Witness Name: ELEANOR GREEN
Statement No: WITN0232001
12 November 2025

IN THE MATTER OF

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR ELEANOR GREEN

I, DR ELEANOR GREEN will say as follows: -

INTRODUCTION

Personal details

Full name: Dr Eleanor Green

Career and Role

My qualifications

- Psychology with Criminology BSc (Northumbria University, 2016-2019)
- Forensic Psychology MSc (University of Newcastle, 2019-2020)
- Doctorate of Clinical Psychology, DClinPsy (University of Sheffield, 2022-2025)

My career

1. I completed my undergraduate and master's qualifications from 2016-2020. Between 2019-2022 I worked ad hoc shifts for an agency (Service Care Solutions) and later the NHS staff bank in adult psychiatric inpatient services (in Newcastle upon Tyne and Darlington) as a healthcare assistant alongside other employment. My first psychology-related clinical role was a part-time position with Cygnet Health Care at Cygnet St Williams, Darlington, an adult male neuropsychiatric rehabilitation unit. This was 2 ½ days per week, with one day as an assistant psychologist, and 1 ½ days as a research assistant (September 2020 - March 2021). I then obtained a full-time assistant psychologist role at Cygnet Victoria House in April 2021, working across the acute and psychiatric intensive care unit wards. I worked here until June 2022. I took a two-month career break to travel before commencing the doctorate in clinical psychology at the University of Sheffield (2022-2025). I completed this in September 2025 and I am now employed as a clinical psychologist with Rotherham, Doncaster and South Humber NHS Foundation Trust (since October 2025).

My role(s) at Cygnet Health Care ("Cygnet") and Cygnet Victoria House.

2. During my employment with Cygnet I held the roles of research assistant (2020-2021) and assistant psychologist (2020-2022). As an assistant psychologist, I held a psychology degree but had undergone no clinical training, all work was completed under supervision of a qualified psychologist. I began working at Cygnet Victoria House in April 2021, under the supervision of Dr Lorraine Bobbie Turnbull, Consultant Clinical Psychologist. The role of an assistant psychologist (AP) is defined by British Psychological Society (2024) paper: 'Expected standards for the recruitment and employment of assistant psychologists (APs)' [WITN0232002]:

   "An AP, as distinct from a Practitioner Psychologist, has not undergone further training to enable them to register with the HCPC as a Practitioner Psychologist. An AP should be supervised by a Practitioner Psychologist who holds appropriate professional responsibility for their work (such as clinical work). An AP cannot work independently of, or instead of a Practitioner Psychologist, and (in clinical settings) cannot make independent diagnostic or treatment decisions"

3. Further comments include:

   - *"APs are professionally accountable to a Practitioner Psychologist to provide appropriate levels of supervision and retain full responsibility for all aspects of their work.*
   - *APs cannot operate autonomously and professional accountability resides with the supervising Practitioner Psychologist*
   - *The supervising Practitioner Psychologist (whether regular or interim) should hold clear accountability for any work completed by the AP, including (where relevant) accountability for clinical decisions."*

     [WITN0232002]

4. As an assistant psychologist at Victoria House, my role involved following the clinical model of care pathway as set out for acute and psychiatric intensive care (PICU) [CYGN0000002]. I attended daily morning meetings with the multi-disciplinary team (MDT), ward rounds and discharge planning meetings for patients whose care I was closely involved in. I facilitated psychological formulation meetings, psychoeducation and wellbeing groups on the acute and PICU ward, completed assessments and brief psychologically-informed interventions, all under the supervision of a qualified clinical psychologist.

5. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 07/10/2025 (the "Request").

   At the outset I wish to express my sincere condolences to the families of VC's victims, and I sympathise with those affected by his actions on 13 June 2023.

BACKGROUND

Psychological services

6. The psychiatrist is often the responsible clinician and is involved in making decisions about patient care from a medical perspective, including psychiatric diagnosis and the prescription of medication. Other members of PICU staff include nurses who would also be involved in the administration of medication and supporting patients throughout an inpatient admission. Other staff included occupational therapists, activity coordinators and healthcare assistants/nursing assistants.

7. Dr Turnbull was the qualified psychologist at this time. I will answer to my role as an assistant psychologist (AP), as this was my position at the time. It is beyond the scope of my role at the time to comment on the psychology provision as a whole.

8. The psychology team were not involved with medication. As an AP, I was included in MDT discussions and the psychology work I did on the wards and with patients involved facilitating psychology groups, 1:1 assessment, formulation and brief intervention work. Decisions about patient care, management and treatment would be made through discussion in the MDT and with the consultant clinical psychologist.

9. The broad purpose and aims of providing psychological treatment or therapy to inpatients would depend on the presenting problem and treatment goals of the work. Psychological treatments in this setting would be supported by an evidence-base and in-keeping with clinical guidelines such as National Institute for Health and Care Excellence (NICE) and British Psychological Society (BPS).

10. Dr Turnbull was the qualified clinician involved in making psychological treatment decisions at the time and would be supervising any psychologically-informed interventions.

11. Circumstances for this would be if psychological treatment was identified by the patient/MDT as relevant to their inpatient treatment and following a screening and consultation with the consultant clinical psychologist.

12. Within the scope of my role at the time, I would not attempt to complete psychological work with a patient on the ward without their consent. There were occasions when patients may decline to attend their formulation meeting (to develop a shared understanding of the factors affecting an individuals' mental health and what has led up to the hospital admission) and the information for this would be extracted from the patient notes system/collateral history obtained from the person's wider network. This is because formulation was part of the care pathway for the admission, although best practice is to do

this collaboratively with the patient and people involved in their care. Further psychological involvement (groups, 1:1 assessment and therapy) required voluntary attendance.

13. If a patient does not engage with psychological treatment or therapy, this would be discussed in clinical supervision, with a qualified clinical psychologist.

14. Within my experience as an AP, if consent was not provided to work directly with individual patients, the psychology team may work systemically with the wider staff team to offer support if this was required. Less formal opportunities to work with psychology were offered through psychology groups on the wards which enabled rapport building and psychoeducation.

15. Daily morning meetings enabled opportunities to share progress and observations with the MDT. If the psychology team were closely involved with a patient, they would endeavour to attend the weekly ward round meeting and other MDT discussions. All staff in the MDT were invited to psychology-led formulation meetings. Patient clinical notes were also accessible by the MDT.

16. Within my role as an AP, we used the "5 Ps" formulation model (presenting, predisposing, precipitating, perpetuating, protective) to understand an individual's challenges affecting their mental health, including factors that may increase/maintain risk-related behaviour. On occasions deemed necessary, comprehensive standardised risk assessments (e.g. HCR-20) were completed by the psychology team and feedback given to the MDT; these were extremely time and resource-demanding so were not routinely done.

17. At the time I understood the term 'insight' to mean the degree to which an individual was aware that they were experiencing a mental health disorder and symptomology associated with this. I understood the term 'masking' to mean the suppression of true thoughts, feelings and behaviours relating to a mental health disorder e.g. not disclosing the experience of hearing voices when asked or deliberately not reacting to unseen stimuli when around others.

18. Independent sources of information to inform a judgement on insight and masking may include ward staff observations, information from relatives and people who know the person well and clinician judgement based on clinical assessment.

Involvement with VC at Cygnet Victoria House

19. I do not recall my involvement with VC when he was admitted to Victoria House in September 2021. I may have been made aware of him as a new

admission arriving via email or in the daily morning meeting or through conversation with hospital staff. I believe my first contact with VC was on 15 September 2021 when I made an entry on his clinical notes [p.21, CYGN0000050].

20. My knowledge about his admission would have most likely come from reviewing the clinical notes. It is possible I spoke to ward staff and other members of the MDT but I do not remember.

21. I note from VC's 14 September 2021 'patient review form' [CYGN000060] that an action point was for me to speak with VC and try and engage with him. To clarify, in this ward round note the term "psychologist" and reference to my name should have been written as "assistant psychologist".

22. I do not remember how this was communicated to me; this may have been communicated via email as a ward round action or told to me in a morning meeting. In accordance with standard procedure at the time, my input would have been to ensure that VC's care involved the MDT with a range of disciplines. The purpose of my input would have been to meet VC and consider if he would engage with the psychology provision on the ward (including his formulation meeting, any optional group sessions and possible 1:1 work if goals were identified for this). Based on the notes, I introduced myself to him, spoke to him about why he was in hospital and any ongoing treatment needs, how he was feeling and invited him to the psychology group. I later arranged a formulation meeting with him.

Initial assessment

23. I believe my first contact with VC was on 15 September 2021 [CYGN0000050; p.21]. In that note I referred to making introductions. I cannot recall meeting or speaking to VC at this time as this occurred over 4 years ago.

24. I cannot recall details of how he communicated in tone and content and whether he seemed withdrawn or guarded, however I note from the records that I used the term "*polite*" [CYGN0000050; p.21] and it appears he engaged in conversation with me.

25. Based on the entry in the notes [CYGN0000050; p.21] I wrote, "*VC denied hearing any voices or seeing anything unusual and said he does not require any further support*". This may have been an example of masking if this was not his true experience however this was my first time meeting him and it appears that the conversation was brief so I was unlikely to have made a judgement about this at that time.

26. I also wrote: "*He said he does not need to remain in hospital and has no issues with his mental health*" [CYGN0000050; p.21]. This may have indicated

a lack of insight. I did not document any sign of aggression or violence and wrote that he was "*polite*" and told me he was feeling *"fine"* [CYGN0000050; p.21], therefore I do not believe he was behaving in an aggressive manner when we spoke.

27. I do not remember speaking to VC about medication and treatment the first time I spoke with him however for him to say he "*does not need to remain in hospital*" with "*no issues with his mental health*" [CYGN0000050; p.21]. I interpret this to mean that he did not think that the hospital admission (including medication and treatment) was necessary.

28. Whilst I cannot recall this conversation on 15 September 2021 with VC, based on the note entry [CYGN0000050; p.21] I think VC did not want to remain in hospital and did not acknowledge any difficulties with his mental health. I have not documented him asking for any specific support from psychology or expressing any interest in the group offered, and based on him rating his mood as "*fine*" and declining support, it appears unlikely that he wanted to work with the psychology team on the ward.

29. I do not recall my response to VC's comment that his admission had been the result of "*an incident which has been taken out of proportion*" [CYGN0000050; p.21]. It was unlikely that I had enough information about the incident or about VC at that time, as this was the first time we met and I would not expect to be in a position to make a definitive judgement about this.

30. I do not recall my response to VC's comment that "*he does not need to remain in hospital and has no issues with his mental health*" [CYGN0000050; p.21]. It is likely that at the time I would have thought that it was significant that VC did not think he required hospital admission or support for his mental health as he was on a psychiatric intensive care unit which is a restrictive environment. This also suggests that he did not agree with a treatment plan that involved the hospital admission and medication for his mental health.

31. I do not recall VC's comment that "*he does not require any further support*" [CYGN0000050; p.21] however based on my notes I think the comment related to care and treatment generally, including psychological support.

32. Given that in accordance with my standard practice at the time I would have made an entry in the patient notes if VC had attended the psychology group, therefore it appears that he did not.

Formulation

33. The purpose of a formulation was to develop a shared understanding of the factors affecting an individuals' mental health and what has led up to the hospital admission.

34. Given the level of detail under the heading 'Presenting' in the formulation document [CYGN0000029], it is very likely that I extracted some information from other entries made in VC's clinical note record. Within the formulation - CYGN0000029; p.2 -, I recorded that VC described the "*incident with the police*" occurring at a time he had been employed in a warehouse job and he made a comment about "*poor judgement on his part*". From recollection, I believe he may have been making the comment about poor judgement as a reflection of working long shifts at his new warehouse job. However, this conversation was a number of years ago so I do not say this with any certainty. I do not remember additional comments that may not have been documented.

35. My clinical note entry on 22/09/2021 [**CYGN0000050; p.12**] stated that VC attended his formulation meeting, he gave "*limited answers*" and at the time I described him being "*minimising about the events that led to his admission*". Given the level of detail in [CYGN0000029], it is very likely that I extracted some information from other entries made in VC's clinical note record. I cannot comment on whether VC demonstrated any insight into his previous violence and aggression from memory.

36. I documented that VC was "*unable to give any reasons which may have triggered this first episode*". It is likely that when I asked about these things, he did not speak much about this as I documented him giving "*limited answers*" [**CYGN0000050; p.12**].

37. Within my experience as an assistant psychologist and healthcare assistant, I had met people who held delusional beliefs relating to conspiracies and surveillance. Broadly speaking, these types of beliefs held by VC were therefore somewhat familiar to me.

38. I do not remember how VC's beliefs were specifically explored in the formulation meeting. The note I wrote said he gave "*limited answers*" and that he had "*not heard any voices since several weeks before the incident with the police*" [**CYGN0000050; p.12**]. I did not document him speaking about researching his beliefs so it is likely that he had not told me this at the time.

39. I do not recall being aware of websites relating to VC's beliefs at the time or any specific research.

40. It is difficult to comment on any particular risks with patients researching their delusional beliefs and finding material which appears to verify or validate those beliefs, or which normalises their experiences. This is because delusional belief systems are wide ranging in content. From what I understand about the nature of delusional beliefs, they are fixed and not changed by evidence. Based on the formulation document, VC did not appear to speak about researching his beliefs.

41. Researching his beliefs was not a risk I identified in the formulation. I would have needed more information and any steps to address potential risk would have been discussed with the MDT; I would not have independently managed this risk as an AP.

42. Based on the records, I believe VC's delusional beliefs in the formulation document was a description of his beliefs prior to admission, although I cannot recall.

43. The formulation included some information about VC's opinions concerning his medical treatment. This included that VC was *"ok with the haloperidol"* as a protective factor. I do not recall, but this information was likely retrieved from other documentation, as CYGN0000060 patient review on 14/09/21; p.4 states: "*Regarding his medication he mentioned that he is ok with the haloperidol and we be happy with an increased dose. He has also not had any side effect.*"

44. Based on the information in the formulation document, non-concordance/non-compliance with anti-psychotic medication had been a precipitating factor that led to his admission. Therefore, VC's acceptance of his current medication was significant because it indicated that he felt "ok" and was not identifying reasons to cease taking it.

45. Based on the information in the formulation document, VC's non-concordance with medication was a factor that led to his admission so it is likely I would have been concerned it may happen again.

46. At the time, it was outside of my remit as an AP to be including medication-related recommendations, such as depot medication, as a plan in his formulation. This recommendation most likely was documented already in his clinical record by a medical professional and I included this information to contribute to the formulation because a history of non-compliance was a known issue [notes indicate this was discussed in a ward round I did not attend on 21/09/2021, **CYGN0000050; p.14**].

47. In the formulation I commented that VC acknowledged he had been experiencing a psychotic episode relating to his first admission (July 2020) which suggests some degree of insight retrospectively, although at the time of

the conversation on 22 September 2021 I documented that he did not believe he had any current mental health difficulties.

48. I do not recall how VC acknowledged that he had been experiencing a psychotic episode at the time of his first admission. Throughout all my involvement with VC as documented in the notes, it appears that he maintained that he was not currently unwell and did not need to be in hospital.

49. The formulation [CYGN0000029] identified protective matters including listening to music and walking/exercise, along with hobbies of chess, films and reading. An activity coordinator was present in the formulation meeting therefore this information was made available to her at the time and the wider MDT when the document was saved in VC's clinical record. I have not documented any specific action taken by myself in relation to these.

50. I do not remember this particular formulation meeting and whether Dr Shoilekova attended. Dr Shoilekova did attend some formulation meetings when she was available (although she was not documented to have attended VC's) and the MDT were always invited. On the document [CYGN0000029; p.1] I recorded that CM (AC) also attended the meeting, along with VC. I believe CM refers to Charlotte Metcalfe, Activity Coordinator. I uploaded the formulation document to the patient notes so that this could be accessed by other Cygnet staff.

VC's engagement with psychology

51. VC did engage in the conversations I have documented, answered questions and attended his formulation meeting.

52. Due to workload (working across both the acute and PICU – 26-bed capacity), it was not possible for me to attend every patient review. Feedback was shared (if necessary) via morning meetings, email communication and documented in the clinical notes. During patient review meetings, patient clinical notes would often be reviewed **[CYGN0000050]** and input from disciplines (such as psychology) not present in the review would be considered.

53. I have very minimal recollection of VC so have nothing further to add than what has been documented. It is possible I saw him at times I was on the ward but I am confident I would have made an entry onto his clinical notes if we had any meaningful interaction.

54. Based on the documentation I have reviewed, I would say VC engaged superficially with me. He did not refuse to speak to me and attended his

formulation meeting which indicates some engagement however I have recorded him giving "*limited answers*" and "*minimising about the events that led to his admission*" [CYGN0000050; p.12] which indicates that I thought he was not answering fully.

55. VC did not have a lot of involvement from the psychology team during his admission at Cygnet Victoria House. An intended benefit of the formulation meeting was to support people to make sense of, and build understanding for the team involved in their care, the factors contributing towards admission and mental health difficulties. Based on the documentation of this, I am not confident he engaged as fully as possible. He was also invited to attend the psychology group on the ward but it appears that he chose not to.

56. Lack of engagement can be a concern but depends on factors such as acuity of illness and capacity. Patient choice, trauma-informed working and preference is also considered and attending psychology sessions was not a mandatory requirement. VC did not refuse to speak with psychology, I have documented that he was polite when we spoke initially and he attended his formulation meeting. In VC's case, although he gave '*limited answers*' [CYGN0000050; p.12], he did somewhat engage by attending and speaking in these sessions.

57. In Cygnet's 'Acute/PICU and Older Adults Mental Health Inpatient Services' [CYGN0000002; p.11, 5.4] it is stipulated that a baseline psychological screening should take place within one week of the admission. VC was admitted on 11th September and I completed this initial psychology review on 15th September. VC was not referred for specific psychological treatment, so was offered a formulation meeting, which he attended, and invited to attend the ward psychology groups. Due to limited psychology provision and depending on individual needs, completion of every action listed in the psychology pathway was not expected [CYGN0000002; p.19]. In my opinion within the scope of my role at the time, the pathway was adequately followed.

58. Based on the role I held at the time, I do not have recommendations to prevent similar attacks in the future, nor comments for improvements to be made locally and nationally to multi agency working to increase effectiveness in preventing similar outcomes in the future.

59. **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.

Signature

GRO-B

Eleanor Green

12 November 2025

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No.	Inquiry URN	Document Description
1	CYGN0000002	Cygnet Clinical Mode of Care Operational Framework
2	CYGN0000050	Medical records of Valdo Calocane from 11/09/2021 - 01/10/2021, Cygnet Victoria House Albert Ward
3	CYGN0000060	VC's 14 September 2021 'patient review' form
4	CYGN0000029	Clinical note 'formulation' for VC dated 22/09/2021
5	WITN0232002	British Psychological Society Expected standards for the recruitment and employment of assistant psychologists.