1998), psychiatrists should be aware of an increased risk of clinical hypothyroidism in their patients taking lithium.

Bocchetta, A., Cherchi, A., Loviselli, A., *et al* (1996) Six-year follow-up of thyroid function during lithium treatment. *Acta Psychiatrica Scandinavica*, **94**, 45–48.

Dunn, J. T. (1998) The epidemiology and prophylaxis of iodine deficiency worldwide. In *Schilddrüse 1997: Henning-Symposium on "Jod und Schilddrüse"* (eds C. Reiners & B. Weinheimer), pp. 3–7. Berlin: de Gruyter.

Dussault, J. H. (1993) Iodine intake in Canada. In *Iodine Deficiency in Europe. A Continuing Concern* (eds F. Delange, J. T. Dunn & D. Glinoer), p. 131. New York: Plenum.

Johnston, A. M. & Eagles, J. M. (1999) Lithium-associated clinical hypothyroidism. Prevalence and risk factors. *British Journal of Psychiatry*, **175**, 336–339.

Kirov, G. (1998) Thyroid disorders in lithium-treated patients. *Journal of Affective Disorders*, **50**, 33–40.

Laurberg, P., Pedersen, K. M., Hreidarsson, A., *et al* (1998) Iodine intake and the pattern of thyroid disorders: a comparative epidemiological study of thyroid abnormalities in the elderly in Iceland and in Jutland, Denmark. *Journal of Clinical Endocrinology and Metabolism*, **83**, 765–769.

Leutgeb, U. (1999) Overt hypothyroidism and goitre during prophylactic lithium treatment: the influence of ambient iodine supply. A critical review. *Neurology, Psychiatry and Brain Research*, **7**, 121–130.

Shopsin, B., Shenkman, L., Blum, M., *et al* (1973) Iodine and lithium-induced hypothyroidism. Documentation of synergism. *American Journal of Medicine*, **55**, 695–699.

U. Leutgeb The Practice "Rotmaintal" for the Treatment of Affective and Anxiety Disorders, Bayreuther Strasse 15, 95500 Heinersreuth b. Bayreuth, Germany

Consent in mandatory homicide inquiries

Since 1994, an independent inquiry has been required in all cases of homicide by discharged psychiatric patients (Department of Health, 1994) and health authorities have needed to develop local procedures for terms of reference for inquiry teams. Methodological inconsistencies have been highlighted (Buchanan, 1999) but the definition of the process of obtaining consent from the patient involved (to allow the inquiry team access to their medical and other relevant case notes) has been neglected.

Issues regarding consent and capacity are assuming ever-increasing importance in clinical practice. Psychiatrists routinely assess this with respect to consent to medication, and rigorous safeguards exist to ensure patients understand their right to withhold or refuse consent. However in the case of homicide inquiries there are neither guidelines nor consensus. According to the terms of reference for homicide inquiries (Department of Health, 1994) it is the responsibility of the health authority to obtain consent. In order do identify current practice, we wrote to 22 health authorities that had commissioned homicide inquiries. Details of the procedures/process used by inquiry teams to obtain consent (and a copy of the actual consent form used) were requested.

Only 11 responses were received, seven providing a copy of the consent form used. These were broadly similar, requesting consent for access to all records (health, social services, probation and housing). Only one reply explicitly stated assessment of capacity. Two authorities did not know how consent was obtained and suggested we contact the psychiatrist on the inquiry team. All respondents included the terms of reference and procedures issued to the inquiry team. None of these mentioned how consent was obtained. A variation in practice for obtaining consent was evident; consent forms were directed through solicitors, prison medical officers and inquiry psychiatrists. Only two consent forms explained that reports would be compiled and published.

Our limited study demonstrates that the important issue of consent appears to have been neglected, which is surprising as inquiry reports rely on full access to medical notes. It is of concern that none of the health authorities could demonstrate adequate procedures for obtaining valid consent. This raises the issue of what patients understand they are consenting to when they sign consent forms to release their records to an inquiry. Understanding fully the consequences of an inquiry (some of which is inevitably negative) is a difficult conceptual task. It is, therefore, most important that patients are presented with clear and comprehensive detail (e.g. with sufficient time allowed to consider the information, explanation of the right subsequently to withdraw consent and that the report will be published). The procedure should be conducted in accordance with the British Medical Association (BMA) guidelines; thus, patients must be able to understand and retain the main benefits and possible risks, be shown to believe that information and be capable of weighing-up the information in order to make a choice (BMA & The Law Society, 1995). We recommend that health authorities adopt and expand the BMA guidelines to ensure they obtain informed valid consent.

Although it is not the responsibility of the patient's current responsible medical officer to assess the capacity of the patient to give consent, we believe it should be good practice to do so. If this procedure is followed, there is a risk of an increasing proportion of patients refusing to consent to the release of confidential information. If no guidelines exist for health authorities in such circumstances, the whole inquiry process might grind to a halt. Finally, we raise the legal spectre that if valid consent cannot be obtained by health authorities, that they may subsequently be accused of breaking patient confidentiality and be open to a legal challenge from patients who have been subjects of homicide inquiries.

The value of continuing mandatory local inquiries is an important debate but before further inquiries are commissioned we propose that issues surrounding the process and extent of consent be better clarified in the interests of both patients and health professionals.

British Medical Association & The Law Society (1995) *Assessment of Mental Capacity – Guidance for Doctors*, p. 66. London: BMA.

Buchanan, A. (1999) Independent inquiries into homicide. *British Medical Journal*, **318**, 1089–1090.

Department of Health (1994) *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community.* HSE (94) 27. London: Department of Health.

H. Rees Yate Health Centre, 21 West Walk, Yate, Bristol BS37 4AX

A. Lillywhite Fromeside Clinic, Blackberry Hill, Stapleton, Bristol BS16 1ED

Medical roles in mental health review tribunals

Richardson & Machin (2000) draw attention to the dual role imposed on the medical member of mental health review tribunals (MHRTs), and to the fact that, having made a preliminary examination, they are unlikely to come to a tribunal hearing with an open mind as to whether or not the patient should continue to be detained.

Having served on a great many tribunals, I can say that tribunal members understand that they must reach their decision on what they read in the reports presented to them,

https://doi.org/10.1192/bjp.176.5.496-a Published online by Cambridge University Press