**The Coroner Role Virtual Conference**

**Dr Dorit Braun, OBE: Speaker bio**

Dorit retired in 2019, having worked as a Charity Chief Executive and in a variety of senior management and governance roles in the social care and family support sectors. She provides some mentoring to senior managers and trustees of charities, and is the independent chair of the Parenting Programmes Alliance. Following a very traumatic family bereavement Dorit is active in trying to improve mental health care and the ways NHS staff and organisations learn from deaths. She is on the UCH Learning from Deaths research programme steering group, and in this capacity has edited manuscripts for publication, she is on the AvMa beneficiaries participation group, and has provided training to NHS trusts and other professionals by speaking about her family's experiences. Dorit obtained her PhD in 1980 from the University of Manchester; her research was on the political economy of the pharmaceutical industry in Colombia. She was awarded the OBE in 2000 for services to parenting. Dorit is also an artist, exhibiting from time to time.

**Dorit Braun: Abstract**

My much loved daughter in law Mariana Pinto died, aged 32, on 16 October 2016.

Just after Mariana was pronounced dead (at 5 pm), the police explained to us that this was an ‘unexplained death’ and so would be referred to the Coroner. There would be an inquest. We had absolutely no idea what this would entail.

I will outline how we felt about the Inquest into Mariana’s death, and how we experienced it in order to highlight the following key points:

* Inquests are an unknown quantity for the bereaved family and so an additional source of stress and worry
* While statements are gathered for the inquest, including from the family, other parallel processes are also ongoing, such as the Serious Incident Review so that the family can feel lost and bombarded
* All this is taking place while the family (and friends) are grieving and at least initially are at the very early stage of shock, trauma and disbelief
* Some of the investigative processes add to the trauma of the bereavement
* Families want to know what happened and why it was allowed to happen. They want to know it won’t happen again to anyone else
* Families need legal representation at the Inquest to offer advocacy and support to them and to make sure that the questions they have are addressed
* The statements and reports produced for Coroners can be extremely distressing to read for the family
* How the Coroners’ office responds to and liaises with the family before and during the Inquest can make a huge difference – kindness, respect, care and information do help

**Dorit Braun: Relevant Blogs**

Inquests: a family perspective

<https://www.makingfamiliescount.org.uk/2020/12/09/inquest-a-familys-perspective/>

Working to improve mental health service<https://www.makingfamiliescount.org.uk/2021/06/02/makingfamiliescount/>

Safer outcomes for people with psychosis

<https://www.pslhub.org/learn/improving-patient-safety/safety-stories/by-patients-and-public/safer-outcomes-for-people-with-psychosis-r774/>

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