	REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013 Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).
1.	**CORONER** I am Simon BURGE, HM Assistant Coroner, for the coroner area of Hampshire, Portsmouth and Southampton.
2.	**DATE OF REPORT** 06 May 2026
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.
4.	**THIS REPORT IS BEING SENT TO** 1. NHS England (PFDs/Reg28) 2. Chief Coroner - PFD Reports You are under a duty to respond to this report within 56 days of the date of this report, namely by June 28, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**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.
6.	**SUMMARY OF CORONER'S CONCERN**

	a) the lack of guidance at a national level concerning the transfer of patients with both serious eating disorders and complex emotional needs from one trust to another eg when they leave home to go to university in another part of the country and **b) the lack of a clear treatment pathway/protocol for such individuals.'**
7.	**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.
8.	**INVESTIGATION AND INQUEST** On 29 May 2024 I commenced an investigation into the death of Sunny Elise EYMOND aged 23. The investigation concluded at the end of the inquest on 01 May 2026. The conclusion of the inquest was that: Narrative
9.	**CIRCUMSTANCES OF DEATH** Firstly, the jury would like to offer their sincere condolences to the family. It is clear from the evidence and not in dispute that Sunny died at Winchester Hospice, Romsey Road, Winchester, Hampshire on 27th May 2024. Sunny had been suffering from Anorexia Nervosa together with a personality disorder and complex Post Traumatic Stress Disorder for many years, having spent lengthy periods of time in and out of hospital, whilst detained under Section 3 of the Mental Health Act and being subjected to forced feeding by nasogastric tube. Her first episodes of nasogastric tube feeding started in October 2020 at the Royal Hampshire County Hospital for anorexia nervosa before being transferred to The Priory where she was detained under the Mental Health Act under section 3. During this time spent at Skylark ward Sunny was fed via nasogastric tubing under restraint, which we believe contributed to the start of her complex PTSD. Sunny did however, make progress in terms of weight gain. During this period, Sunny's diagnosis was changed from anorexia nervosa to EUPD and eating disorder and then 6 months later, anorexia nervosa was removed and EUPD was the formal diagnosis. We find that whilst this may have been helpful for Sunny and her family for her treatment and care, we recognise that this had an impact on further treatment pathways when being discharged (and in future interventions). It is noted that Sunny took an overdose of paracetamol in September 2021 prior to her discharge in October 2021 at this point she was no longer sectioned under the mental health act. In 2022 Sunny was detained under section 2 of the mental health act and admitted to Royal Hampshire County hospital and subsequently transferred to ICU on two separate occasions for life saving treatment which included chemical restraint. From the professional evidence we heard this would have had a traumatic effect on Sunny going forward along with ongoing continuous force-feeding in hospital. Sunny was transferred from hospital and a bespoke ward at Parklands hospital was created for her. Whilst at Willow

ward, Sunny made significant progress despite ongoing challenges and was able to receive 100% nutrition orally by September 2023. We recognise that it was important for Sunny to set and achieve a goal of attending Bristol University, and we acknowledge that the healthcare providers involved worked hard to achieve that goal. After Bristol's fit to study panel, they accepted her. Sunny was able to complete the first term at university however her weight dropped and had to spend an extended period of time at home after Christmas. Following Sunny's overdose on the 23rd April 2024 she was admitted to BRI for emergency treatment in ICU. Sunny made a good physical recovery from this. Sunny was then transferred to the hospice for symptom treating care on the 10th May 2024 . Following the exploration of options in the professional meeting on the 16th May, all professionals were in agreement that the end of life trajectory was the correct pathway and she sadly passed away on the 27th May 2024.

a) There were multiple referral processes, being carried out simultaneously, and the process took several months. We do not consider these delays to have had any significant causative effects in relation to her death.

b) We consider that there were multiple failings in communication and sharing of information between members of Southern Health Trust and AWP e.g. failure to share tribunal records from Southern Health, multiple emails reportedly sent/not received or read). However, we consider that this did not contribute more than minimally, negligibly or trivially to Sunny's death.

c) We acknowledge healthcare professionals in both Hampshire and Bristol made great efforts to try and find a sensible solution for joint working. This was difficult because of the different corporate and functional structures in place in Hampshire and Bristol. The unique complexity of this case added to the difficulties faced by all involved.

d) Whilst understanding that this was a complex and extremely challenging handover of care, we do agree that there were some joint failings in relation to the care package particularly around the lack of community mental health provision and Sunny's understanding of where this would come from over time and how it would be continued. We agree that a robust care package was not established prior to the transfer of care due to the uniqueness of the case, for example, Bristol making it evident that they were unable to replicate the bespoke care package which was established at Parklands for Sunny.

e) We find that there were no grounds for delaying the transfer of care, although we recognise that following the formal handover meeting on the 15th April, there was uncertainty who would be providing Sunny with psychological support.

f) There was a failure in the overall oversight of the transfer of care as there is no evidence that this was escalated to Trust senior management in Bristol. If senior management had been engaged, this could have provided support for the patient facing unit and might have accelerated the assembly of a complete care package; including the appointment of a care-coordinator or equivalent.

	Due to the issues with the referral process, there should have also been an escalation to Trust senior management in Hampshire to aid effective communication going forward in the transfer of care. This also includes the complications of navigating the legal framework. g) There was a failure that Sunny was left from 17th April until 29th April without any planned 1:1 sessions with a professional. This failure arose because of the points we discuss below. h) Whilst we acknowledge that risks were discussed at the transfer of care meeting there was no suitable risk management plan established. This was particularly relevant for the period of time immediately after the transfer when Sunny was left without appropriate professional support. Having considered all the evidence concerning the transfer of care between Hampshire and Bristol services, we have identified some systemic and communication failings. We do not, however, consider the cumulative effect of these identified failings contributed more than minimally, negligibly or trivially to Sunny's death. Sunny's death was due to an irreversible illness affecting Sunny's cognition and causing profound weight loss.
10.	**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: 1. While the two trusts involved in the inquest (Southern Health and Avon & Wiltshire Mental Health Partnership NHS Trust) have undertaken reviews, learned lessons and implemented changes following Sunny's death, the same has not happened at a national level/England wide Trust level. 2. Firstly, I am concerned that a risk of death may arise in the future if the concerns raised are not addressed more widely and brought to the attention of other Trusts and consideration is not given to the production of national guidance on cross Trust transfer of complex cases, particularly those involving patients with a diagnosis of an eating disorder and complex Post Traumatic Stress Disorder/Emotionally Unstable Personality Disorder/complex emotional needs. 3. Secondly, I am concerned that there is a gap at a national level (identified by both SH and AWP) in terms of a pathway for those with a diagnosis of both an eating disorder and complex emotional needs. This lack of a pathway created difficulties when Sunny was transferred from SH (Hampshire) to AWP (Bristol) in order to attend university. It meant that there was an inability to appropriately 'map' her treatment needs to the available mental health services in Bristol. I believe that this needs to be addressed at a national level and not just left for each Trust in England. It is a real concern, given the very high risk of death associated with those with both Anorexia Nervosa and a personality disorder, as was the case here. 4. There is currently no national guidance on how best to manage and plan for Trust to Trust transfers of highly complex cases (in particular those involving patients with both a diagnosed eating disorder such as AN and complex

	emotional needs). Guidance is therefore required as to the need for: a) Senior management oversight of the transfer b) Risk assessments at the time of transfer c) Clear escalation procedures if concerns are raised during the transfer and d) Training on any such national guidance 5. There is currently no national specified treatment pathway for individuals who present with co-existing eating difficulties and complex emotional needs. This, in turn, impacts how services are commissioned, as commissioning arrangements are largely organised around set, diagnosis-specific pathways. To ensure patient safety and national consistency, there is a need for national guidance addressing: a) How to develop a pathway/protocol for patients with eating disorders and complex emotional needs b) When bespoke services (such as the creation of Willow Ward at Parklands Hospital in Sunny's case) are required c) How patients with overlapping needs should be assessed and managed using a formulation-led approach, where single- diagnosis pathways are not appropriate
11.	**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: *[please do not use individual's names, but instead roles/titles]* • **Treating Clinician (KB)** • **Broadmead Medical Bristol** • **Avon and Wiltshire Mental Health Partnership NHS Trust** • **Hampshire Hospitals Foundation Trust (HHFT)** • **Southern Health Foundation Trust (now HIOWH)** • **Bristol University Wellbeing Department** • **Parents** • **University Hospitals Bristol & Weston** • **Hampshire County Council** • **Chief Coroner - PFD Reports** 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.

12.	**SIGNATURE** **Simon BURGE** **HM Assistant Coroner for** **Hampshire, Portsmouth and Southampton**