COVID-19 in children: analysis of the first pandemic peak in England

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ABSTRACT
Objectives To assess disease trends, testing practices, community surveillance, case-fatality and excess deaths in children as compared with adults during the first pandemic peak in England.
Setting England.
Main outcome measures Trends in confirmed COVID-19 cases, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) positivity rates in children compared with adults; community prevalence of SARS-CoV-2 in children with acute respiratory infection (ARI) compared with adults, case-fatality rate in children with confirmed COVID-19 and excess childhood deaths compared with the previous 5 years.
Results Children represented 1.1% (1,408/129,704) of SARS-CoV-2 positive cases between 16 January 2020 and 3 May 2020. In total, 540 305 people were tested for SARS-CoV-2 and 129,704 (24.0%) were positive. In children aged <16 years, 35,200 tests were performed and 1408 (4.0%) were positive for SARS-CoV-2, compared to adults, in 19.1%–34.9% adults. Childhood cases increased from mid-March and peaked on 11 April before declining. Among 2,961 individuals presenting with ARI in primary care, 351 were children and 10 (2.8%) were positive compared with 9.3%–45.5% in adults. Eight children died and four (case-fatality rate, 0.3%; 95% CI 0.07% to 0.7%) were due to COVID-19. We found no evidence of excess mortality in children.
Conclusions Children accounted for a very small proportion of confirmed cases despite the large numbers of children tested. SARS-CoV-2 positivity was low even in children with ARI. Our findings provide further evidence against the role of children in infection and transmission of SARS-CoV-2.

INTRODUCTION
Experience from countries recovering from large outbreaks of COVID-19 shows that children rarely develop severe or critical illness,1 or die from the infection as compared with adults.2,3 It is still unclear why the epidemiology, clinical features and outcomes of COVID-19 are so different in children compared with adults. COVID-19, caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), typically presents as an acute respiratory illness. Common symptoms include fever and cough, as well as fatigue, chest tightness and dyspnoea, although individual symptoms or clusters of symptoms have moderate to low sensitivity and specificity for the infection.4 While most individuals recover without specific treatment or hospitalisation, some, especially older adults, may progress to acute respiratory distress syndrome and multiorgan failure, which is associated with high case-fatality rates despite early and aggressive management in intensive care settings.5,6

In England, with a population of 55 million individuals, the first imported cases of COVID-19 were identified at the end of January 2020. Initially, case numbers increased slowly and were related to imported cases. However, despite contact tracing and testing individuals who met a geographic and symptom-based case definition, cases with no clear transmission chains or overseas travel started to emerge at the end of February. These cases were detected through community sentinel surveillance schemes, and cases without overseas travel were diagnosed in intensive care units (ICUs), through ICU sentinel surveillance, on the first week of March. Cases increased rapidly during the subsequent 2 weeks with evidence of community transmission across the country.
On 12 March, the UK moved from a containment to a delay phase of the government response to the pandemic, with emphasis placed on slowing the spread of the virus, lowering the peak impact on hospital and ICU services and pushing it away from the winter season; this included the recommendation for anyone with fever or cough to stay at home. Available testing capacity from individuals with mild symptoms in the community was also shifted to those who required hospitalisation and for outbreak investigations in closed institutional settings (such as care homes and prisons). On 23 March, the UK government closed all but essential shops and services and recommended that the entire population stayed at home unless they provided an essential service or were a key worker.

In England, Public Health England (PHE) has been conducting enhanced national surveillance of COVID-19 since the first cases were reported in Wuhan, China, in December 2019. While adults rightly remained the primary focus of national surveillance, an extensive surveillance strategy was also established to contemporaneously monitor childhood COVID-19 in England. Currently, COVID-19 cases have peaked and hospital admissions are the lowest since 23 March in England. Here, we describe the surveillance, epidemiology and outcomes of childhood COVID-19 during the first peak. In addition to disease trends, we assessed SARS-CoV-2 positivity rates in different childhood age groups compared with adults, community surveillance of SARS-CoV-2 in children and adults presenting with acute respiratory infection in primary care, cause of death in SARS-CoV-2-positive children and monitoring excess deaths in children compared with the previous 5 years.

**METHODS**

PHE initiated COVID-19 surveillance in England after the first cluster of cases was reported in Wuhan, Hubei Province, China in December 2019. In early January, an RT-PCR diagnostic test for SARS-CoV-2 was developed and validated by PHE. By early March 2020, the tests were also delivered by PHE regional laboratories and National Health Service (NHS) laboratories across England. Case definitions for SARS-CoV-2 testing varied over the course of the first peak of the pandemic (table 1). Throughout this period, confirmed cases and their close contacts were isolated to prevent transmission into the community. During the delayed phase of outbreak control, emphasis was shifted to testing those presenting to hospital with suspected COVID-19 with the aim of rapidly diagnosing cases and protecting those who were SARS-CoV-2 negative. Clinical follow-up of confirmed cases in children aged <16 years began at the start of the pandemic and is ongoing. Fatal cases were identified through regular linkage with the Patient Demographic Service, an electronic database of all NHS patients, as well as direct reporting of deaths by paediatricians and local Health Protection Teams.

**SARS-CoV-2 Positivity**

The respiratory DataMart system and Second Generation Surveillance System (SGSS) were used to assess SARS-CoV-2 testing in different age groups. SGSS receives reports of all positive SARS-CoV-2 tests, as part of its laboratory data capture. In addition, the previous DataMart system and SGSS were modified to include negative results from NHS and Public Health laboratories, which were then consolidated in a unified database which used a probabilistic algorithm to remove duplicates and results from patients that had tested positive. Positive results from one laboratory that only reported positives and results from patients outside England were excluded.

**Table 1** Summary of case definitions for population testing for SARS-CoV-2 in England

<table>
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<tr>
<th>Time period</th>
<th>Case definition</th>
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| Before 7 February 2020 | Epidemiological criteria
  In the 14 days before the onset of illness: |
  - travel to China OR contact with a confirmed case of COVID-19; |
  - severe acute respiratory infection requiring admission to hospital with clinical or radiological evidence of pneumonia or acute respiratory distress syndrome; |
  - acute respiratory infection of any degree of severity, including at least one of shortness of breadth (difficult breathing in children) or cough (with or without fever); |
  - fever with no other symptoms. |
| From 7 February 2020  | Epidemiological criteria
  In the 14 days before the onset of illness: |
  - travel to affected countries, including transit, for any length of time, in these countries OR contact with a confirmed case of COVID-19; |
  - severe acute respiratory infection requiring admission to hospital with clinical or radiological evidence of pneumonia or acute respiratory distress syndrome; |
  - acute respiratory infection of any degree of severity, including at least one of shortness of breadth (difficult breathing in children) or cough (with or without fever); |
  - fever with no other symptoms. |
| From 13 March 2020    | Inpatient definition
  - requiring admission to hospital; |
  - have either clinical or radiological evidence of pneumonia; |
  - acute respiratory distress syndrome; |
  - influenza-like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breadth, sore throat, wheezing or sneezing. |

*Imported cases were defined as cases with travel to countries with known COVID-19 circulation at the time or with contact with a confirmed case while abroad within a maximum incubation period of their onset of symptoms.

†Secondary cases were defined as cases that had contact with a confirmed or probable/suspected case in the UK and did not fit the definition of an imported case.

‡Sporadic cases were defined as cases with no travel history to countries with known COVID-19 circulation, and no known contact with a confirmed case.

**COMMUNITY SWABBING**

Community-based surveillance for influenza-like illness was established by the Royal College of General Practitioners Research and Surveillance Centre creating a network of general practices across England and Wales >50 years ago. Adults and children presenting to around 100 participating general practices with an influenza-like illness (defined as fever with one systemic and one respiratory symptom) had a nasopharyngeal swab taken for testing. Clinicians were instructed to sample one or two patients a week. Details of the swabbing scheme are detailed elsewhere. In March 2020, this surveillance was extended for SARS-CoV-2 testing in the community, including expanding the number of virology sampling practices to 300.
Figure 1  Epidemic curve (A), cumulative number of confirmed cases (B) and proportion of test positives (C) by age group for COVID-19 in children during the first pandemic peak (February to May 2020) in England.

MORTALITY TRENDS
Data on death registrations until midnight on each day are sent the next day to PHE by the General Registry Office. Death registrations since 1 January 2015 were aggregated by age in years, date of death, date of registration, gender and region. To model weekly all-cause deaths by week of death in children, the Euromommo algorithm was used to fit a trend to deaths in the past 5 years using only spring and autumn data (to avoid potential spikes from influenza and cold weather). The data were modelled using a Poisson distribution with rescaling based on overdispersion and an expected number calculated along with predictions limits (+2 Z-scores). To account for delays from death to registration, which could be long if reported to a coroner, an adjustment to data from the previous 50 weeks was applied using a model of the proportion of deaths registered with each time lag from 0 to 50 weeks. The same model is used to estimate excess mortality in older age groups with the exception that a cosine wave is used to capture the usual pattern of higher deaths in the winter compared with summer. Results of excess mortality trends are reported to Euromomo each week and presented as a Z-score analysis (https://www.euromomo.eu/).13

RESULTS

EPIDEMIOLOGY
Between 1 January and 3 May 2020, 129 704 (24.0%) out of 540 305 people tested positive for SARS-CoV-2 in England. In children, the first confirmed cases were reported on 29 February 2020. Cases started to increase during the second week of March and peaked on 11 April 2020 before declining gradually, corresponding to the trends observed in adults (figure 1). COVID-19 cases were confirmed across the country, with greater numbers diagnosed in large cities (figure 2). Children accounted for 1408 (1.1%) confirmed cases across all age groups and 742 (52.7%) were male. The median age of childhood cases was 5.9 years, with higher number of cases in infants and older adults (figure 3).
(178/959) in those aged 45–64 years, 20.6% (74/359) in those aged 65–79 years and 45.5% (150/330) in adults aged ≥80 years (figure 5). Samples were taken throughout the surveillance period and children rarely tested positive at any time, especially those aged 3–9 years, where only 1 of 168 (0.6%) was positive.

Deaths
There were eight deaths in children with confirmed COVID-19. Four children aged 10–15 years, three of whom had multiple comorbidities, died (CFR, 0.3%; 95% CI 0.07% to 0.7%) of the infection. In the remaining cases, another cause was identified and SARS-CoV-2 was reported to be incidental or an indirect contributor to death.

Mortality surveillance
There has been no increase in excess deaths in children aged 0–15 years until 3 May 2020 (figure 6). Between weeks 12 and 18 of 2020, where excess deaths have been reported in other age groups, the cumulative number of corrected daily deaths in children was one fewer than the expected number for this period when compared to the same period in the pre-COVID-19 era.

DISCUSSION
The experience in England adds to the growing body of evidence on the limited role of children in the COVID-19 pandemic, with just over 1% of confirmed cases occurring in children. Infants, especially those children aged <3 months and those aged 1 year were the most tested age groups and had the highest number of positive cases. With nearly half a million SARS-CoV-2 tests performed during the first 4 months of 2020, the positivity rate among 35 200 children tested was only 4.0% compared with 19.1%–34.9% in adults and older adults. Community testing of children presenting in primary care with acute respiratory infection identified very low rates of SARS-CoV-2 positivity (2.8%) even at the peak of the pandemic, especially among preschool and primary school-aged children. This contrasts with the higher positivity rates with increasing age in adults, reaching nearly 50% in those aged ≥80 years. Currently, SARS-CoV-2 positivity rates in the community are low across all age groups.14 Reassuringly, the case-fatality rate in children was below 0.5% with no evidence of excess mortality during the first peak of the COVID-19 pandemic in England.

Other countries with widespread SARS-CoV-2 testing practices have all reported low COVID-19 rates in children, who accounted for only 1%–3% of total confirmed cases.3 Inclusion of negative test results provides further reassurance of the large numbers of tests performed across all age groups, including children. The lower risk of COVID-19 may be due to lower expression of the cell surface enzyme ACE2 in the nasal epithelium of children compared with adults.15 This binds to the SARS-CoV-2 spike protein and promotes internalisation of the virus into human cells. Although clinical follow-up of childhood cases is ongoing, our initial assessment based on the source of paediatric testing suggests that around half the confirmed cases were hospitalised, which compares with 33% in the USA and 67% in Italy.16 17 Those that were not hospitalised were mainly during the containment phase when close contacts of confirmed cases,
specifically children of key workers, were screened for the virus, along with children attending the emergency department with acute respiratory infections.

A key unanswered question remains whether asymptomatic children might be contributing to community transmission of SARS-CoV-2. Reports of asymptomatic carriage in children are mainly from active follow-up of contacts of confirmed cases or screening children without adequate follow-up to determine whether they were presymptomatic or truly asymptomatic, as has been reported in adults. Although community testing of SARS-CoV-2 in England was not as widespread as some other countries, especially during the peak of the pandemic, our data found that only 4.0% of children nationally and only 2.8% of symptomatic children with acute respiratory infection in the community tested positive for SARS-CoV-2.

In Iceland, only 38/564 (6.7%) children aged <10 years who were symptomatic, had recently travelled to high-risk countries or had contact with infected persons, were positive compared with 1183/8635 (13.7%) individuals aged ≥10 years. The difference was more marked in population screening during lockdown when daycare and elementary schools remained open, yet none of 848 children aged <10 years were positive compared with 100/12 232 (0.8%) in children aged ≥10 years. In the Netherlands, community testing of patients presenting with acute respiratory infection in primary care also did not identify SARS-CoV-2-positive children. Additionally, children were never the first to be infected or to be the source of infection in the household. This is supported by other household transmission studies where children of confirmed cases, especially those aged <10 years, were significantly less likely to be SARS-CoV-2 positive or becoming symptomatic when compared with adults in the same household. This also applies in educational settings. In New South Wales, Australia, 9 students and 9 staff from 15 schools had confirmed COVID-19 and 735 students in primary care. Limitations include the suboptimal sensitivity of nasopharyngeal and oropharyngeal swabs for SARS-CoV-2.

The lack of reliable serology during the pandemic also meant that cases could not be confirmed retrospectively. Important questions still remain unanswered. We need more information on asymptomatic childhood SARS-CoV-2 infection and transmission as well as seroincidence studies in community and educational settings. Such studies are underway (https://www.gov.uk/guidance/covid-19-paediatric-surveillance) and will become particularly important to ease the lockdown and allow children and teachers safely back to school, and to understand transmission patterns should a second peak emerge.

CONCLUSIONS

England is currently nearing the end of the first peak of the COVID-19 pandemic. Consistent with other countries, children account for a very small proportion of confirmed cases and have very low case-fatality rates. Despite the large number of children tested, only 4% were positive for SARS-CoV-2. In the community, SARS-CoV-2 positivity was low even in children presenting with acute respiratory infections. Community transmission and serosurveillance will become increasingly important as lockdown measures are gradually eased.

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REFERENCES