

## Written evidence from Dr Clare Craig (DTA 09)

### Public Administration and Constitutional Affairs Committee Data Transparency and Accountability: Covid 19 inquiry

1. I am Dr Clare Craig, a Consultant Pathologist. I have carried out research into the COVID epidemic as an individual. The perspective of a pathologist is critical to understanding the problems with data collection.
2. Overall, the government's attempts at transparency have been laudable but there were some dangerous failings.
3. The emphasis on the publication of daily data resulted in devaluing of the quality of that data to such a degree that damaging decisions have been taken since spring.
4. Public Health England published a case definition which included the requirement that a patient have symptoms as well as a positive test. In an epidemic the definition of a case is that they have disease and so the presence of symptoms must be a fundamental requirement for the definition of a case. However, in an attempt to minimise the time from testing to data publication, there has been no sense check in place. The doctors caring for the patients have had no input whatsoever into the daily case numbers. A 'case' has been defined by a positive test result in a single, sometimes flawed, test. The Government's policy have all been driven by these flawed figures.
5. Similarly, the definition of a COVID death was driven entirely by laboratory reporting of data with no input from doctors caring for the deceased. What's more having defined a death as a COVID death using this flawed centralised system, doctors may have felt under pressure to include COVID on the death certificate rather than to oppose the edict from Central Government which had already declared their patient dead from COVID.
6. Adjustments in death certification to enable a functioning system during a pandemic are a reasonable thing to consider. However, allowing for certification over the telephone by doctors who have not seen the patient means that mistakes will be made and the effect is likely to have inflated the COVID death figure resulting, again, in Government policy being driven by false data.
7. Evidence for the above claims comes from the different characteristics of patients diagnosed as cases before peak deaths and those diagnosed afterwards. Before peak deaths 60% of cases were in the over 60s, since summer that figure has been below 20%. Before peak deaths 60% of deaths were in men. This was diluted after peak deaths becoming 50% by summer. The mortality per hospital admission was high in spring at about 6%. By summer this had fallen to 1.7% which is in line with the background mortality rate for all hospital admissions. The first 200 patients admitted to intensive care with COVID were disproportionately of black ethnicity, accounting for 17%. Of intensive care admissions since Sept 1<sup>st</sup> only 5% are of black ethnicity compared with an estimated 4.6% in the general population.
8. On this background a more fundamental problem occurred. It is imperative that testing for disease during an epidemic has a two phase strategy. While deaths are increasing, sensitive testing is required to detect every possible case and to reduce spread. Once deaths have peaked it is necessary to switch to more specific testing to ensure that every outbreak is a

definite outbreak. Having diagnosed an outbreak more sensitive testing of contacts can be carried out. The UK still has not made this shift to phase 2. I have evidence that the result was a slower fall in the number of COVID deaths than should have occurred because patients were misdiagnosed as having COVID and then misdiagnosed as having a COVID death.

9. The above problem is about data collection but it could only be solved by involving an expert in diagnostics with relevant knowledge of epidemic testing. No such expert is on SAGE or on the Public Health Boards of any of the four nations.
10. On a more minor note, there could have been more transparency on the percentage of positive tests reported. This data was published but only up until 20<sup>th</sup> August. It is a critical data point. Public Health Scotland has led on transparency of data and has shared three different ways of calculating percentage positives which have proved invaluable.

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