**Investigations of deaths and serious incidents in mental health services**

**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, a member of the Making Families Count (MFC) team, and provides training to NHS trusts and other professionals by speaking about her family's experiences. Dorit is coordinating a new project with MFC which will work with a range of professionals and services to consider how best to help families to keep people safe in a mental health crisis. Please do contact her if you are interested.

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: contact details**

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**Dorit Braun Abstract**

**Looking at deaths & serious incidents from a user/family perspective**

Following the traumatic death of my beloved daughter in law, Mariana Pinto, the Mental Health Trust who had conducted the Mental Health Act assessment, and to whose Crisis Team she was referred, conducted a 48 hour review and then a Serious Incident Review. We had already submitted a complaint, and the Trust assured us that all the points we made in the Complaint would be investigated as part of the SI review.

This talk will cover how it felt as a family to be involved in these reviews, what could have been done differently and why that matters.

**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/)