


ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Chief Executive, The Financial Conduct Authority, 25 The North Colonnade, Canary Wharf, London, E14 5HS</p>
1	<p>CORONER</p> <p>I am Jonathan David Leach, Area Coroner, for the Coroner Area of West Yorkshire (Eastern)</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 1st June 2016 I commenced an investigation into the death of Naseeb Singh Chuhan, date of birth 05/03/1995. The investigation concluded at the end of the Inquest on the 19th December 2017. The conclusion of the Inquest was that of suicide. The medical cause of death was:-</p> <p>1(a) Hanging</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>This young man was a Student in his first year at Leeds Beckett University, Leeds. He had a history of borrowing from payday loan companies. Immediately prior to his death he had attempted to borrow further without success. Shortly afterwards he was found hanging at his Student accommodation.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) The conduct of the payday loan companies contributed to his situation in that they were aware that he had become dependent on the loans and that such dependence was encouraged.</p> <p>(2) Financial checks were inadequate.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.</p>

7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th June 2018. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] [REDACTED] DWF Law LLP and Governance and Legal Affairs - Leeds Beckett University.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he 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 by the Chief Coroner.</p>
9	<p>9th April 2018</p> <p style="text-align: center;"></p> <p style="text-align: center;">JONATHAN DAVID LEACH Area Coroner West Yorkshire (Eastern)</p>