DEATHS AT GOSPORT HOSPITAL – TIMELINE

August 1998 - Mrs Gillian Mackenzie reports the death of her mother (Mrs Gladys Richards) at Gosport Hospital to Hampshire Constabulary which launches an investigation (including seeking expert medical advice from Professor Brian Livesey). No charges.

1999 - A second police investigation is launched after several families come forward with concerns about deaths of their relatives at Gosport Hospital. Dr Jane Barton (a GP who worked at Gosport as a clinical assistant) is interviewed by the police. No charges are brought.

April 2000 - Dr Barton leaves Gosport Hospital but continues to work as a GP.

July 2000 - The General Medical Council first became aware of concerns relating to Dr Barton.

August 2001 - Hampshire Police were at this stage investigating 5 deaths at Gosport hospital and shared their concerns with Commission for Health Improvement (CHI).

February 2002 - Hampshire Police decided not to proceed further with investigation into the 5 deaths at Gosport

June 2002 - Mrs Mackenzie asked the GMC formally to investigate Dr Barton; she was informed there were no grounds for any action.

July 2002 – CHI's report found systemic failings in the monitoring and prescribing of medication for elderly patients at Gosport.

5 September 2002 – The then CMO, Liam Donaldson, commissioned a review of deaths from Professor Richard Baker of Leicester University.

September 2002 - Police began a third investigation into 92 deaths at Gosport Hospital.

November 2002 – Portsmouth NHS Trust which then ran Gosport issued an action plan in response to the CHI report.

2006 - Hampshire Police announced that, after third investigation, they had found no criminal negligence in 80 of the 90 cases examined. Ten deaths were referred to the Crown Prosecution Service (CPS) but no charges were brought.

October 2007 - The Crown Prosecution Service concluded that there was insufficient evidence to prosecute any health professionals.

Early 2008 - Police reports were passed to the Portsmouth coroner, David Horsley.

Early 2008 - DH passed a copy of Professor Baker's Report to GMC (as requested by a notice under Section 35A of the Medicines Act).

May 2008 - MoJ agreed to grant inquests into 10 of the deaths (permission was required as several of the bodies had been cremated).

2008 – MoJ granted an inquest into death of 11th patient (Mrs Gladys Richards)

July 2008 – The GMC issued an interim order against Dr Barton which allowed her to keep working with some restrictions on prescribing.

18 March 2009 - Inquests into 10 deaths at Gosport begin.

April 2009 - Inquests concluded.

July 2009 – GMC Fitness to Practise Panel investigation began (delayed until after the inquests).

29 January 2010 - GMC FTP panel decided that Dr Barton should be allowed to continue to practise, subject to 11 conditions.

31 March 2010 – The Council for Healthcare Regulatory Excellence concluded that the GMC decision was wrong, but not unduly lenient so as to be appealable.

August 2010 – The Crown Prosecution Service's 3rd review of the case concludes that there is insufficient evidence for prosecution

February 2011 - Dr Barton applies to have her name removed from the Medical Register.

May 2011 – Pre-inquest hearing into the death of Mrs Richards (inquest to be held "in Autumn 2011")

May 2012 – Portsmouth Coroner announces intention to hold the inquest in December 2012

18 April 2013 - Conclusion of inquest into death of Mrs Richards.

2 August 2013 - Professor Baker's report published