Mr Simon Burge
HM Assistant Coroner
for Hampshire, Portsmouth
and Southampton
Coroner's Office
Castle Hill
Winchester
Hampshire
SO23 8UL

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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8 June 2026

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Dear Mr Burge,

Re: Regulation 28 Report to Prevent Future Deaths – Sunny Elise Eymond who died on 27th May 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 6th May 2026 concerning the death of Sunny Elise Eymond on 27th May 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Sunny's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Sunny's care have been listened to and reflected upon.

Your Report raises the following concerns:

1. There is a lack of national guidance concerning the transfer of patients with both serious eating disorders and complex emotional needs from one trust to another. Your report notes there also ought to be national guidance addressing when bespoke services are required, and how patients with overlapping needs should be assessed and managed when single-diagnosis pathways are not appropriate.
2. There is a lack of a clear treatment pathway/protocol for such individuals.

NHS England expects to publish the Mental Health Personalised Care Framework shortly. The Mental Health Personalised Care Framework sets out the approach and related principles and actions for delivering personalised care for adults and older people with severe mental health problems. The framework includes a section on expectations for any transfer of care between services including the following:

- What works best for the person in terms of engagement and their preferences around care.
- Personal relapse indicators: how these manifest, what does and does not work for the person in preventing relapse at different stages of becoming unwell, what harms could occur when they relapse.
- How the person can rapidly regain access to higher intensity services when needed following a step down in care – including through self-directed

referral when appropriate. Access routes should reflect what is known about the person's illness and relapse indicators. Where significant time has passed or the presenting problems are different, it may be appropriate to include re-referral through primary care.

- Any current medication prescribed by the transferring team: indication, monitoring requirements, expected duration of treatment and arrangements that should be made if the person wishes their medication to be changed or reviewed.

In January 2026, NHS England published National Guidance for eating disorder services for children and young people. The guidance highlights that Children and Young People Eating Disorder Services (CEDS) are integral to the integrated care pathway. The guidance states it is important that all care pathways are locally co-produced with stakeholders, including Children and Young People and their families, and that they are also involved in care planning with other key stakeholders, as this ensures optimal pathway integration and delivery of evidence-based, outcomes-focused care.

In cases where Children and Young People present with a primary diagnosis of a mental health condition, and have co-occurring problems with eating, the care of that child or young person will typically be managed by Children and Young People Mental Health team with input and support provided by CEDS. In this instance, CEDS are expected to ensure effective support of the eating concerns whilst the Children and Young People Mental Health team address the primary diagnosis. This may include, but is not limited to, providing:

- Shared care in partnership with Children and Young People Mental Health team as the primary treating team
- Consultation and clinical supervision
- Training and supervising of the wider workforce

Generally, consideration should be given to prioritisation of interventions based on the level of risk. Where the impact of the eating disturbance is high, eating disorder treatment will usually be required initially, alongside support to avoid exacerbation of the co-occurring condition.

The guidance recognises that many young people may be in their first treatment episode when they reach 18 or transition to Community Adult Eating Disorder Services (CEDS-AEDS), therefore it is important for services to take an individualised, flexible approach to transition if treatment is incomplete. Some of the principles for managing transition are:

- Comprehensive and timely planning: multi-agency/disciplinary planning in a timely manner that allows treatment to be provided without delay. Clear planning will include arrangements such as transfer of clinical records, medication management, physical and psychological interventions and any other care needs.

- Clear protocols and pathways for patients transitioning. Children and Young People and their families, as well as clinicians and managers, should be consulted during the development and evolution of such protocols.
- An agreed and well-structured, patient-centred transition care plan, focused on the child or young person rather than on organisational considerations.
- Transition coordinators – often services appoint these roles to support the transition between Children and Young People and adult mental health services. These roles may involve the identification of a key worker from each service or a permanent joint post shared between services. The role of the transition coordinator is to guide and support young people and carers through the transition process and function as a point of contact.

In 2019 NHSE published guidance for commissioners and providers on Adult Eating Disorders. The guidance highlights the importance of joint working across services, it states that coordinated care and good communication across services is essential to ensuring that people with an eating disorder receive the care they need, to ensure clear access and referral pathways so that all services can work together to prevent gaps in provision and deliver the right care for the person.

Integrated care arrangements across services are essential and should:

- Set clear parameters around working relationships, including protocols regarding referrals, assessments, access to treatments, and possible inpatient admissions or intensive care.
- Use joint or interoperable record systems (digital records) where possible.
- include regular liaison and joint working meetings, including coordinated review meetings, joint training and education opportunities.
- Be based on a care plan that is co-produced (developed and written with a person and their family, partner or carers).
- Have clearly established processes for when someone is not ready to engage or refuses treatment.

The guidance also highlights that managing effective transitions is critical to ensuring good quality care and it highlights that young people moving away from home or attending university/college are particularly vulnerable. Principles for managing these transitions are stated in the guidance:

- Transition protocols should be in place to ensure good communication between services to avoid inconsistent messages or management approaches. This should be based on a transition plan that includes risk assessment and monitoring, and an agreed next appointment with the CED team or with the person's allocated care coordinator.
- For geographical transitions, CED services should work closely with primary care providers, CED services in other areas and university mental health services to remove gaps in care and delays in treatment that tend to occur when a person moves to a new area and needs to register with a new GP. Transitions should be seamless, with no gaps in support or quality of provision. People should be seen by the new CED service without delay.

In addition, the guidance highlights the person's level of need may require input from multiple services at the same time. An integrated rather than sequential approach should be taken, with careful thought given to which service should be the lead in this process to ensure continuity of care. Having a comorbid condition should not be a reason for delaying or rejecting someone for treatment.

Regional Response

NHS England's South East Regional Team have liaised with the Integrated Care Board (ICB) about this Report. It is noted that the two NHS Trusts involved in the inquest have already undertaken reviews, learned lessons, and implemented changes following Sunny's death. From a regional perspective there is learning for the oversight of NHS commissioned services, particularly where complex patients move across different services and geographical boundaries. As a region we will take this learning to our respective contract quality review meetings with our Lead Providers to ensure that there is adequate assurance of improvement being embedded and sustained to ensure such a tragedy does not happen again.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Sunny, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director
NHS England