PRIVATE AND CONFIDENTIAL

PSYCHOLOGY REPORT

in respect of

Civil Proceedings

Mr. B vs. [redacted]

DATE OF REPORT: 9.4.2021

Dr Zenobia Storah, Child and Adolescent Clinical Psychologist

DClinPsy, CPsychol

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1. Introduction

1.1. This report was written following instruction by solicitors representing Mr. B (acting as litigation friend to Child A). Mr. B has instructed Jackson Osborne Employment Lawyers to represent him in a legal challenge to [redacted] providing education to Child A. He has demanded retraction of new school policies regarding the wearing of masks in schools by pupils and staff, and the introduction of other Non-Pharmaceutical Interventions (NPIs) due to the lack of risk assessment around the potential for mental and physical harm to children.

1.2. I have been asked to provide evidence to the court regarding the harms, if any, which have been, or may be, experienced by Child A.

2. The Writer

2.1. I am Dr Zenobia Storah, Clinical Psychologist. My specialist field is Child and Adolescent Clinical Psychology. I am registered with the Health and Care Professions Council and a Chartered Psychologist with the British Psychological Society. I qualified with a doctorate in Clinical Psychology from University College London in 2010. I have expertise in child and adolescent development and emotional well-being. Since qualifying, I have worked in Child and Adolescent Mental Health, both in the NHS and privately, providing assessment and intervention for children and young people presenting with mental health difficulties.

3. Background

3.1. These Civil Law proceedings concern claims set out in the letter sent by Mr. B (dated 8th March 2021), addressed to Headteacher at Child A's School, [redacted], and Head of Education at [redacted]. Child's A School is part of the [redacted].

3.2. Prior to schools reopening in full on March 8th 2021, the Department of Education recommended the use of masks inside secondary school buildings, including in classrooms. Government has stated that this is not compulsory, but part of a range of measures aimed at limiting transmission of SARS-CoV-2.

3.3. Child A (aged 12), attends X School. On the 8th March, with the return of secondary school students to school following the third national 'Lockdown', additional measures intended to reduce transmission of SARS-CoV-2 were introduced within Child A's school. These included the stipulation that 'staff, adults and all secondary pupils must wear a face mask at all times unless a) in a room on their own, b) medically exempt, c) teaching primary students'(1). Students are required to wear a mask on arrival at school, and whenever inside the school buildings, including classrooms. NHS Test and Trace asymptomatic testing (using lateral flow devices), was also introduced. Testing is 'voluntary but strongly encouraged' (1). These measures were in addition to those introduced in the autumn term of 2020 (social distancing, phased movement around the school, one-way systems and a 'Bubble' system to group children with the aim of reducing contacts between individuals within the school).

3.4. Mr. B, in his letter of 8th March 2021, objected to these changes to school policy, and demanded that that the school retract:

- a policy requiring or encouraging children in the school to wear a face covering
- any other Non-Pharmaceutical Interventions (NPIs) without conducting suitable and sufficient risk assessment

3.5. I understand that the school has not retracted these policies and that commencement of Civil Proceedings is now contemplated.

4. Instructions and purpose of report

4.1. I have been instructed to provide a report to assist the court, commenting on the following: -

> *'.. the effects of policy of requiring and/or encouraging the wearing of face coverings in schools. The report of course must focus on the harms, if any, which have been or may be suffered by Child A. However, we expect that this will also require you to have regard to the impact of this and other NPI's, whether current prior to the recent introduction of face coverings into the classroom and generally since March 2020, both in the schools and in the wider community as it might affect Child A whether directly or indirectly.'*

4.2. Given my expertise as a Child and Adolescent Clinical Psychologist, I can comment on psychological harms.

5. Summary of conclusions

5.1. Child A's School has introduced a number of 'Non-pharmaceutical interventions' (NPIs) in response to government guidelines around the reopening of schools in the context of SARS-CoV-2.

5.2. Key interventions include promoting mask wearing by students and teachers and social distancing.

5.3. These measures do not appear to have been risk assessed in terms of potential for physical and psychological harm.

5.4. Child A is a student at the school. They have described their experience of these measures and their impact.

5.5. Child A's testimony identified several difficulties which have arisen due to these measures.

5.6. These include adverse effects on perceptions of self, perceptions of others, teaching, learning, socialising, psychological and physical comfort.

5.7. Psychological research and knowledge around children's development, especially during the adolescent period, is considered.

5.8. It is concluded that the current measures are likely to be causing psychological harm to children.

5.9. Measures interfere with normative development during the adolescent period.

5.10. Research suggests that government measures have already caused harm to children and young people.

5.11. Ongoing measures, including newer interventions such as masking children for the duration of the school day, are likely to add to this harm.

5.12. The extent of psychological harm to young people is unknown, due to the unique nature of the 'social experiment' currently underway in schools, and in wider society.

6. Documents considered

6.1. I was sent the following documents for my consideration, which I received and read:

- Letter from Mr. B, addressed to the Headteacher at Child A's School, and copied to Head of Education at [redacted] (dated 8th March 2021)
- A document entitled, '[redacted] Master Risk Assessment from March 2021 for the full reopening of schools after Lockdown 3'

7. Interview with Child A, 28th March 2021

7.1. To gain understanding of Child A's perspective with regards the changes to school policy, I met with them virtually, via Zoom, on 28th March 2021. Child A's mother and father consented to their child being interviewed. They were present throughout the discussion.

7.2. Child A described the following experiences and opinions:

7.3. Child A explained that they had decided not to wear a mask in school following the changes in school policy. They made this decision independently. They do not wear a mask because they do not want to wear one. They do not think they are necessary and they do not like wearing them.

7.4. Child A is the only child in their class who refuses to wear a mask. They say there a *'a few'* others across the school. Most children who do not wear masks are exempt due to Special Educational Needs and wear a lanyard to signal this.

7.5. Child A has been challenged by staff at school on numerous occasions. They report that they are often followed by staff who notice that they are not complying with the expectation to wear a mask and are asked why they is not wearing one.

7.6. Child A informs staff that they have chosen not to wear a mask. They reported that on some occasions, they are questioned further and asked repeatedly why they are not wearing a mask.

7.7. Child A said that *'Sometimes if you give them your answer they say 'Well, you should be [wearing a mask]'.*

7.8. The response to Child A's explanation varies, depending upon the particular member of staff involved.

7.9. On one occasion, a teacher shouted across the class at Child A, challenging them publicly as to why they were not wearing a mask and repeating his challenge when Child A explained they had chosen not to wear a mask. Child A felt singled out and upset. Following this lesson, they were reportedly kept back by the teacher, who told them that they should wear a mask *'next time'*.

7.10. Child A reported that there have been several assemblies during which children have been told that they must wear a mask because *'you'll pass it on to everyone else'*. Child A said they have not been provided with clear evidence as to the role masks may play in reducing transmission of SARS-CoV-2. Instead, children are told that if they don't wear a mask, they are *'putting everyone at risk'*. They have been told that they are at risk of exclusion if they do not comply with COVID-secure policies.

7.11. Child A feels strongly that they should exercise their right not to wear a mask, but said *'I feel guilty, because I'm not wearing one and everyone is looking at me... the teachers make me feel worse'.*

7.12. Child A said the effect of masks and social distancing in school has been to depress the atmosphere. They said, *'It's not how I imagined school... it's not how I wanted secondary school to be. No one talks to anyone anymore... in class, it's miserable. It's not the same as it was. Everyone would be having a laugh but it's not like that now. It takes the fun out of school'.*

7.13. They reported that wearing masks *'affects the atmosphere... it's hard to communicate and have fun'.*

7.14. They reported that on the first day of masking, *'everyone laughed it off... on the second day after we'd gone back everyone was tired of it. It's like the class itself is just tired and everyone is sad'.*

7.15. In class, teachers wear masks. They remain at the front of the class in a designated area two meters away from the first row of children. Child A reported that it is often difficult to understand what teachers are saying due to the masks. Sometimes children are not sure what is expected of them as they have not understood instructions. Teachers can be impatient about this, not understanding that it has been difficult for students to make sense of what they are saying.

7.16. Child A said it is particularly difficult to understand teachers in foreign language lessons.

7.17. Child A reported that the teaching methods are limited due to social distancing, so this makes classwork less fun. They said, *'We don't get to do partner work so you don't get to know people as much. It's just not fun anymore...'.*

7.18. They reported that some of the teachers had commented and asked the children in their class why they were so quiet.

7.19. Child A reported that in their class, although they are the only child who does not wear a mask, all the other children except one object to the introduction of masks in school (i.e. 29/30 children are reportedly unhappy with the requirement to wear a mask in school). They dislike wearing them and complain about it. Child A said, they are *'fed up'* and say *'I can't be bothered with this'*. They said, *'They only wear them because they think the teachers will have a go at them'.*

7.20. Child A believes that most children do not realise that wearing a mask is not compulsory. They said, *'Everyone thinks you have to wear masks, but you don't'.*

7.21. They said children behave like they are finding their masks uncomfortable. They said, *'They keep moving them so they can breathe'* but are told *'Pull your mask up, please'*.

7.22. Child A reported that when they are unsupervised, children pull their masks down. They said that sometimes children ask staff members if they can pull their masks down *'for a bit'*, but are told *'No, because you'll put us all at risk'*.

7.23. They have heard children who are reprimanded for pulling their masks down tell their teachers *'I pulled it down so I can breathe'*.

7.24. One of Child A's friends has asthma but wears a mask because she does not want to be different or to be told off. Child A reported that on one occasion recently, their friend had been having an asthma attack but was expected to wear her mask as she walked through the school to the medical room.

7.25. Another of Child A's friends suffers from anxiety. Child A has observed their friend *'trying really hard [to comply]... he feels pressurized, but it makes him panicky. When he had a panic attack, he had to wear his mask until he got to the medical room'*. Child A said, *'He says it makes his anxiety worse and he feels claustrophobic'*.

7.26. Child A's parents have not consented to their child taking part in the routine asymptomatic testing of students. Child A reported that they did not experience any difficulty with this, because day-to-day there is no way for others to know if you are being tested or not. However, they reported being upset for a friend who had experienced the lateral flow nasal and throat swabbing as distressing and had cried following the testing at the start of term.

7.27. In the week prior to our interview, Child A had lost a special pet. They had some days off school due to this loss, but on their return to school they felt upset that they could not interact properly with their friends and that they were not allowed to hug them. They said, *'It could have been better if you could smile and hug'.*

7.28. Child A said, *'It's getting a bit much now. When the masks were in the corridors it wasn't too bad. It was uncomfortable but you could do it. But it's unbearable when you have to wear them all day'.*

7.29. In relation to teachers challenging students if they do not wear a mask or if they wear them incorrectly in order to breathe more easily, Child A said, *'They make you feel you have to do it. It's not fair... they are fully grown adults and we are twelve-year-old kids'*. Child A said that this is the reason, in their view, that children are complying and not exercising their right to choose not to wear a mask despite their discomfort.

8. Issues for consideration identified by Child A's testimony

8.1. All aspects of health and development contribute to a child's wellbeing, with it being widely recognised that emotional and psychological health is of equal importance to physical health (2). This is true throughout children's development, from infancy through to the end of adolescence and into young adulthood. Research suggests that brain development continues well into the twenties (3). We also know that children's learning, growth and development 'is not just something that happens. It requires attention - and much more investment' (4). Crucially, this investment includes the nurturing of a child's emotional and physical connection with loved ones, engagement in play and leisure activities, provision of a sense of structure, safety and predictability and a sense of community belonging.

8.2. In the UK, from the age of five years, schools are the place where, second to their own homes, children spend the most time (approximately between 30 and 35 hours a week). Therefore, schools play a significant and vital role in children's social and emotional growth and development, and in maintenance of their emotional well-being.

8.3. It is therefore crucial to consider how children's experiences are being directly affected by current SARS-CoV-2 measures in schools and the potential consequences.

8.4. The risk assessment document supplied by [redacted] does not consider potential for physical or mental harm as a direct or indirect result of SARS-CoV-2 measures introduced into school.

8.5. Child A's account of their experiences of masking in school identify a number of areas of concern.

8.6. Although Child A has recounted their personal experience, as well as their perception of the other children's experiences in their Year 7 class, it is important to note that throughout the UK, the great majority of secondary school children are currently masked throughout the school day. Many of the issues Child A raises are, therefore, likely to be widespread, both across the school and across the country.

8.7. I have identified five key themes from Child A's testimony. I will consider each of these in terms of potential for psychological harm or interference with normal psychological development, both to Child A personally, and to other children. These are:

8.8. Undermining (and harassment) of children who are choosing to exert their right not to engage in voluntary measures

8.9. Interference with effective communication in lessons

8.10. Interference in children's communication with each other, their socialising and experience of relationships

8.11. Interference with children's development of sense of self and their attitudes to others due to 'fear messaging' within the school

8.12. Interference with children's experience of school as safe, comfortable and enjoyable environments in which they can learn and develop

9. Undermining (and harassment) of children who are choosing to exert their right not to engage in voluntary measures

9.1. Child A described experiencing multiple challenges from teachers, due to their choice to exercise their right not to wear a mask in school. They described being continually questioned, having their justification dismissed or undermined and being made to feel, through these interactions with teachers, '*guilty*'. They also described an incident when they were socially shamed, with a perceived degree of verbal aggression, which left them feeling vulnerable and upset in front of other students.

9.2. Masking and the messaging around them in school (e.g. in terms of teachers' language when promoting mask wearing, and in instructional assemblies as described by Child A) allow for discrimination, as the implication for a child who will not wear a mask is that they are behaving selfishly and in a morally reprehensible manner. Child A is being treated differently to their masked peers by teachers who are advocating mask-wearing.

9.3. Child A is aged 11 and in Year 7 at school. Year 7 is the first year of high school in the UK. Children in Year 7 are relatively new to the school community and is building relationships with teachers. When challenged by staff, they clearly state their reasoning for making the choice not to wear a mask. The fact that they continue to be questioned, or that their responses are met with dismissive comments, will be a continual source of stress and is likely to have a negative impact on Child A's self-esteem and sense of self. They are clearly aware that they are displeasing teachers with whom they will be learning throughout their time at high school.

9.4. Child A's choice to exercise choice in this matter, as advocated by government, appears to have been met by responses which undermine their legitimate decision. Research shows that social undermining has a significant role in supervisor/supervisee relationships and that it leads to various negative outcomes including feelings of irritability, anxiety, depersonalization, and depression. It shows that social undermining also affects work ethic and well-being. Social undermining also interferes with the ability to establish and maintain positive interpersonal relationships, success and a good reputation (6).

9.5. Child A described feeling '*guilty*', despite their conviction that they have made the right choice in their decision, based on their appraisal of the current situation, and described their sense that '*everyone is looking at me.. the teachers make me feel worse*'.

9.6. Given that these experiences are ongoing, Child A may internalise these perceived negative appraisals of their actions, becoming hypervigilant to criticism, with negative impact for their self-esteem, for their enjoyment of school and their learning outcomes (7). Long term consequences of guilt and shaming include anxiety, feelings of worthlessness and disruption to self-conceptions (8).

9.7. Child A's manner of describing their experiences in school during our interview suggested that already they see themselves as in conflict with teachers and thought of badly by them. Research shows that student–teacher relationships are critically important and influence children's academic, social, behavioural and emotional development, having predictive and protective functions in all these areas (9). The establishment of a conflictual relationship with school authority within months of their arrival at high school appears to be already interfering with Child A's assimilation into the school community and their appraisal of school life (e.g. *'It's not how I imagined school.. it's not how I wanted secondary school to be')*.

9.8. Currently, Child A appears to have evaded any significant harassment from peers due to their decision. They report that they have been *'looked at'* and questioned by some students but did not give the impression at interview that they experienced these conversations to have been difficult or persistent. It is probable, however, that Child A was recalling these incidents with some degree of bravado, and that when they are confronted by peers this is an uncomfortable experience given that they are the only child in the class to have made the choice not to wear a mask. Moreover, it seems fair to assume that peer attitudes may change and become less tolerant should masking in schools be continued and become normalized, especially if verbal challenge and critique is continually modelled by teachers. It is likely tolerance levels might vary, depending upon the perceived threat of COVID-19 to the community at any given time.

9.9. It is important to note that peer harassment (or bullying) is a major problem affecting children and adolescents internationally. By not wearing a mask, Child A is visibly identifiable as a minority, which has many well documented negative implications for physical and psychological health (10) including increased risk of victimisation.

9.10. Research also suggests that problematic teacher-student relationships (which Child A reports) predict negative peer-peer relationships. Both direct and

indirect student-reported teacher-to-student aggression are associated with increased peer victimization and increased student-reported peer aggression (11). Child A and other children who do not wear masks in school, for whatever reason, risk being discriminated against, stigmatised and harassed or bullied by peers.

9.11. Bullying and harassment is associated with increased risk of mental disorder and social and relationship difficulties, both in the short and long term (12).

9.12. Some of Child A's peers are exempt from wearing a mask due to physical or psychological health reasons and wear a lanyard to signal this. These children are wearing visual identifiers which alerts peers to the presence of disability or some other 'difference'. For these children there may be some additional detrimental psychological impact. They are expected to 'wear their disability' in a public manner in order to evade repeated questioning from members of staff. In a secondary school environment, in which 'peer fit' is a primary motivation for adolescents, this may have implications for internalising beliefs of deficit (e.g. that 'there is something wrong with me') which is associated with adverse psychological outcomes (13). They may also be targeted by peers due to their disability/difference.

9.13. Given that the clear message from the school authorities is that children who do not wear a mask are putting the community 'at risk' and a threat to others, it seems likely that should individuals within the school or wider community experience significant sickness, or even death, due to SARS-CoV-2, children who choose not to wear a mask, or are exempt, may be blamed, harassed or bullied. Children who cannot wear a mask may also self-blame. The significant and adverse psychological outcomes of bullying and guilt have been outlined previously.

10. Interference with effective communication in lessons

10.1. Whilst schools make vital contributions to children's development in a number of ways (e.g. social, emotional, moral), most people would understand the primary purpose of schools to be education.

10.2. During interview, Child A described how, since March 8th, in line with the school's risk assessment protocol, teachers are masked whilst teaching. They also described how, due to infection control regulations, teachers remain at the front of class throughout lessons in a demarcated area which is two meters away from the nearest row of children. They deliver all teaching from the front of class, whilst also meeting the needs of students who are self-isolating at home via a laptop.

10.3. Child A has described frustration because they struggle to understand what teachers are saying, sometimes missing crucial instructions and not knowing what is expected of them. They also described finding it particularly difficult to understand teachers and benefit from teaching during foreign language lessons.

10.4. There have been a number of studies on the complex topic of nonverbal communication with varying results. However, most experts agree that between 70 to 93 per cent of all human communication is non-verbal (14), emphasising the importance of facial expressions. It is self-evident that masks cause an impairment of non-verbal communication via the blocking of facial expressions. This creates difficulties in the reading of emotional and cognitive states (15) which are crucial for multiple aspects of social interaction. Removal of facial expressions can cause distress (16), and covering the face can lead to a sense of social isolation, anonymity and changes in social dynamics such as increased distrust and aggression (17). The importance of reading and mirroring facial expressions in the development of relationships, and effective learning through these relationships, is well-established in infants and young children (18). This phenomenon is likely to remain relevant well past infant development, as human interaction and attachments develop throughout childhood and adolescence.

10.5. Research provides explanation as to why Child A experiences difficulties during educational interactions when their teachers' faces are covered. Teachers themselves have reported the technology of facial expressions to be essential in the teaching-learning process, having an important role in effective communication of information to students and the attainment of students' learning outcomes (19).

10.6. In addition, Child A and other children are highly likely to struggle to understand teachers' speech due to masks preventing their ability to use lip-reading, along with aurally received information, to make sense of what their teachers are saying. Research shows that visual data received from the face and mouth have an important role in speech comprehension even in people with normal hearing (20). Clearly, preventing the ability to lip-read will be more problematic for children who have some degree of hearing impairment, which is a relatively common additional need amongst children in the UK (21) and is statistically likely to affect a number of children at Child A's School.

10.7. It is therefore reasonable to assume that students at Child A's school and at other schools in the UK are experiencing a sub-optimal educational experience when their teachers are masked during lessons.

10.8. The interaction between teachers and students works both ways, however, and with students also masked, there is further interference with effective teaching and communication. The importance of teachers' ability to read students' facial expression is also established by research, which shows that facial expression is the most frequently used mode of nonverbal communication by students. Facial expressions of students are significantly correlated to their emotions which helps teachers to recognize their comprehension and to respond and tailor their teaching to that feedback (22).

10.9. Moreover, in addition to impairment of teachers' ability to recognise comprehension and children's response to teaching material due to masks, it is also important to note that the broader role of the teacher, in providing support and monitoring the emotional well-being of students, is compromised by masking. Given that the intervention of masking children in classrooms is novel, there is little research about the impact on the child/teacher relationships of routine use of clinical masks in classrooms. It therefore seems relevant to include anecdotal evidence from my own clinical practice, in which in recent weeks I have heard accounts of children being distressed or anxious in class but these experiences not being noted by teachers who remain at the front of class and who may struggle to recognise facial expressions of distress, confusion or anxiety in their students due to face coverings. In the words of one young person who experienced distress due to mental health difficulties during one lesson, *'It feels very lonely.. you can feel invisible'*. Such experiences are likely to lead to further emotional distress and impact on learning.

11. Interference in children's communication with each other, their socialising and experience of relationships

11.1. Classroom teaching involves not only communication between teachers and students, but between students themselves. Interactions between students during lessons, both informal (social) and formal (part of the lesson) are an important part of the classroom experience. These interactions, however fleeting, contribute towards the sense of their class community and reinforce children's connections with each other. Since the implementation of the masking policy in school, Child A has noticed the impact on the classroom atmosphere and the mood of their fellow students.

11.2. They said: ***'No one talks to anyone anymore... in class, it's miserable. It's not the same as it was. Everyone would be having a laugh but it's not like that now. It takes the fun out of school.. it affects the atmosphere.. it's hard to communicate and have fun... It's like the class itself is just tired and everyone is sad'.***

11.3. Child A's explanation of the onset of this change in mood with the use of masks in the classroom seems credible, given knowledge about masking and its interference with non-verbal communication. When children are in lessons, non-verbal communication is the most likely means by which they communicate – to share humour or understanding, for example, or to indicate interest or friendliness (via a smile). It is crucial not to underestimate the importance of these often-fleeting moments of human connection during group experience. The loss of these interactions with peers, especially in the current situation, where due to current SARS-CoV-2 policy, 'partner work' and other peer supported teaching techniques are not in use, might be felt more. It seems that opportunities for children in Year 7 to *'get to know'* children outside their immediate friendship groups during structured lesson time is severely limited by the masking and other NPIs in school.

11.4. At interview, Child A described a number of ways in which their interactions with peers have been affected since the introduction of masks into school, and more recently, into the classroom. As a Year 7 student in an exceptional cohort, which did not experience the benefits of the full primary-secondary transition programme available to all previous years, Child A and their peers arguably arrived at High School in September 2020 at a disadvantage. Since that time, they have had one full term, which, for many, will have been disrupted by (sometimes multiple) periods of isolation due to NHS Test, Track and Trace programme within the school. Bubble systems in school and fixed seating plans which aim to reduce potential transmission of SARS-Cov-2 also necessarily reduce contacts between children and access to broader social experience. With the third national lockdown, these children then missed two months of the Spring term. Due to these multiple interruptions and impediments, it is clear that Child A and their peers will not have had the same opportunities as children in previous years to form and cement new friendships across the year group and school community, and for their class to bond.

11.5. Adolescence (commonly understood to span the ages of 10-18 years) is a distinct phase of the developmental life cycle in humans (and other animal species), involving significant physical, emotional, cognitive and social change. As young people start their journey towards 'individuation' (gaining a sense of self which is separate to their parents/caregivers), this is a period characterised by heightened sensitivity to social stimuli and the increased need for peer interaction (23). Much of young people's 'developmental work' is achieved via their social interactions with peers during this phase. *Fitting in*, or gaining peer acceptance, is a primary objective of youth in the high school context and, for many adolescents, may be more important than academic goals (24). These high school experiences become source material for more enduring perceptions of 'self' and of social fit for adolescents (25). Furthermore, some theorists argue that social learning precedes and directly influences cognitive development during this period, as in earlier stages of development (26).

11.6. Physical distancing measures and other NPIs interfere with the ability of young people to interact freely and to engage in behaviours which are necessary for their social, emotional and, indeed, cognitive development. Researchers are already considering the disproportionate and potentially far-reaching consequences of such interventions for young people (27).

11.7. In my opinion, especially after a several periods of social deprivation during lockdowns and self-isolation over the past year, many of the measures in place at [redacted] and at other schools across the country (in particular masks and social distancing) are significantly interfering with children's development because they suppress human behaviour which is essential for effective communication and interaction. Social relationships are impeded, in the manner described at Section 10 of this document, via the covering of faces and obscuring of facial expressions. Research tells us that subtle changes in facial expressions are used, more or less consciously, in order to achieve a social goal, for example to obtain attention or support, and for interpersonal experience. Moreover, we know that interpersonal

interaction is regulated by emotional expression, whilst simultaneously emotional experience is regulated through interaction (28). Therefore, inhibiting this vital element of social communication significantly limits the ability of students to recognise, respond to and regulate each other's social responses and emotional states, especially when they are only just getting to know each other (29).

11.8. In addition to this, school policy is denying children the experience of touch and close physical proximity with other children. For example, Child A described returning to school after the loss of a well-loved pet and experiencing sadness and frustration because their friends were not allowed to physically comfort them. Even within day-to-day interactions which are less emotionally fraught, touch is a powerful tool for communicating positive emotions in humans, and plays an important part in the development, maintenance and reinforcement of social structures and human bonds (30). In addition to this, research over recent decades has increased our understanding of the role of social chemosignals (e.g. hormones and pheromones) in human social interaction. This is the oldest sensory system for coordinating social (and reproductive) behaviour and necessarily requires human proximity (31). It is concerning that SARS-Cov-19 health and safety measures in school (and indeed wider society) appear blind to such fundamental human needs. The short, medium and long-term impact of such interference with evolutionarily conserved systems, especially for the highly-sensitised adolescent brain, must give pause for thought.

11.9. It is telling but not surprising that, given these policy-created impediments to communication and interaction, since the introduction of these measures children in Child A's peer group are reportedly less motivated to engage with each other (***'No one talks to anyone anymore... in class, it's miserable'***). This is concerning, and indeed very sad, given that we know that normally developing adolescents should be highly interested in, and motivated by, peer interaction.

11.10. It is my opinion that policies which coach children to resist normal, emotional responses to other (e.g. urges to comfort, display physical affection or engage in tactile playfulness) are worrying. Such interventions deny Child A and their peers, both at X School and other schools in the UK, the normal opportunities for emotional engagement, physical closeness and social touch. This has the potential to cause significant harm to the development of peer relationships and children's social skills generally.

11.11. Given that the current situation of such social curbs is novel, it is plausible that these measures could be harmful to these children's social development and future capacity for normal emotional closeness and intimacy in ways which we do not yet understand. Currently, it seems schools and society at large are making the assumption that when measures are removed, children will return to their previous belief systems and social behaviours. We do not know that this will be the case, however, and in my opinion, the longer these measures remain in schools, children's social behaviour, their capacity for normal intimacy and ability to respond to each other in a pro-social and attuned manner may be permanently changed. The psychological and societal outcomes of such change, for a whole generation, could be devastating.

12. Interference with children's development, sense of self and their attitudes to others due to 'fear messaging' within the school

12.1. Child A described messaging within school, both from individual teachers and from the school leadership in the form of assemblies, which use fear of contamination in order to promote behaviours including mask-wearing and social distancing. The phrases which they hear repeated during the school day are:

- *'You'll put everyone at risk'*
- *'You'll pass it on'*
- *'You'll put us all at risk'*

12.2. In addition to these directly communicated messages, children are also being subjected on a daily basis, both in school and in the wider community, to environmental cues will also have the effect of triggering reminders of death, contagion and illness, either consciously or subconsciously, and are likely to lead to continual feelings of underlying fear. The almost universal wearing of masks in schools (and in other public spaces such as shops and places of worship) is possibly the most powerful and prominent of these environmental cues. However, other features of the school environment including changed behaviour of others (e.g. teachers keeping a distance from students), signage about contagion and one-way systems, designated areas for certain activities (e.g. teachers' demarcated spaces at the front of class) and whole-school asymptomatic testing also play powerful roles in creating and maintaining an atmosphere of danger.

12.3. These are all clear messages of contamination which suggest that everyone in the school is infected with a dangerous virus and that each child poses a significant risk to the community. This is despite the fact that that it is widely accepted that children are not, except in extremely rare circumstances, adversely affected by SAR-CoV-2. In addition, I understand that there is now strong evidence that children are not drivers of transmission (32) and questions about whether asymptomatic cases play a significant role in transmission (33). Fear messaging in school is therefore both confusing and, arguably, damaging for children. At Child A's School, as in other schools across the country, school policy reflects the UK government's 2020 Public Health campaign 'Act Like You've Got It' and asks young people to deny their own experience and knowledge (that they are healthy) and consider themselves to be a risk to others.

12.4. To increase compliance with pandemic related restrictions, the Government has used a strategy to deliberately increase fear amongst the population, often at a subconscious level (34). Institutional health and safety policies in wider society (including in schools) have reflected this strategy over the past year. The psychological ethics of this government approach are questionable in and of

themselves given professional codes of ethics (relating to issues of informed consent and appropriate use of psychological techniques) (35). However, the ethics of these techniques concerning children are even more questionable. As young people's brains are not fully formed, they will be unable to contextualise information relating to risk and harm in the same ways as adults. This could leave them feeling more fear and confusion than adults subjected to the same techniques in the wider community.

12.5. In my view, schools' adoption of fear messaging as part of their approach to ensure compliance with policy, including voluntary measures such as masking, is unethical. It is potentially harmful to children's ability to form trusting relationships with adults in authority. In addition, fear messaging, and associated increased levels of individual fear, reduces children's sense of safety, impacting upon their ability to thrive and learn (36). Most importantly, however, it teaches children to be both wary of others and to consider themselves a danger to their friends, family and the wider community. There is significant potential for harm, in terms of their sense of self, their relationships with others and their capacity to practice normal intimacy, both currently and long-term.

13. Interference with children's experience of school as safe, comfortable and enjoyable environments in which they can learn and develop

13.1. In their interview, Child A described negative experiences of school life due to the implementation of the masking and social distancing policies. There was a clear sense that pleasure in the school day, in learning and in socialising has been adversely affected by these interventions. For Child A, their experience of being continually questioned, and the message that they are behaving in an unacceptable and irresponsible manner by exerting their right to choose not to wear a mask, will, no doubt, impact upon their sense of ease within the school environment and their ability to enjoy the school day. In addition, they are bearing witness to the discomfort of peers, the vast majority of whom wear masks all day. For those children there is experience of physical discomfort due to restricted breathing,

which Child A has observed both generally across the class, as well as during more extreme experiences in which those their friends who have additional medical or mental health difficulties have been distressed. Child A described witnessing children being denied the opportunity of a few moments unrestricted breathing, and friends with asthma and anxiety being expected to continue restriction to their breathing despite distress. For Child A, whilst their breathing remains unrestricted due to their choice, there will be the sense that children are being subjected to unpleasant experiences by staff and school leadership. This sense is likely to have been increased by their experience of witnessing a friend's distress following lateral flow swabbing of the throat.

13.2. It is not surprising, therefore, that, at interview, Child A's view of school and staff was mostly negative. It is difficult to see how the current approach to implementing COVID-19 health and safety policy within school promotes one of the seven 'Agreed Principles of Effective Learning' on the school's website: 'Positive relationships based upon mutual respect between staff and students' (45).

13.3. Child A's description of their peers as '*sad*', the atmosphere as '*miserable*', and their peers as relatively demotivated to interact is supported by recent findings from Germany, where children have been wearing masks in school since August 2020. Researchers there have raised concerns due to accumulating evidence that children and adolescents experience significant difficulties caused by wearing masks (37). It seems surprising that evidence from this study has not been widely discussed in this country or considered by UK government's Department of Education and by individual schools when developing policy ahead of the reopening of schools in March. The German study involved over 20,000 respondents reporting on children's experiences of mask wearing in schools. Impairments caused by wearing the mask were reported by 68% of the parents. These included irritability (60%), headache (53%), difficulty concentrating (50%), less happiness (49%), reluctance to go to school (44%), malaise (42%) impaired learning (38%) and drowsiness or fatigue (37%).

13.4. Both the introduction of masks and the implementation of social distancing policies within in school appear to have had a significant and adverse impact upon Child A's experience of school life and on that of their peers. Physical and psychological discomfort, and unhappiness, due to the measures themselves and the manner in which they are being implemented are likely to impact negatively upon children's mood and sense of subjective happiness, as suggested by Child A's account and early research findings from Europe, as well as their ability to thrive within the school environment and attain good educational outcomes (38).

14. Conclusion

14.1. This report has detailed current policy at X School, described Child A's experiences and has considered the potential psychological impact of SARS-CoV-2 measures on children using psychological theory and research.

14.2. It is my professional opinion that current policies intended to reduce SARS-CoV-2 transmission within Child A's School, and their manner of implementation, are causing unintended psychological and developmental harm to young people within the school community. It is my view that there is the potential for significant harms to young people's social, emotional and cognitive development and their well-being.

14.3. Children across the UK are being subjected to psychological and developmental harms due to the widespread adoption of government-endorsed SARS-CoV-2 policies in schools.

14.4. Due to the novelty of the current situation within schools and the lack of clarity about the extent to which interventions that interfere with normative adolescence development and experience may impact children, we must rely in the

main on existing knowledge about how adolescents interact, develop and thrive, and the known consequences of interference with these processes. Research has shown that social deprivation and isolation have unique effects on brain and behaviour in adolescence compared with other stages of life, for example (27). It is reasonable to extrapolate from accumulated knowledge in this area that, given the importance of adolescence in the developmental trajectory of human beings, and increasing knowledge about the sensitivity of the adolescent brain to environmental influences and stressors (39), there is real potential for far-reaching consequences. Findings from recent studies have started to confirm concerns about harm caused to children and young people by such unprecedented social policies (e.g. 40, 41).

14.5. Since March 2020, Coronavirus-related government policy has seen schools close, children compelled to stay at home and refrain from organized sport and other normal activities. They have been forbidden to engage in face-to-face contact with extended family members, friends and peers. For the first time in British history, such rules have been imposed by a government upon a whole generation of children and young people, in spite of decades of accumulated knowledge and understanding about the necessary circumstances for optimal child and adolescent development. It does not seem unreasonable, therefore, to describe this as a social experiment which has been conducted without informed consent, and without due consideration of the enormous potential for harm. The introduction of social distancing and other NPIs in schools since their reopening, and the recommendation of masking secondary school children, has clearly not been appropriately risk assessed.

14.6. Already there is compelling evidence that children and young people have borne a disproportionate psychological burden on behalf of the nation. Research findings indicate that they are facing an unprecedented mental health crisis, the full scale of which is yet unknown (40,41). Incidence of mental health disorders in young people, which had risen sharply since 2007, appears to have escalated further since March 2020. The outgoing Children's Commissioner, Anne Longfield, has cited data

from NHS Digital collected in July 2020, which found that clinically significant mental health conditions amongst children had risen by 50% compared to three years earlier. A staggering 1 in 6 children reported behaviours and symptoms that suggested a probable mental health condition, up from 1 in 9 in 2017 (44). Clearly, we cannot say how much of this rise has occurred over the past three years, and how much was a direct result of the pandemic and government response. However, mental health conditions in children had risen very gradually over the previous 15 years, which strongly implies this significant and rapid rise was the result of the pandemic. Since July 2020, children and young people in UK have endured a further nine months of restrictions of varying degrees. It seems reasonable to assume that these experiences will have had further detrimental impact on young people's mental health. It is increasingly evident that the pandemic has taken a 'devastating toll' on the mental health of the young which will impact on their lives for years to come (43).

14.7. In this context, it is arguable that, now more than ever, schools have a duty of care to young people, to safeguard and promote the healthy, normative development and emotional well-being of their students. Child A's school website states that its vision is to create an environment 'where all people thrive' to deliver an education that 'supports students to fulfil their potential' (45).

14.8. Professionals working with children are trained to hold the interest of children as paramount and have a duty to place their needs at the forefront of all they do. The Children's Act (2004) states that welfare and safeguarding of children is everyone's responsibility. The UK government is also beholden to the UN Convention on the Rights of the Child, which it ratified in 1991. The four core principles of the convention are: non-discrimination, devotion to the best interests of the child, the right to life, survival and development, and respect for the views of the child.

14.9. It is therefore deeply disturbing that since March 2020 the principles of this legislation and the Convention appear to have been forgotten, both by many professionals and officials with responsibility for children's welfare, and by the UK government itself.

14.10. SARS-CoV-2 policies in place both within schools and wider society, work against the manner in which child psychologists and other child professionals are trained to work with and think about children and young people. Since March 2020, the government has enforced or recommended interventions which hinder communication, lower self-esteem, increase anxiety and impair development to an extent that if this happened in a private family it would be considered a safeguarding issue.

14.11. In keeping with the principles of the Children's Acts (1989, 2004), there is a professional obligation on the part of all people working with, or on behalf of, children (e.g. teachers, social workers, psychologists, those in local authority, public health officials, civil servants, MPs and cabinet ministers) to consider whether a plan of action does in fact place children's rights as paramount and whether it is in their best interests.

14.12. For the reasons outlined in this report, I am forced to question whether this is the case with the indiscriminate use of NPIs in schools.

14.13. In my opinion, school policy in relation to limiting SARS-CoV-2 transmission not only prevents the school from supporting Child A and their peers to 'thrive' and 'fulfil their potential' but is likely to be causing them psychological harm of unknown quantity.

14.14. The practices at Child A's school are similar to those introduced in most secondary schools across the country, meaning that the scale of damage to children

is potentially monumental. Therefore, the widespread implementation of non-risk assessed and potentially harmful policies, both now and in the future, is an urgent matter for all concerned with the welfare of children and young people.

15. Duties as an Expert Witness

1. I understand that my primary duty in writing reports and giving evidence is to the Court or Tribunal rather than the party who engaged me.

2. I have endeavoured in my report and in my opinions to be accurate and to have covered all relevant issues concerning the matters stated which I have been asked to address.

3. I have endeavoured to include in my report those matters which I have knowledge of or of which I have been made aware that might adversely affect the validity of my opinion.

4. I have indicated the sources of all information I have used.

5. I have not, without forming an independent view, included or excluded anything which has been suggested to me (in particular my instructing solicitors).

6. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.

7. I understand that:-
   a) my report, subject to corrections before swearing as to its correctness will form the evidence to be given under oath or affirmation.
   b) I may be cross examined on my report by an advocate assisted by an expert.

c) I am likely to be the subject of adverse criticism if the Court or Tribunal concludes that I have not taken reasonable care in trying to meet the standards set out above.

8. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent upon the outcome of the case.

9. I am aware of the requirements of Part 35 and practice direction 35, this protocol and the practice direction on pre-action conduct.

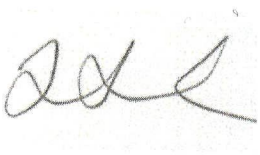
16. Statement of Truth

16.1.1 I understand my duty to the court and have complied with that duty. I am aware of the requirements of Part 35 of the Civil Procedure Rules, the corresponding Practice Direction 35 and the Guidance for the Instruction of Experts in Civil Claims 2014.

16.2 I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true.

16.3 The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

16.4 I understand that proceedings for contempt of court 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 in its truth.



Signed: Dr Zenobia Storah, Child and Adolescent Clinical Psychologist

Date: 5th April 2021

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45. Website for X School

Appendix: Curriculum Vitae

Dr Zenobia Storah
Clinical Psychologist
MA (Oxon), DipPsych, DClinPsy, CPsychol

Summary Overview

- Experienced Chartered, HCPC registered clinical psychologist specialising in working with children, adolescents and families
- Broad experience gained both within generic CAMHS teams, and within specialist services including those for adopted children, Looked After children, children with learning disabilities and children with neurodevelopmental conditions
- Extensive experience of providing a range of psychological assessments and interventions as part of NHS, Local Authority and private healthcare providers, as well as in private practice
- Extensive experience working as part of multi-disciplinary teams that provide assessment for neurodevelopmental conditions (ASD and ADHD) as well as post-diagnostic support for children and families both within the NHS and for private healthcare providers
- 'Expert Witness' for the Family Courts in cases where psychological assessment of children is required to inform Care Proceedings

Career History Summary

January 2018- present

Clinical Psychologist in private practice and

Clinical Lead on the Knowsley Neurodevelopmental Pathway, Liverpool

Independent psychologist worked independently, delivering therapy to young people privately and under NHS contracts. I provide clinical lead, therapeutic interventions and neurodevelopmental assessments for various NHS trusts.

October 2016 – January 2018

Senior Clinical Psychologist and ASD psychology lead, Warrington CAMHS

Lead Psychologist for ASD and other neurodevelopmental conditions, providing specialist clinical assessment and interventions for young people with ASD and/or ADHD presenting with co-morbid

mental health problems. Lead on service development in this area. I provided specialist mental health consultation and supervision for staff in CAMHS and partner services.

Additionally, I held generic responsibilities included providing routine and emergency assessment and interventions for children and adolescents with a wide range of clinical presentations.

February 2013 – December 2017

Various posts in Trafford Child and Adolescent Mental Health Services (CAMHS):

Clinical Psychologist

Clinical Psychologist, Learning Disabilities Team and Neurodevelopmental Pathway, Trafford CAMHS

Post-Adoption Clinical Psychologist, Trafford CAMHS and the Local Authority Adoption Team

- Provided routine and emergency assessment and psychological intervention for children and adolescents with a wide range of clinical presentations in generic CAMHS
- Provided assessment and psychological interventions for children and young people with moderate to severe learning disabilities and neurodevelopmental conditions.
- Provided autism assessments and diagnoses for young people, and post-diagnostic interventions.
- Provided psychological assessment and interventions for 'Looked After' and adopted children presenting with a range of attachment and trauma-related difficulties
- Provided lead on service development, delivered training to professionals and parents, developed links with partner services and provided clinical supervision to junior colleagues in CAMHS and colleagues in social care

September 2003-April 2010

Department of Clinical Health Psychology, University College London

I studied for my doctorate (Doctorate in Clinical Psychology) over six and a half years. I trained in London and Manchester.

I carried out my doctoral research across various forensic mental health settings and at the Home Office. My thesis examined the construct of '*Insight into offending behaviour*'.

September 2000-July 2003

- Various research/clinical assistant posts, at Imperial College, London; The Institute of Psychiatry, Kings College London; Learning Disabilities Team, Hackney, London

Education

2003-2010	UCL, University of London
	Doctorate in Clinical Psychology
1999-2000	Royal Holloway, University of London
	Conversion Diploma in Psychology - Distinction
1995-1998	Herford College, Oxford University
	MA English Language and Literature
1988- 1995	Loreto Grammar School, Altrincham
	4 A-levels (A grade), S level English Literature
	9 GCSEs (8 As, 1 B)