MISS N PERSAUD
HER MAJESTY'S AREA CORONER
EAST LONDON
East London Coroners, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 100016

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] **Secretary of State for Foreign, Commonwealth and Development Affairs** [redacted]
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25th July 2015, I commenced an investigation into the death of Lee Bradley Brown, age 39 years. The investigation concluded at the end of the jury inquest on 4th November 2022. The conclusion of the jury was a narrative conclusion with neglect. The findings of the jury are as follows: *Lee Bradley Brown's death took place on the 12th April 2011 at 8pm in Bur Dubai Police Station in Dubai, UAE.* *The factors that probably contributed to Lee's death were as follows:* • *The beatings Lee Bradley Brown received from other detainees and police officers/guards*

	• *The lack of adequate food and water* • *The lack of habitable living conditions* • *Lack of access to the necessary medical care whilst in Bur Dubai Police Station* *The factors that possibly contributed to Lee's death were:* • *The lack of access to consular services* • *Inadequate clothing provided for the conditions that he was staying in* *To confirm, neglect was by Dubai Police authorities* [in Bur Dubai Police Station].
4	**CIRCUMSTANCES OF THE DEATH** Lee Brown arrived in Dubai on the 7 April 2011. He was arrested at the Burj Al Arab Hotel during the afternoon on the 7 April 2011. He was taken to the Bur Dubai Police Station and placed into the custody of Dubai police authorities. On the 8 or 9 April 2011, Mr Brown was placed into a solitary cell. Telephone calls were made to the FCDO and to Mr Brown's family on the 11 and 12 April 2011, by detainees of the Bur Dubai Police Station, reporting that Mr Brown was covered in bruises, was lying on the floor of his solitary cell and was in need of urgent assistance. The family of Mr Brown made calls to the FCDO on the very late evening of the 11 April and during the 12 April to raise their concerns about Mr Brown and to request urgent consular assistance. At around 22.00 on the 12 April 2011 a guard observed Mr Brown in an unnatural position within his cell. A paramedic was called who pronounced his life extinct. The medical examiner who attended at around 0100 on the 13 April 2011 considered that it is likely that Mr Brown had passed away around 8-9pm on the 12 April 2011.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters 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. The inquest heard evidence that there is no emergency access protocol to ensure that consular officers can reach detained British nationals in the event of a reported emergency. 2. The inquest heard concerns in relation to the current FCDO travel advice. There was considered to be insufficient information relating to the possible consequences of detention in Dubai (and the possible circumstances of such detention). The inquest heard that the number of new cases of British Nationals reporting allegations of torture or mistreatment in Dubai to the FCDO has risen from 3% of the global total in 2016 to 13% of the global total in 2020. 3. A concern was raised at the inquest in relation to the procedures in place to gain consular access to detained British nationals who may be suffering from a mental health crisis. Such British nationals may not be able to provide the necessary consent for consular services.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have 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 **9 January 2023.** 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 Interested Persons to the Inquest. I have also sent it to the local Director of Public Health 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. 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.
9	**13 November 2022**