with professionals from a local charity, One-to-One. The charity offers a range of services on a one to one and group basis for those adults with learning difficulties and autism. Services are offered by individuals

with lived experience, to support the individual to access interests and services to reduce isolation and support their wellbeing.

It should be noted that despite this service offering the potential for Trey to be supported to engage in his preferred activities such as football, he was not referred to the service. This was a missed opportunity.

Additionally in talking to Trey's mother she was clearly struggling to strike a balance between protecting her son and allowing him the freedom that other young adults, would be expected to have. This clearly was a cause of friction between Trey and his mother.

Trey's mother's experience illustrates the challenge faced by many parents of young adults: balancing a child's growing independence with concerns that they may not recognise potential risks.

One-to-One is exploring possibilities to expand its services to include support for parents. Such an initiative could, going forward, assist individuals facing challenges similar to those experienced by Trey's mother by guiding them through these difficulties.

What can we learn from local and national research?

Research on loneliness and mental health: There is clear evidence to help professionals understand the significance of loneliness in adolescence. Research suggests that lonely adolescents may be more likely to use social media as a way of coping with limited social contact in everyday life (Jamil et al 2022).

Across Trey's life, several significant events were associated with periods of loneliness or a decline in mental health. Research also indicates that adverse childhood and adolescent experiences—such as abuse, neglect, bereavement, or living with parental mental health or substance misuse difficulties—can have lasting effects on mental health in later life (Department for Culture, Media and Sport and Department for Digital, Culture, Media & Sport 2022).

Theme 2 *The effectiveness of multi-agency communications and information sharing*

An analysis of the findings

In considering the effectiveness of the professionals working together as a system, and sharing information to ensure Trey was appropriately safeguarded, the view of Trey's mother is that this worked well until he started college.

This is a significant time as children are transitioning to adulthood.

Although Trey had a diagnosis of autism, which was known to services who were involved with the family whilst Trey was a child, this information was not shared with all appropriate services, including the college and adult social care as he transitioned to adulthood.

Additionally, key professionals including the college and GP were not aware that Trey had experienced the death of his father, an important male figure in his life.

In considering how the system worked together to respond to Trey's needs there are examples of comprehensive information sharing.

The college in making an adult safeguarding referral, provided comprehensive information on what he was accessing online, following up on the referral with updates on escalating concerns, including screenshots.

When the GP referred Trey to mental health services information shared was comprehensive, including his experience of bereavement, his diagnosis of autism, the range of sites he was accessing online and his online gambling.

There were a number of occasions where fragmented information or failure to share information, impacted on the care Trey received.

The GP records raise concerns that mental health services did not update the GP about Trey's care in a timely way, with key information not received until after his death.

Additionally, Adult Social Care were not aware of the referrals made to mental health services by the GP in June 2024.

Given the range of risks Trey presented with, these gaps in information across the system did not support a joined-up safeguarding response.

Some referrals did not set out concerns with sufficient clarity to ensure that Trey's needs were fully understood and that the response was appropriate to his presentation.

This may reflect a lack of clarity about the appropriate pathways for someone with Trey's combination of needs. These pathways are considered further in Theme 4.

What can we learn from local and national research?

A consistent learning theme: Communication and information sharing are recurring issues in safeguarding reviews.

Changes in service provision during transition increase the risk that professionals will not all have the information they need.

National work on service transition and transitional safeguarding is seeking to reduce the risk of young people approaching adulthood falling through gaps between services.

Theme 3 *Approaches and responses of professionals when interacting with individuals exposed to potentially harmful online content.*

An analysis of the findings

Within this review there is a picture of both professionals and Trey's mother becoming concerned regarding the time Trey was spending and the content he was accessing online.

The college utilised effective systems of monitoring Trey's online activity in line with the six core standards all schools and colleges are expected to be working towards

and meet by 2030 (DfE 2022 updated 2026). Effective monitoring of online activity presents significant human resource and financial challenges. At the college attended by Trey, with approximately thirteen thousand students, safeguarding oversight of online monitoring is the responsibility of a single professional.

The college conducted an exercise to review its current systems and the costs to the organisation are detailed in Table 1 below.

Table 1

Product	One-off cost (ex VAT)	Year 1 cost (ex VAT)	Year 1 cost (inc VAT)	3-year total (ex VAT)	3-year total (inc VAT)
StudentKeeper	£6,000	£25,200	£30,240	£81,600	**£97,920**
Smoothwall	£14,500	£27,780	£33,336	£97,840	**£117,408**
NetSupport (no image analysis)	£0	£26,250	£31,500	£78,750	**£94,500**
NetSupport (with image analysis)	£0	£49,000	£58,800	£147,000	**£176,400**

These costs are high and may present potential barriers to upholding the highest level of online safety in schools/colleges. A national approach should be considered to prevent inequity between different educations settings.

In May 2024, when the college attended by Trey made a safeguarding referral due to concerns about his online activity, it is positive that they recognised and raised their concerns.

However, the online world is a rapidly changing one and, in talking to a range of professionals and Trey's mother, there is an evident lack of awareness about sites including Black Pill ideology and Bitchute and the level of risk that they may represent.

Trey's mother described Trey "looking at things I didn't know anything about".

The visit that followed by the MASH professional resulted in the professional speaking to both Trey and his mother. However, in analysing their responses to the questions asked as part of the assessment, there was insufficient triangulation of the responses against the evidence in the screenshot provided by the referrer, to accurately assess risk.

Trey and his mother provided the professional with a reassuring response, and it may be that there was insufficient insight into the significance and potential impact of the material being accessed.

It is not clear to what extent the context of Trey's experience of a young male living with autism was taken account of in reaching the conclusion re risk.

What can we learn from local and national research?

Online risks incorporate a heterogeneous set of intended and unintended experiences which increase the likelihood of harm to an individual. These include contact risks (where the individual participates in risky peer or personal communication), content risks (where the individual is a recipient of unwelcome or inappropriate mass communication) and conduct risks (where the individual acts themselves to contribute to the risky contact or content) (Macmillan et al 2022).

The Government have had a focus on the need for ongoing review of Prevent, the thresholds for Channel, and considering alternative intervention opportunities.

Recent reviews, including the Southport Prevent Learning Review, have highlighted the absence of a systematic process to confirm that onward referrals have been made, received by partner agencies, or followed up appropriately. The Home Office is considering pilot programs in various regions to address this gap and explore methods of managing cases below the counter terrorism threshold where other, often complex, needs are identified.

Theme 4 *To what extent the responses of professionals and services to Trey's expressions of suicidal ideation were personalised, trauma-informed, and aligned with best practice standards*

An analysis of the findings

Trey died in January 2025 as the result of suicide. In April 2023, Trey had been taken to North Middlesex hospital by ambulance from the college he attended, after disclosing suicidal thoughts, bereavement, and gambling losses. At this point Trey reported to hospital professionals that he had been experiencing suicidal thoughts since December 2022. The period between professionals becoming aware of those thoughts and the date of his death, offered a reachable period to explore Trey's lived experience and explore appropriate responses.

Trey's mother recalled the period leading up to Trey's death "He told me he was going to kill himself and he packed his bag and walked out, but because he had packed his bag and walked out before I thought he would come home"

"if he had had a system in place to help him he would have achieved a lot".

Discussions with professionals suggest that they recognised the need for this kind of support. However, several did not have all the information required to respond fully to Trey's needs.

- Some were unaware of his autism diagnosis.
- Some did not know that his father had died.
- Some did not have a full understanding of the significance of the material he was accessing online.

In response, it is essential that referring professionals are clear as to whether the referral pathway involves a single process or necessitates concurrent pathways to ensure comprehensive assessment and intervention that effectively leverages relevant expertise.

In reading the agency reports and hearing the voice of practitioners who were responding to Treys range of presenting needs, there is a need to clarify where and via which pathway/s referrals should be raised.

Professionals often raised concerns by making referrals through pathways, based on past experience of a helpful response. This approach is understandable, given the stress professionals hold when responding to someone expressing suicide ideation. However, in doing this, it may not result in all of the presenting needs being addressed.

In exploring this as part of this review it is clear that the role of Prevent would not typically handle cases purely about suicidal thoughts but would consider involvement if there were concerns about extremist content.

Some professionals had expressed the point that they experience high numbers of individuals, for whom it is hard to find the right support, alongside previous experience of referrals to mental health services being declined, despite the skill set of those workers being seen as important when the presentation of an individual like Trey is multidimensional.

In considering the response to Trey's suicidal ideation, it is unclear whether safeguarding professionals from the Multi-Agency Safeguarding Hub (MASH) were the appropriate initial point of contact to undertake the home visit, given that these staff may not have had the degree of training that those working in mental health roles will have received. Although it needs to be acknowledged that their intention in providing a timely response should be commended.

Given the complexity of Trey's situation—including bereavement, suicidal ideation, access to potentially harmful materials, mental health challenges and neurodiversity—a clear pathway, underpinned by skilled professional enquiry, adopting a trauma informed approach is required to ensure comprehensive assessment and intervention that utilises the relevant expertise.

What can we learn from local and national research?

Trey's isolation and lack of friends or support networks may have led to experiences of loneliness, which in and of itself can significantly increase risks for depression and anxiety. In turn, people with either chronic illnesses or disabilities are at higher risk of chronic loneliness.

In terms of the response to suicide, professionals shared that they were aware of incidents where children or care leavers had died as the result of suspected suicide.

In undertaking this review professionals shared details of work currently being led by LBE's Public Health team in relation to the Suicide Prevention Strategy and the potential for improving and managing referrals more effectively.

In addition, the London Shares Network was examining a thematic SAR focusing on the mental health support provided to asylum seekers.

There is an opportunity for learning from Trey's experience to inform the work currently under way, supporting the continued development of strategy and associated pathways and clarifying how these interface with other pathways, including Prevent and safeguarding.

Theme 5 *The extent to which Trey's voice, as a young adult, was acknowledged and addressed by professionals when he sought their support.*

An analysis of the findings

In considering the chronology, summarised as two key practice episodes, the most significant feature is the lack of recording that gives insight or any direct sense of Trey, his day to day life, relationships with his parents, sibling and extended family and the wider world and the influence his experience as a young male of mixed heritage may have on his decision making and response to professionals.

Trey exhibited a multifaceted array of presenting concerns, although there were instances when both he and his mother offered explanations that appeared to minimise the perceived level of risk. In considering all information available for the review there was insufficient evidence as to what consideration professionals gave as to how Trey's mixed heritage and Nigerian background might have influenced their interaction with services. There was also a lack of clarity about how cultural factors and neurodiversity intersected with safeguarding needs.

Integrating cultural competencies is a crucial factor in achieving the principles of Making Safeguarding Personal (MSP), ensuring that the adult's voice is acknowledged, their needs are understood within context, and support is appropriately tailored. The MSP approach should be applied to all safeguarding practices. Its core principle is to empower individuals, offering them choices and enabling control over how they wish to live their lives. MSP advocates for meaningful discussions on how safeguarding responses can be delivered in ways that enhance participation, choice, and autonomy, thereby improving quality of life, well-being, and safety. This approach recognises people as the authorities of their own experiences and emphasises collaborative efforts to define desired outcomes. In implementing this approach, it is essential to appreciate the unique perspectives and needs of specific groups, such as young males, such as Trey, of mixed heritage.

Trey was seen on a number of occasions with his mother present, both as an adult and during his transition to adulthood. As a matter of good practice, young people who are Gillick competent and adults with capacity should routinely be offered the opportunity to speak with professionals alone, even when parents are present. In Trey's case, repeated contact taking place primarily in his mother's presence may have limited professionals' ability to hear his voice directly and to develop a fuller understanding of his lived experience, wishes and level of risk.

It was reported that different services had Trey's mother's contact details rather than Trey's direct contact telephone number. This would have impacted upon Trey's voice being heard.

In engaging with professionals from the college, Trey attended, there was clear evidence that their contact with Trey's mother was consent based, acknowledging Treys rights as a young adult.

However, there were multiple instances where for other professionals, Trey's mother served as the primary point of contact rather than Trey himself. For example, when Trey reached out to the mental health crisis line, the service made two planned follow-up calls and only spoke to his mother, who reported that there were no concerns. Consequently, Trey's case was closed without any direct assessment of his current mental health status from his own perspective. It is unclear why the practitioner did not take further steps to rearrange contact so that Trey himself, as an adult, could be spoken to directly. Reliance on information provided by his mother limited the opportunity to hear Trey's current presentation, wishes and lived experience first-hand, and may have reduced the robustness of the assessment. This is particularly significant given the known concerns regarding his mental health, neurodiversity and vulnerability. The circumstances highlight the importance of services maintaining systems that routinely review and update contact arrangements when a young person reaches adulthood, so that the adult is recognised and approached as the primary point of contact unless there is a clear and justified reason otherwise.

The home visit by the MASH professional demonstrated some elements of appropriate practice, including seeing Trey separately from his mother. However, the assessment appears to have relied heavily on self-report and parental reassurance in circumstances where the presenting concerns warranted a more analytically robust exploration of risk. Trey was a young adult with neurodiversity, social isolation, exposure to potentially harmful online content, and a history of suicidal ideation. In that context, safeguarding practice required not only the gathering of information, but also professional curiosity, triangulation of available evidence, and careful consideration of how autism may have affected Trey's communication, insight and presentation of distress. While his mother's involvement was relevant, there is a risk that her interpretation of Trey's behaviour and online activity was given disproportionate weight. This may have reduced the extent to which Trey's own lived experience, understanding of risk, and potential vulnerability were fully explored. As a result, the assessment may not have sufficiently recognised the cumulative safeguarding significance of the known indicators of harm

What can we learn from local and national research?

Research on the voice of young adults highlights that engaging their perspectives is crucial for effective service development and delivery, fostering personal development, and reducing societal mistrust. Youth voice, or "experts by experience," drives authentic engagement and improves decision-making, though it faces challenges from tokenism and age-based power imbalances

Theme 6 *Identification of best practice, including the way agencies worked together*

An analysis of the findings

In undertaking this review it is important, that in addition to highlighting areas of potential learning, areas of good practice are highlighted. This allows professionals to consider the potential of mirroring that practice within their own service.

The comprehensive evidence observed during this review highlighted the willingness of various professionals and managers to engage in reflective practice and demonstrate openness to learning from Trey and his family's experience.

The college attended by Trey had robust systems in place to monitor students' engagement with the online world.

When Trey had GP appointments text reminders were sent. In considering Trey's experience of living with neuro diversity this is good practice.

Part of Trey's online activity resulted in him losing significant money through his engagement with gambling sites, adding to his stress. Between April 2021 and January 2023. Enfield professionals actively engaged in research undertaken to support those people working in services that help people with gambling problems.

The research considered the evidence underpinning potential questions, designed to see if a person might have problems gambling, alongside staff training to use the question with enquirers/service users and put people affected by gambling harms in touch with sources of help (Norrie et al 2025).

The Mental Health Trust who provided services for Trey have, during the review process, planned and hosted a conference, alongside the Department for Education, to raise awareness about different elements of online safety.

Presentations included:

- How to identify factors that increase vulnerability to online harms and exploitation
- The links between gaming and radicalisation
- Tech-enabled domestic abuse and stalking.
- The increased use of AI by perpetrators and vulnerable people

The audience was professionals working with either adults at risk or children, but did not include service users or carers.

In response to the death of Trey a number of single agency reviews to elicit learning at an early stage have taken place.

The local police conducted a review of their missing persons procedures; however, this process yielded fewer lessons for improvement.

A review was conducted by Mental Health Services following Trey's death by suicide, through which several areas for learning were identified.

Any learning and the response will be overseen by the individual agency.

What can we learn from local and national research?

Executive functioning and access to services: Research on communication with neurodivergent individuals suggests that, although findings on autism and executive functioning are mixed, self-reports from autistic people and their families indicate difficulties with organisation, memory and planning that can affect attendance at appointments (Kenny et al 2024). Text-message reminders and similar prompts can therefore play an important role in reducing missed appointments and supporting access to services.

8. Recommendations

The recommendations arising from this review are detailed below, with details of the theme with which they align.

	Recommendation	Themes that the recommendation emanates from
1	The ESAB should establish a stakeholder group to ensure that the key themes arising from Trey's death are shared in order to influence policy and practice at both local and national level. The group should focus on the following areas: **National policy and platform accountability** • Agree approaches for engaging with social media platforms, service providers and central government to share the learning from Trey's death as a neurodivergent young adult. • Use this learning to strengthen awareness of the need for increased safeguards and accountability in the online environment, including national oversight of online platforms and protections for vulnerable adults as well as children. **Online monitoring in education settings** • Agree communication with central government regarding the potential benefits of a centralised national online monitoring and filtering system operating across education settings in the UK. • This should support timely reporting, active oversight by trained moderators, and improved access to data about online activity in school and college	**Theme 3:** Approaches and responses of professionals when interacting with individuals exposed to potentially harmful online content.

	settings, particularly those regulated by Ofsted and the DfE. **Local awareness and learning** • Agree local approaches to raise awareness of the risks presented by the rapidly changing online world among carers, service users and professionals. • This work should include input from people with lived experience and relevant national experts.	
2	Consideration should be given to how the ongoing developments of the Enfield Suicide Prevention Strategy can ensure it aligns and enhances the clarity of referral pathways. This includes addressing the various existing referral processes and their intersections to ensure a coordinated response when individuals present with needs related to mental health, suicidal ideation, safeguarding, and concerns about potential radicalisation.	**Theme 4:** The responses of professionals and services to Trey's expressions of suicidal ideation were personalised, trauma-informed, and aligned with best practice standards
3	ESAB should seek assurance from its partner agencies that cultural competence is actively embedded in both policy and front-line practice	**Theme 5:** The extent to which Trey's voice, as a young adult, was acknowledged and addressed by professionals when he sought their support.
4	ESAB should seek assurance that professionals across partner agencies receive autism training and that partners working with neurodivergent individuals employ suitable methods of enquiry to understand and appropriately respond to the specific needs presented by those individuals. ESAB should assure themselves that • Partners can evidence their staff are accessing Autism training programs, such as the Oliver McGowan Mandatory training • Partners can evidence impact of the training by way of improved understanding, support, and care for autistic individuals. • Partner organisations working with neurodivergent individuals use appropriate enquiry methods, such as	**Theme 1:** The extent to which professionals understood and responded to Trey to ensure he received appropriate care and support up to the time of his death in response to areas of vulnerability. Including his diagnosis of autism

	person-centred interviews or validated assessment tools, to fully understand the presenting needs of those individuals. • Partners can evidence that staff are aware of the services available to support those living with autism and their carers, this includes charities such as "One to One,"	
5.	The ESAB should work with the Enfield Safeguarding Children Partnership (ESCP) to seek assurance that partner agencies have clear policies, procedures and staff training to support direct engagement with adults and young people in all cases involving safeguarding concerns associated with suicidal ideation, unless there is a clear and justifiable reason why this is not possible. This should include assurance that systems and practice support the adult or young person to be recognised as the primary point of contact, with their views, wishes and lived experience informing assessment, risk analysis and decision-making.	**Theme 4:** The responses of professionals and services to Trey's expressions of suicidal ideation were personalised, trauma-informed, and aligned with best practice standards

9. Closing Statement

The independent author wishes to formally acknowledge the substantial contributions made by Trey's family and by the many professionals and managers who participated in this review. Trey's death has had a profound impact on many people.

Summary of Trey's experience

Trey was a young adult living with autism whose childhood was shaped by significant challenges, including financial hardship and mental health difficulties among the adults in his life. He also experienced the death of his father during his formative years.

As he moved into college, Trey found it difficult to build social connections. Although college staff saw him as an important part of the community, Trey described feeling invisible. Over time, his mental health concerns increased, and he spent more time both at home and in college engaging online.

The online environment Trey was navigating was rapidly evolving and was not fully understood by some professionals or members of his family.

This review highlights the importance of professional practice that can identify interconnected needs and risks, while ensuring clear pathways and referral processes are in place to support an effective response.

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11. Glossary

Black Pill is the movements way of describing the world where it is futile to try and change the way things are set out for an individual as the system is pre-determined.

Bitchute is a video-sharing site, which claims it is committed to freedom of expression and is against censorship.

Incel. The incel movement is where (often) young men describing themselves as "involuntarily celibate" and can gather harmful ideas. There is often negative influence from other incel supporters with some encouraging each other to kill themselves.

Looksmaxxing is an online subculture, primarily among young men, focused on maximizing physical attractiveness through, at times, extreme measures to enhance features like the jawline, eyes, and skin. It ranges from "softmaxxing" (skincare, dieting, gym, grooming) to "hardmaxxing" (surgeries, filler, or dangerous "bone smashing" techniques) to achieve a "glowing up" transformation

Prevent is a UK government programme aimed at stopping people from becoming terrorists or supporting terrorism. Part of the CONTEST counter-terrorism strategy, it offers voluntary, multi-agency support to vulnerable individuals through the Channel programme to intervene early, manage risk, and prevent radicalisation, rather than criminalising them

Reddit is an American proprietary social news aggregation and forum social media platform. Registered users submit content to the site which are then voted up or down ("upvoted" or "downvoted") by other members. Posts are organized by subject into user-created boards called "subreddits