Safeguarding Children in a Pandemic: Pandemonium with Possibility?

Working as a paediatrician over the last few months has been unlike any other time in my career. The restrictions and changes for children, young people and their families have been enormous. My colleagues and I have felt anxious about the risk to children and young people while schools are closed, services are reconfigured and families are ‘locked down’ at home. As a paediatrician with a special interest in safeguarding, this has posed a range of challenges and offered a few unexpected opportunities. Our task, as we begin to restore our services, is to build on the handful of positive outcomes that have arisen from this pandemic and work together to address the immense safeguarding challenges emerging over the coming months and years.

This paper explores some of the clinical situations in which safeguarding challenges have presented themselves during the pandemic. It then explores some of the opportunities that the reconfiguration of services has presented for those working in child health.

Emergency Department Attendances

One of the biggest worries for those of us working in child health has been delayed presentations to health services. Parents and carers have felt understandably anxious, particularly about attending emergency departments, and have often waited until their child is very unwell before going to hospital. I have seen children presenting with injuries, sepsis or a deterioration in a long-term condition like diabetes who have been more unwell at presentation because of a delay in coming to hospital. It has been challenging to convey the seriousness of delaying while recognising that, in most cases, this was in response to public health messaging to stay away.

Another noticeable change is an increase in infants presenting with feeding problems and crying. New mothers have not been allowed visitors in most maternity units and this, combined with worry about exposure to coronavirus in hospital, has meant people leaving with their newborns very quickly after birth. Most areas were not running face-to-face consultations with health visitors, and home visits from midwives in those early post-natal days have been limited. As a result, new parents have been left with a fraction of the

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breast feeding, immunisation, crying and sleep advice that they usually receive in the early weeks. This has inevitably endangered perinatal mental health with parents and carers having fewer health encounters during which to express worry or for health professionals to flag concerns. It may be some time before the full impact of this on breast feeding and immunisation rates comes to light. In the meantime, we have seen an increase in very young children brought to hospital with injuries typical of abuse (Unicef, 2020). In a letter to the Archives of Disease in Childhood, Sidpra et al. (2020) reported an increase in admissions to their hospital with abusive head trauma in the month following lockdown. However, this report was based on ten cases over one month in a single institution; whether or not this represents a wider shift in incidence remains to be seen. A combination of reduced community services, fewer opportunities to socialise and access wider family support, as well as exposure to more domestic abuse could contribute to the potential for an increase in child abuse.

Nor is the problem confined to younger children. We have seen a surge in acute presentations of young people following deliberate self-harm or with thoughts of killing themselves (Young Minds, 2020). The effect of an overnight severing of their face-to-face interactions with peers, loss of the stability school affords them and the extra pressure of being forced to spend more time with their families at home have all contributed. It has been particularly tricky to plan a safe discharge from hospital with adequate community follow up, especially given the uncertainty about how long it will take for services to be fully restored.

Outpatient Clinics

We have also completely changed how we see children and young people in the outpatient department. Almost overnight our clinics were converted to virtual appointments, most commonly conducted by phone and sometimes via video. Before the pandemic, I could count on one hand the number of virtual clinics I had done; in a matter of weeks, it has become the norm. Learning to build rapport in a room you are not really in and wondering who is listening when you talk to a young person has been hard. I have been very conscious of what is not being said and missing all the opportunities a face-to-face meeting provides to observe, react and ‘read the room’. It has been especially challenging for families who do not have English as their first language and those with limited access to devices or Wi-Fi. I am getting better at eliciting the voice of the child, but it is certainly harder to configure an electronic room in a way which best allows them to be heard.

Across the UK there has been a reduction in the number of referrals for child protection medicals (Local Government Association, 2020), despite increases in calls to Childline from children worried about the impact of coronavirus (National Society for the Prevention of Cruelty to Children, 2020). The closure of schools for most children has removed teachers as important ‘eyes and ears’ for early signs of abuse. Around 20 per cent of referrals for child protection investigations come from schools and, while they are closed, I feel rising anxiety about those children below the radar (Department for Education, 2019). The most vulnerable children are not attending school though they have been
encouraged to (Department for Education, 2020). So, there are two issues: those we were already worried about not being at school to access support and all those we do not yet know about. We are all worried about when and how this abuse will be detected but also what the impact on services might be when it is. There can be little doubt that we have paid a child safeguarding debt forward with potentially devastating consequences.

Supporting Staff

The final big challenge for me has been around the working relationships that I cherish and which are such an important part of providing good care for children and young people. We have moved our peer review online which allows us to discuss complex cases and reflect more generally on how we are feeling. But it does feel somehow inferior to a catch up over a cup of tea and a chance to talk through an issue. I am conscious too that my more introverted colleagues perhaps do not find the virtual environment easy and rely more on quiet conversations with individuals. Our work can be harrowing and providing space for colleagues to support each other and take stock is vital.

Glimmers of Hope

It is not all doom and gloom for children's services and safeguarding. The move to virtual platforms has allowed staff to access teaching that they would not otherwise have been able to, across sites and shift patterns. This is an exciting prospect for upskilling the children's healthcare workforce, particularly those working in small units and for those working part-time. It has been invaluable for peer review too as busy clinicians are able to support colleagues across the region from their desks. Nevertheless, part of the success of these virtual meetings is that they build on years of face-to-face encounters and well-established relationships. It remains to be seen whether continuing to work in the virtual space is as productive in the future.

Attendance at multi-professional safeguarding meetings has never been better. Almost for the first time, we have had senior nurses, social workers, general paediatricians, subspecialty paediatricians and named safeguarding professionals all together in a virtual room to discuss complex cases. This has sped up decision-making and undoubtedly improved the quality of the conversations possible, where before we may have had to rely on a proxy less familiar with the child or written notes. Again, only time will tell if this is sustainable. Having meetings held virtually has certainly encouraged attendance as busy professionals can move from one meeting to another without travel time. However, these meetings were being held at a time when professionals could not take annual leave and were restricted from doing much besides working.

Finally, the disruption brought by health appointments may be much less as we move to virtual consultations. Children and young people need not miss school and carers will need less time off work to attend appointments previously conducted at healthcare facilities often hours away. Young people are used to interactions occurring online and are undoubtedly more adept than
their paediatricians at using these platforms so there is much scope for them to educate us about how they want them to be conducted.

Conclusion

The disruption caused to children and young people by this pandemic cannot be understated. From a health perspective, we have already seen changes in emergency presentations to hospitals and considerable changes to the way we conduct our consultations. Children and young peoples’ health and wellbeing have been impacted in ways which we do not yet fully understand. Going forward we will need to be more vigilant than ever about those who are most vulnerable and be ready to advocate continually for them. We must endeavour to take the learning and shreds of hope gleaned over the last few months with us as we rebuild our services, to make them even better for the children and young people who will need them so desperately over the coming years.

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