: "In spite of the verdict which three of the families found helpful to some extent, this was never a proper case for a coroner's inquest. These deaths should have always been investigated through a public inquiry. A public inquiry would investigate the role of individuals and organisations in the NHS, police and regulators in order to establish what went wrong, were mistakes were made, and could problems have been picked up earlier. These are beyond the remit of an inquest."

Inquests into just ten of the deaths and the previous investigations were never going to answer the wider systemic questions that need to be answered in such a large scale series of incidents.

AvMA is also involved in supporting families affected by the scandal at Stafford Hospital and calling for a public inquiry there, which has so far been denied, but is facing a legal challenge through judicial review. I see a worrying pattern emerging here of the Department preventing genuinely independent inquiries in favour of different fragmented investigations, tightly defined by the Secretary of State, which are never going to provide the big picture of why the systems it itself is responsible for have failed with such tragic consequences.

The IoS has learnt that a fitness to practice hearing to assess the competence of Dr Jane Barton - the doctor at the centre of many of the prescribing allegations - has been set for June. The GMC received complaints about Dr Barton as far back as 2000 but say criminal investigations have taken precedence. Mrs Mckenzie - whose mother's inquest is still to begin - is incensed as several hearing dates have been cancelled to avoid prejudicing the jury.

While several of other relatives say they have not heard anything from the GMC for many months.

Meanwhile lawyers last night appealed for the other 82 families to come forward so that all the evidence could be presented , unite in their calls for a public inquiry were preparing to present the CPS with new evidence uncovered over the last few weeks as well as considering a class civil action in an attempt to get full disclosure of all the evidence pertaining to the deaths. ????

Lawyers acting for five of the families also failed to persuade Mr Bradley to call several key witnesses and could dad to recycle old police evidence because there were insufficient funds to commission new expert opinions.

Ann Alexander "A coroner's inquest is not the correct system for identifying what happened, what should have been

done and most importantly, what are the important lessons to learn for the future to make sure this doesn't happen again. This is not about the hospital saying its sorry and assuring people things have now changed. This is about providing patient safety and making sure lessons are learned from what happened and applied throughout the country."

The death of Gladys Richards, 91, in 1998 triggered the first hospital and police investigation after complaints by her daughter Gillian McKenzie. Mrs Mckenzie, 71, believes her mother died after she was unnecessarily prescribed high doses of morphine and that the cause of death of her death certificate, bronchopneumonia, was inaccurate.

In 2001 the Police Complaints Authority upheld complaints by Mrs Mckenzie about the incompetence of the first two investigations. Reports of this in the local papers triggered scores of other families to come forward which led to a four year police investigation but resulted in no charges.

Mrs Mckenzie's mother was inexplicably excluded from the initial 10 inquests but has been since granted a separate one after legal intervention. A date is yet to be set by Mr Horsley.

The death of Gladys Richards, 91, in 1998 triggered the first hospital and police investigations after complaints by her daughter Gillian Mackenzie. In 2001 the Police Complaints Authority upheld complaints by Mrs Mackenzie about the incompetence of the initial investigations. She was inexplicably excluded from the initial 10 inquests but was granted a separate one after her lawyers intervened. The coroner is yet to set a date.

Professor Ford "Although Mr Cunningham was admitted for medical and nursing care in order to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing notes are inadequate in documenting his clinical state at the time."

Last night Mr Farthing said: "I think the jury did its best with the sparse evidence it was allowed to have, but the process was clearly manipulated from start to finish. An absolute farce from my viewpoint and crass waste of public money, and justice is just as far off as it ever was before the start. Until all the information is on the table and looked at in the cold light of day I will never be happy, and I am sure I speak for all the families involved. A public inquiry is surely the only way forward from here."

It is notoriously difficult for families to obtain legal aid to pay for legal representation at inquests. Lawyers acting for five of the families believe the other five families did not get a fair hearing.

John White said: "We still don't know the extent of the problem because only half of the ten were truly tested. Many of the important points on the five cases without representation were not pressed which therefore diluted many of the arguments for all 10.

And Professor Richard Baker's 2002 review into death rates at Gosport - the only such review since Harold Shipman - has still only been seen by the Government and the General Medical Council.