Witness Name: Anthony Rogers

Statement No: WITN0245001

Dated: 27 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ANTHONY ROGERS

I, ANTHONY ROGERS, will say as follows: -

INTRODUCTION

1. I am His Majesty's Chief Inspector of the Crown Prosecution Service Inspectorate.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 2 October 2025 (the "**Request**"). I have been assisted by counsel and Government Legal Department lawyers in the preparation of this statement.

BACKGROUND

3. I was appointed by the Attorney General as HM Chief Inspector of the Crown Prosecution Service Inspectorate on 1 February 2025, having held the role temporarily since 2024.

4. Much of my career has been as a civil servant working across a range of departments. This has included the Department of Social Security ("**DSS**") (now part of the Department of Work and Pensions ("**DWP**")), the Inland Revenue (now HM Revenue & Customs), HM Land Registry and DWP. I left DWP in 2003 to join HM Crown Prosecution Service Inspectorate ("**HMCPSI"**) as a business management inspector. As well as leading numerous Crown Prosecution Service ("**CPS"**) Area inspections, thematic inspections, and joint inspections, I was also responsible for the management of the inspection support team and audit team. I became a member of the inspectorate's management board in 2006. From 2012, I was Deputy Chief Inspector. I then left HMCPSI in 2013 to take up a senior civil servant (SCS1) role in the CPS. I left the Civil Service in 2016, returning to HMCPSI in 2018 as Head of Inspection. In 2019, I was promoted back into the Senior Civil Service ("**SCS**"). I was Deputy Chief Inspector prior to being appointed to the role of Chief Inspector.

5. I have extensive experience outside the Civil Service as a management consultant and non-executive director.

6. My various roles in the CPS and HMCPSI, as well as my work with the other Criminal Justice Inspectorates, have given me a broad experience of the Criminal Justice System and the dependencies between each of the agencies.

7. In my role as HM Chief Inspector of the CPS, I am responsible for leading an independent inspectorate. This entails holding responsibility for the production

of all inspection reports, including findings and recommendations. I am also responsible for providing independent assurance to the public and the government on the effectiveness of public prosecutions. The Chief Inspector is the organisation's voice and spokesperson and is responsible for providing clear and visible leadership to staff.

8. The Chief Inspector is responsible for setting an inspection programme that provides an appropriate level of reassurance.

9. The Chief Inspector provides objective and comprehensive findings and recommendations that the government and others can use to improve the operation, efficiency, and effectiveness of the public prosecutors.

10. HMCPSI is an independent inspectorate. The statutory remit of HMCPSI includes a duty to inspect the operation of the CPS and the Serious Fraud Office ("**SFO**"). This includes submitting an annual report on the operation of these organisations to the Attorney General. Pursuant to Section 2(2) of the Crown Prosecution Service Inspectorate Act 2000 ("**the CPSIA 2000**"), the Attorney General will lay before Parliament a copy of the annual report. Further, HMCPSI undertake any inspection requested by the Attorney General, as set out in Section 2 of the CPSIA 2000, and amended by the Anti-social Behaviour, Crime and Policing Act 2014. We also inspect other prosecuting services by invitation.

11. We are committed to the ten principles of public inspection **[WITN0245002]**.

HMCPSI REVIEW OF THE CASE OF VALDO CALOCANE

12. The Attorney General superintends the CPS and the SFO and is accountable to Parliament for those organisations' performance. HMCPSI has a statutory duty to inspect the operation of the CPS and SFO. We will also report to the Attorney General on any matter connected with the operation of the CPS which they refer to me under Section 2(1)(b) of the CPSIA 2000.

13. My predecessor, Andrew Caley CMG KC, received a letter – dated 29 January 2024 – from the then Attorney General (Baroness Victoria Prentis KC). Valdo Calocane had been sentenced four days earlier at Nottingham Crown Court. Following this, there had been criticism expressed by some of the bereaved family members as to the CPS's acceptance of pleas to manslaughter by reason of diminished responsibility. Bereaved family members had also met with the Prime Minister on 29 January 2024 expressing concerns as to the conduct of various organisations and calling for a Public Inquiry.

14. The Attorney General commissioned HMCPSI to undertake a thorough and rapid inspection of CPS actions in the Valdo Calocane case. The request was made pursuant to Section 2(1)(b) of the CPSIA 2000. The commission requested that our inspection address the concerns raised by the victims' families about the charging decision and the approach taken by the CPS in engaging with the families. A copy of the letter from the Attorney General is set out in an annex to the report we published on 25 March 2024 **[HMCP0000625]**.

15. Chief Inspector Andrew Cayley CMG KC had tendered his resignation a couple of weeks prior to the inspection being commissioned and so, as Acting Chief Inspector, I took the lead for managing HMCPSI's inspection.

16. Given the fact that the Attorney General had requested a rapid inspection which asked for findings before Easter, decisions had to be taken on who was available to conduct the inspection. At the time, HMCPSI were already fully committed to an inspection programme. Looking at committed resources, it was apparent that we could free up two legal inspectors, if other inspection activity were to be delayed. However, this resource would not be enough to complete the inspection in the timescales set. It was clear that we would need to supplement the resource available with a mixture of personnel with inspection experience and experience of dealing with prosecuting serious and complex cases. The then Chief Inspector (Andrew Cayley CMG KC) created a shortlist of senior individuals who worked at the Bar to seek a view of immediate availability. The first he contacted, Richard Whittam KC, had appropriate experience as former First Senior Treasury Counsel (crime). He was available and was co-opted onto the inspection team with immediate effect. We also contacted a former legal inspector who had recently retired from HMCPSI. He was also immediately available. He was brought back on a fee paid basis to join the team.

17. I led the inspection. I was immediately available, given that my resource is not allocated to the inspection programme. Also, given the high-profile nature of

the assignment, and the need to engage with the bereaved families and Ministers, I thought it right the inspection should be led by the Chief Inspector.

18. The legal inspectors, James Jenkins (retired senior legal inspector), Emma Jones and Joanne Milner (legal inspectors), and Richard Whittam KC all undertook a review of the evidence, interviews and report writing as part of their roles. Given the usual inspection methods, it would be unusual for each inspector to have specific responsibilities. The approach to an inspection is to work as a team with tasks being allocated on the basis of availability and experience.

19. I was responsible for the development of the inspection scope, leading the family meetings, quality assuring the inspection, testing the judgements and findings, and presenting findings to the family and media engagement. I also engaged with Attorney General's Office to update on progress.

20. When undertaking an inspection, we usually start with a scoping and planning exercise to consider the inspection's objectives. During this, we will define what we will look at, how we will gather evidence, and what resources we will need. Given the urgency in which this commission was received and the time given to deliver our inspection, I prepared a brief scoping paper which set out our inspection question and the aims of the inspection.

21. Our inspection question was: "*Did the CPS make appropriate decisions on charge and acceptance of pleas in this case, and did they engage appropriately with the bereaved families?*"

22. The aims of the inspection were:

- To determine whether the right charge was selected;
- To determine whether it was appropriate for the CPS to accept the three pleas to manslaughter, by reason of diminished responsibility, as alternatives to the original charge of murder;
- To determine whether the CPS considered all relevant information and evidence, and followed the Code for Crown Prosecutors (including any relevant policies in place) in reaching the decision to accept the pleas;
- To determine whether the CPS adhered to the requirements set out in the Code of Practice for Victims of Crime and the Bereaved Family Scheme;
- To assess the timeliness and quality of engagement with the victims' families.

23. To start with, the objectives of our inspection were, therefore, largely twofold. First, to determine whether the CPS had been correct and had acted in accordance with the Code for Crown Prosecutors. This was in relation to (i) charging the case and (ii) the point at which they accepted the pleas of not guilty to murder but guilty to manslaughter. Second, to determine whether the CPS had met its obligations under The Victims' Code and Bereaved Family Scheme in its engagement with bereaved family members **[WITN0245003]**, **[WITN0245004]**.

24. When meeting with the bereaved families, they raised the question as to whether the CPS had missed any potential earlier opportunities to prosecute Valdo Calocane, prior to his committing the offences of 13 June 2023. From this, and the widening of the Attorney General's initial commission, the inspection then sought to also answer this question.

25. During the course of the inspection, HMCPSI communicated with the bereaved families. On 5 February 2024, I sent – via email – a letter to them **[HMCP0000523]**, **[HMCP0000524]**, **[HMCP0000525]**, **[HMCP0000526]**. In this letter, I introduced our organisation. I gave the bereaved families an explanation of the commission we had received from the Attorney General and set out what our inspection would be addressing. I invited them to a meeting, either in person or virtually to suit them, towards the end of that week or early in the week commencing 12 February 2024. Following further email communication, an in-person meeting was arranged for 9 February 2024 in London.

26. During that in-person meeting, concerns were raised by the families, both verbally and through documentation handed to us, which we detail in Chapter 3, paragraphs 3.5 to paragraph 3.8 of our report **[HMCP0000625]**. Their concerns about the conduct of the prosecution fell into three main strands. The first was in relation to the correctness of the CPS decision to accept pleas to manslaughter by reason of diminished responsibility. More specifically, they raised concerns about the reliability and veracity of the conclusions drawn by the psychiatric experts. The psychiatric experts had concluded that Valdo Calocane was suffering from a recognised mental illness at the time he

committed the killings. This afforded him the partial defence of diminished responsibility. The families raised concerns that the police had made the decision not to take a non-intimate hair sample to test for classified drugs after the defendant had refused to provide intimate samples. They raised further concerns that psychiatric experts had not adequately addressed, or taken into consideration, certain matters which – had they done so – they believe may have impacted on the experts' conclusion as to his mental state at the time of the killings.

27. The second strand of concern the families raised in our meeting regarding the conduct of the prosecution was the unsatisfactory communication and engagement they received from the CPS. More specifically, they raised concerns that they had been provided with information late on in proceedings as to the possible direction the case might take. They felt "railroaded" when the CPS told them that pleas to manslaughter were to be accepted. They raised the concern that the CPS had stated they had consulted with the bereaved families regarding the acceptance of pleas. However, they felt it was the CPS telling them the decision that had been made rather than consulting with them first. Mr James Coates also raised concerns that he had been unaware of two meetings that CPS representatives had conducted with the other bereaved family members. Consequently, he was concerned that he had not received the same level of information and service.

28. The third strand of concern raised was about other alleged offences committed by Valdo Calocane prior to the events of 13 June 2023 and what, if any, involvement the CPS had in advising and dealing with any such allegations. It

was explained in the meeting that our remit was narrow and was in relation only to the offences arising from the events of 13 June 2023. We advised the families that they would need to ask the Attorney General to extend the remit of their commission to allow us to look at CPS involvement in any previous cases involving the defendant. I indicated that I would be willing to examine this issue, but it would mean the scope of the commission would have to be extended. In the meeting, I suggested to the families that – if they raised this in a planned meeting with the Law Officers – I would look on any extension of the remit favourably. I agreed that it would be helpful for them to understand the full picture. Our remit was subsequently extended to consider any previous CPS involvement with the offender, and whether there had been any missed opportunities to prosecute Valdo Calocane.

29. Following the initial meetings with the families, we received further correspondence from Emma Webber, Sinead O'Malley-Kumar and Sanjoy Kumar about various matters **[WITN0245005]**, **[WITN0245006]**, **[WITN0245007]**, **[WITN0245008]**, **[WITN0245009]**, **[WITN0245010]**, **[WITN0245011]**, **[WITN0245012]**. This correspondence related to issues of the veracity of the psychiatric reports and also some of the dealings with prosecution counsel in meetings at court. The correspondence was acknowledged, logged and formed part of the evidence of the inspection report.

30. We again met with the bereaved families in London on the morning of 25 March 2024, a couple of hours prior to publication of our inspection report. We took the families through our report findings. They maintained their concerns regarding the acceptance of pleas and some of their concerns regarding the

CPS engagement with them. But they were grateful for the clarity we provided around the CPS not having an obligation to 'consult' bereaved families or victims when making a decision on evidential grounds. We clarified that the CPS do, though, have an obligation to 'inform' bereaved families and victims of their decisions, and to 'explain' those decisions to them.

31. In conducting our inspection, HMCPSI had access to the CPS electronic case file. The electronic case file included all the evidence in the case. This included witness statements and exhibits, the psychiatric reports, unused material, review notes, conference and meeting notes, counsel's written advice, email communications between the prosecution team and police, and from bereaved family members to the CPS. We also had access to material held on the Crown Court Digital Case System ("**CCDCS**"). Much of this replicated the evidence in terms of statements and exhibits and unused material that was already contained within the CPS electronic case file.

32. We also obtained full typed transcripts of the three Crown Court hearings that took place – (i) the first hearing which took place on 20 June 2023; (ii) the plea and trial preparation hearing ("**PTPH**") which took place on 28 November 2023, and (iii) the sentencing hearing which was held between 23 and 25 January 2024. We had access to logs of engagement and email communications that family liaison officers kept relating to their engagement with the bereaved families and police counterparts and CPS. This covered the period from June 2023 until January 2024. As stated above, we also had correspondence from

the families – some which had been handed over to us at the initial meeting and some received later throughout the inspection.

33. We conducted interviews with the individuals listed below (at paragraph 35 of this witness statement) to provide us with further information around the correctness or otherwise of the decision making and the engagement with bereaved family members.

34. I am satisfied that we had access to all the relevant evidence to facilitate a sufficiently detailed inspection of the case. This was because we were seized of everything that the CPS prosecutors had when the initial decision to charge murder on the threshold test was authorised and when the subsequent decision was then made to accept pleas to manslaughter. That information was supported by further evidence we then obtained from those that we spoke to. This enabled us to determine whether correct decisions, in line with the Code for Crown Prosecutors, had been made. Similarly, we had the correspondence on the CPS electronic case file relating to engagement with the bereaved families. This, together with the extensive family liaison logs we were provided with, and speaking to the bereaved families and interviewing the prosecutors, meant we could be satisfied that all concerns regarding the CPS engagement with the bereaved families could be properly probed. This allowed for sound findings and judgments to be reached.

35. HMCPSI interviewed the following people during the course of the inspection:

- East Midlands CPS complex crime unit reviewing lawyer – specialist prosecutor Alan Murphy **[HMCP0000552]**, **[HMCP0000589]**;
- East Midlands CPS complex crime unit District Crown Prosecutor – Michelle Mannion **[HMCP0000575]**, **[HMCP0000588]**;
- East Midlands CPS complex crime unit head, Senior District Crown Prosecutor – Samantha Shallows **[HMCP0000551]**, **[HMCP0000587]**;
- East Midlands CPS Chief Crown Prosecutor – Janine McKinney **[HMCP0000609]**;
- Lead prosecution counsel – Karim Khalil KC **[HMCP0000576]**;
- Junior prosecution counsel – Peter Ratliff **[HMCP0000576]**;
- Professor Nigel Blackwood – the first prosecution psychiatric expert **[HMCP0000629]**.

36. We selected all the CPS prosecutors and instructed prosecution counsel that had been involved in reviewing and advising on the case and who had met the bereaved family members. These individuals were selected for interview. This was to enable us to get a deeper insight as to their thought processes around the legal decisions made. It also meant that we could hear directly from them on specific concerns raised from the bereaved families around the decisions taken. It also allowed us to examine their understanding of their obligations under The Victims' Code and the Bereaved Family Scheme and where engagement may or may not have been handled differently **[WITN0245003]**.

37. We considered that Professor Nigel Blackwood was clear and unambiguous in his conclusions. However, we appreciated that, nevertheless, the bereaved

families still had some concerns and questions regarding the psychiatric findings. Therefore, we selected Professor Nigel Blackwood to interview so that we could probe and examine further their concerns. This also enabled us to be clear in our final findings as to whether it was correct for the CPS to accept the pleas of manslaughter on the grounds of diminished responsibility.

38. We were provided with the logs of engagement with the bereaved families that Nottinghamshire Police family liaison officers had kept from June 2023 to January 2024. These logs were voluminous. The information they contained was of great assistance and relevance to us in assessing the timing and quality of the CPS engagement with the bereaved family members. They assisted in providing a more detailed timeline of communications. They also enabled us to reconcile what we were being told in interviews with the CPS representatives, together with concerns around engagement that the bereaved families had specifically raised with us in our meeting with them.

39. We did not regard it as necessary to interview the Family Liaison Officers ("**FLOs**"). We do not consider that this was a limitation of the inspection. The logs of engagement were comprehensive. Interviewing the FLOs would not have provided us with any additional information over and above that contained in the logs to have impacted on the findings we were able to reach. We also understood the relationship had badly broken down between one of the bereaved families and their FLOs towards the end of the case. In my view, this meant that it would not have been appropriate for us to have interviewed them in any event.

40. The inspection report, at paragraph 9.57, made a finding that written guidance on diminished responsibility should have been provided by the CPS to the FLOs **[HMCP0000625]**. A FLO is specially trained to provide a two-way flow of information between bereaved families and investigation teams. Their role is to support the bereaved family through the police investigation and the ongoing criminal justice process. They act as a point of contact for communicating prosecution decisions to the family and keeping them up to date with developments in a case. FLOs will naturally have differing levels of experience and expertise. It is not necessarily expected that they will all be fully versed or comfortable in explaining to bereaved family members complex legal concepts or defences such as diminished responsibility, loss of control or insanity etc and what this means in terms of next steps and possible outcomes in a case.

41. We considered how to ensure that bereaved families are receiving the same information and quality of explanation as one another. This is particularly relevant in cases where there are several bereaved families and different FLOs with different levels of experience and expertise assigned to each. It would seem sensible for the CPS prosecutor, who is legally qualified and understands these complex legal concepts, to be responsible for providing written guidance to bereaved families. They could do this once they become aware of a real or live issue in a case. They could explain what it is, what the next steps would be and what it could ultimately mean for the case. We did not make this a formal recommendation. However, we do consider that it would be good practice for the CPS to take a more proactive approach in assisting their police colleagues to explain complex legal concepts, such as diminished responsibility. They

could do this by providing them with tailored written guidance pertinent to the circumstances of the case. We consider that the actual communication or delivery of this written explanation should still be the role of a FLO. If the bereaved families had any questions then arising from that written explanation, the FLO can communicate and feedback to the CPS.

42. The inspection report, at paragraph 9.59, made findings in respect of Ian Coates' family members not being provided with information regarding issues raised by the other bereaved families and a meeting that had been arranged with them **[HMCP0000625]**. By way of explanation, the bereaved families of Barnaby Webber and Grace O'Malley-Kumar had requested a meeting with the prosecution team prior to the PTPH on 28 November 2023. It was clear from the information relayed by the FLOs to the CPS that they required an explanation as to what the partial defence of diminished responsibility meant. They also required an explanation as to what the possible sentencing options were, given the potential mental health issues, and what would happen at the PTPH.

43. These were not confidential or private matters being raised but rather general queries around the legal process and 'route map' for the case. The agenda prepared by the CPS for that meeting did not contain anything of a confidential or private nature pertinent to those bereaved families. Therefore, the offer of a meeting to discuss these same topics could have been extended to Ian Coates' family members. That could have been a separate meeting to Barnaby and Grace's families, or the same meeting, if all families had been consulted and were in agreement.

44. The CPS had arranged the meeting with Barnaby and Grace's families to take place on a date just after which they anticipated receipt of the prosecution psychiatric expert report. This meant these bereaved families would undoubtedly receive important information and clarity on the direction of the case in that meeting. This is, again, why we considered it important for Ian Coates' family to be informed that those families were having a meeting with the prosecution team.

45. We were of the view that it would not have breached any confidentiality or privacy issues for Ian Coates' family members to have been told that the two other bereaved families were having a meeting with the prosecution team prior to the PTPH and the topics that were to be discussed. It is only by being seized of such information that another bereaved family can make a fully informed decision as to whether they too require a meeting.

46. HMCPSI assessed the CPS' decision-making and engagement with the bereaved families, but HMCPSI does not set the standards it inspects against. The Director of Public Prosecutions ("**DPP**") sets the essential standards for criminal prosecutions. As part of the inspection, we assessed CPS performance against the CPS legal guidance on Homicide, Murder, Manslaughter, legal guidance on mental health defendants, the Code for Crown Prosecutors and Attorney General Guidelines on acceptance of pleas.

47. In terms of assessing CPS engagement with the bereaved families, we assessed CPS performance against the obligations set out in the Bereaved Family Scheme and The Victims' Code **[WITN0245003]**.

48. The CPS provides its staff with extensive legal and operational guidance, policy documents and standard operating procedures, which are designed to set standards for all aspects of casework. Many of these are available to the public on the CPS's website. The legal guidance covers the criminal law set out in statutes and case law, and a wide range of procedural and practical aspects. Policy documents cover an equally wide scope, including defendants with mental health issues, domestic abuse, hate crime, youth offending, looked-after children as suspects, and communications with victims. In our inspections (and in this inspection report), we assess obligations, requirements, and compliance against the legal and policy standards of the CPS.

49. HMCPSI have been inspecting CPS casework quality since our inception in 2000. We are in the unique position of having significant insight, from our file examination and other evidence-gathering, into the standard of prosecutorial decision-making.

50. At the final bullet point at paragraph 7.6 of the HMCPSI Report **[HMCP0000625]**, it states that: '*On 7 December 2023, in the absence of any representations from the police, a notice of discontinuance for the assault on emergency worker charge was served on the court, the defence, and police, in accordance with section 23(3) of the Prosecution of Offences Act 1985*.' By way of explanation, when a prosecutor reviews a case that has already been charged and makes a decision that there is no longer sufficient evidence to support a prosecution, or it is no longer in the public interest to continue with the charge, they will often send the police a proposed notice of discontinuance. In this, they will set out their view of the case and request the views of the

officer. They will also ensure the police have no further information or evidence to provide that may impact on the proposed decision to stop the charge.

51. We had been provided access to the assault emergency worker electronic file on the CPS case management system. Therefore, we were able to see the work and communications that had been undertaken on that file. We saw that a proposed notice of discontinuance had been sent to the police by the CPS. This notice stated that it was no longer considered in the public interest to proceed with the prosecution. This was on the basis that Valdo Calocane had pleaded guilty to three offences of manslaughter and three offences of attempted murder arising from the incident on 13 June 2023. We no longer have access to the file. But the assertion would have been made on the basis that the police acknowledged the letter and made no representations, or that the CPS had not received any response from the police to the proposed notice of discontinuance.

52. I consider that the HMCPSI inspection report fully addressed the concerns raised by the bereaved families in respect of both the CPS decision-making and the CPS communication with them. There is nothing further that I consider we could or should have done. This is in respect of responding to the remit of the commission received from the Attorney General, addressing the families' concerns, and in reaching the clear findings that we did.

REFLECTIONS

53. On reflection, I question the timescales that were set to deliver the HMCPSI inspection report. HMCPSI's commission from the Attorney General set tight

timescales; 8 weeks. This was not replicated by the other reviews for the Care Quality Commission ("**CQC**") and the Independent Office for Police Conduct ("**IOPC**"), although I acknowledge the remit of the other reviews were much wider and included much more engagement with Valdo Calocane. Considering the final interaction with the families on the day of publication, I would have liked more time to engage with the families as we reached the stage of emerging findings, and more time for them to review the publication. Having to deliver the findings in a meeting with the families at the same point the report was published is something that I would do differently.

54. The timescales meant that we had little option but to share the hardcopy or electronic inspection report with the families on the day of publication. Having the ability to share the report on an embargoed basis (a few days prior to meeting) to discuss findings and explain judgements would have been more helpful. It also would have given the bereaved families more time to consider their response prior to our final meeting. We did not need more time to conduct the inspection of the evidence, but more time to adjust handling and engagement would, in hindsight, have been helpful.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

GRO-B

Dated: 27 November 2025

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1.	WITN0245002	Website – Criminal Justice Joint Inspection - The 10 principles of public sector inspection
2.	HMCP0000625	Report dated March 2024 compiled by HMCPSI re: An inspection of Crown Prosecution Service actions in the Valdo Calocane case - The events in Nottingham on 13 June 2023
3.	WITN0245003	Website – Ministry of Justice - Code of Practice for Victims of Crime in England and Wales (Victims' Code)
4.	WITN0245004	Website – CPS - Bereaved Families - Guidance on CPS service to bereaved families in homicide cases
5.	HMCP0000523	Letter to Dr Kumar and Dr O'Malley-Kumar from Anthony Rogers, dated 5 February 2024
6.	HMCP0000524	Letter to Mr and Mrs Webber from Anthony Rogers, dated 5 February 2024
7.	HMCP0000525	Letter to Ms Newton from Anthony Rogers, dated 5 February 2024
8.	HMCP0000526	Letter to Mr Coates from Anthony Rogers, dated 5 February 2024
9.	WITN0245005	Email chain from Emma Webber and Dr Sinead O'Malley received by Anthony Rogers – 26 and 27 February 2024
10.	WITN0245006	Email chain from Emma Webber, James Coates and Dr Sinead O'Malley received by Anthony Rogers – 27 and 28 February 2024
11.	WITN0245007	Email from Dr Sinead O'Malley received by Anthony Rogers – 26 February 2024
12.	WITN0245008	Attachment: Email from Dr Sinead O'Malley received by Anthony Rogers – 26 February 2024
13.	WITN0245009	Email chain from Dr Sanjoy Kumar and Kate Meynell received by Anthony Rogers – 20 February 2024
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19.	HMCP0000575	Transcript/notes of interview with East Midlands CPS complex crime unit District Crown Prosecutor – Michelle Mannion
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22.	HMCP0000587	Transcript/notes of interview with East Midlands CPS complex crime unit head, Senior District Crown Prosecutor – Samantha Shallows
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24.	HMCP0000576	Transcript/notes of interview with Lead prosecution counsel – Karim Khalil KC and Junior prosecution counsel – Peter Ratliff
25.	HMCP0000629	Transcript/notes of interview with Professor Nigel Blackwood – the first prosecution psychiatric expert