	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Health and Social Care -** [redacted] [redacted] **Secretary of State for the Home Department-** [redacted] [redacted]
1	**CORONER** I am Christopher Williams, Assistant Coroner, for the area of **London Inner South**.
2	**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	**INVESTIGATION and INQUEST** On the 1/8/23 a coroner's investigation was commenced into the death of **Stella Elizabeth LeClaire**, formerly known as Mia Levy. The inquest was concluded on the 4/12/2025.
4	CIRCUMSTANCES OF THE DEATH 1. On the 28/7/23 at 16:46 pm Stella checked into a hotel in Tooley Street, Southwark. Hotel electronic key records show that she did not leave the room after she checked in. On the 30/7/23 she was discovered unresponsive by hotel staff at 13:45 pm and was subsequently pronounced dead by the ambulance service at 14:56 pm. 2. A police investigation revealed she had sent a farewell email message, to her partner in the United States, timed to be sent at 10:31 am on the 30/7/23, expressing that she could not continue living with constant migraines and nausea and that her health was getting worse. It had not been possible to access Stella's phone and laptop for logistical reasons, but her partner disclosed the email to the police shortly after receiving it. 3. [redacted] in a container recovered from the room, was analysed and found to contain [redacted]. It is not known who supplied the [redacted] to her and the circumstances in which she obtained it. 4. A post-mortem identified the cause of death as 1(a) [redacted]toxicity. This finding was inferred from circumstantial evidence by the post-mortem pathologist. 5. A routine toxicology screening report also detected [redacted], an antiemetic, which has been taken alongside [redacted] in other reported cases. 6. A further toxicology report from a specialist toxicology service, analysed a femoral blood sample, taken at autopsy. This report confirmed the level of [redacted] was extremely high and that it was 'highly likely' that this caused the death. 7. Stella had taken the [redacted] with the intention of ending her own life and I recorded a short form conclusion of "Suicide" in the Record of Inquest.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to a 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. During the course of the inquest I received information from the Toxicology service, that serves my court, that the number of requests by coroners, in 6 coroner areas, for analysis of blood samples for the presence of [redacted], had increased since 2021. 2. I am also aware that in the last 5 years prevention of future death reports have been submitted from a number of other coroner areas. In broad terms the reasons for those reports are concerns that the substance is sold [redacted] advocating its use in suicides [redacted] method. 3. Although there was circumstantial evidence that Stella died from [redacted] toxicity, I was at pains to obtain a specialist toxicological analysis of a blood sample. The reason for this was to ensure that if the supplier of the substance can be identified in future the chances of successful prosecution would be improved by direct evidence of the cause of death. I raise this in case the Chief Coroner may wish to consider issuing guidance on whether blood toxicological analysis should be obtained routinely in coroners' investigations concerning [redacted] poisoning.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 03/02/2026 I, the coroner, may extend the period. 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.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • [redacted] Stella's father • [redacted] Sister • [redacted] I have also sent it to: The Metropolitan Police Service and Nadia Persaud Area Coroner for East London, who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.

9	**9th December 2025**	**Christopher Williams**