Trees of Reflection

MARK BROWNLIE
Silver Birch *(Betula Pendula)* planted in 2016

1970-2015

Mark had a long history of mental illness and had been a regular TCS participant for some time before he took his own life in October 2015. Sadly, I have no personal information about Mark other than the following report taken from the *Hereford Times*.

Coroner Questions Mental Health Intervention Prior to Man's Death

9th March 2016, by Rebecca Miles.

A man who took his own life has led a coroner to question the care he received from mental health services in the month prior to his death. An inquest at Herefordshire Coroner's Court heard Mark Brownlie was found hanged at his home in Cedar Close, Moreton-on-Lugg on October 20 last year. Neighbours had raised the alarm after he had not been seen for a few weeks and police attended the 45-year-old's address.

The county's coroner, Mark Bricknell, told Dr Barnaby Major, from the 2gether NHS Foundation Trust, that he was concerned about the level of intervention from mental health services prior to Mr Brownlie's death. Mr Bricknell questioned why some paperwork classed Mr Brownlie as a moderate risk of deliberate self-harm and/ or suicide, yet Dr Major said he was at a low risk.

Dr Major told the inquest there was a formal process of risk assessment which put him in a moderate risk category but that mental health staff will override this process based on their interpretation and how well they know the patient.

He said: "Medicine is a science but it is an art form as well. It is about following your gut feeling and doing what you think is right for the patient at that moment in time."

Mr Bricknell asked whether Dr Major became concerned when Mr Brownlie did not attend appointments in the months leading up to his death but Dr Major said this was reflective of his condition, a personality disorder, and he would often not turn up for appointments for long periods of time. He said they had to be careful to strike a balance and added: "He didn't want people coming around and knocking on his door at a time that didn't suit him."

Dr Major said the care plan, which said Mr Brownlie should have two members of staff visiting him at home if he did not turn up for appointments, was out of date and had been made in 2012. They had not had time to write a new one. He added: "It is a reflection on modern NHS services. Often there is a gap between policy and process. Often people do things because they are going to be scrutinised. They are going to be leaning towards performance targets."

Dr Major said he was genuinely very shocked when he discovered Mr Brownlie had died and said he had clearly got it wrong. He said he had self-harmed before but he had always done it when he knew he would be found.

Mr Bricknell recorded Mr Brownlie took his own life.
He said: "He was a troubled man with a complicated history of mental health issues. He failed to attend appointments with medical professionals but not withstanding this it is disappointing contact was not made to a greater extent in the month prior to his death. "The difficulty of managing patients in such circumstances must, however, be acknowledged."