**NHS Complaints Summit**

**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. 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 contributed to manuscripts for publication; she is on the AvMa beneficiaries participation group; is a member of the Making Families Count (MFC) team; provides training to NHS trusts and other professionals by speaking about her family's experiences and has blogged about aspects of these experiences.

Dorit is coordinating a new project with MFC: Life Beyond the Cubicle aims to reduce deaths of people during acute mental health crises, by enabling professionals to listen, support and assist families to help keep loved ones safe.

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 has a Masters from Warwick University on Social Research in Health Care; her dissertation was on feminist research methodology. She was awarded an OBE in 2000 for services to parenting. Dorit is also an artist, exhibiting from time to time.

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**Dorit Braun Abstract**

Following the traumatic death of my beloved daughter in law, Mariana Pinto, my son and I made a complaint to the NHS Mental Health Trust about her care. We suspended this complaint while the Serious Incident Review was undertaken, hoping that process would answer our concerns. It did not. We resurrected the complaint which was then thoroughly investigated. In the various liaisons with the Trusts’ Complaints team, I was invited to take part in a Managers Review of Complaints Day held by the trust. I was also invited to speak with the Trust Board about our experience, but this invitation was retracted by the Senior manager, who realised there was an ongoing legal case at the time. (This has ended: the treatment of my daughter in law was not medically negligent in legal terms).

I will talk about the process of the complaint investigation, how complaints were managed (or appeared to be) and what I feel the Trust learnt and failed to learn.

I will highlight the following key issues:

* Families have critically important insights and observations into how they and their loved one experienced care
* Families are very concerned that the Trust learns from the experience and this is the intention of making a complaint
* Families want truthfulness and not to be ‘managed’ or fobbed off – and doing this can add to their trauma and distress and can lead to a more confrontational approach
* Families assume that the Trust operates as 1 organisation – and so when people within a Trust don’t communicate with each other families are left confused and quite probably angry
* Families would like feedback: how has the Trust learnt? What is done differently?
* Some families would like to contribute to the learning and improvement of the Trust

**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 services<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/>

Suicide without ideation

https://www.makingfamiliescount.org.uk/2022/04/20/wp-admin-post-phppost2098actionedit/