Witness Name: Dr John Adrian Copplestone
Statement No: WITN7632001
Exhibits: WITN7632002
Dated: 13th March 2023

INFECTED BLOOD INQUIRY

GRO-C

GRO-C 13/3/23

WRITTEN STATEMENT OF DR JOHN ADRIAN COPPLESTONE

I provide this statement in response to a request under Rule 13 of the Inquiry Rules 2006 dated 13 March 2022.

I, Dr John Adrian Copplestone, will say as follows: -

Section 1: Introduction

1. My name is Dr John Adrian Copplestone of GRO-C Devon GRO-C date of birth GRO-C 1955.

2. I provide this statement in response to an invitation under Rule 13 of the Inquiry Rules 2006 to respond to criticisms made of me by Inquiry Witness W0563 at Paragraph 9 of their statement to the Inquiry (**WITN0563001**).

3. I commenced as Consultant Haematologist at Plymouth Hospitals on 19 October 1987. I joined Dr Prentice and we had Inpatient beds in Greenbank Hospital, Haematology and Transfusion labs at Freedom Fields Hospital and labs in Derriford Hospital. In 1988, the inpatients moved to Birch Ward in Derriford Hospital. We continued to see Outpatients at Freedom Fields Hospital (FFH) for some years. The labs in FFH were moved to Derriford as further clinical services were transferred to Derriford.

4. Dr Prentice and I worked as a single team. In 1993, we were joined by Dr Michael Hamon. Plymouth was a Haemophilia Centre, and we did not have a Comprehensive Haemophilia Centre in the Southwest Region. We used the Oxford Centre for advice and referrals. In general Dr Prentice looked after the paediatric patients and I looked after adult patients with haemophilia and other bleeding disorders.

Section 2: Response to criticism of Inquiry Witness W0563

5. I remember Witness W0563's late brother . He was as described by his sister: a gregarious character (as referred to in paragraph 6 of Statement **WITN0563001**) who largely carried on with life, although this could lead to bleeding problems e.g. in the fight outside the pub in 1988 (paragraph 35). Luckily, he did not fall off his motorbike (as referred to in paragraph 36 of Statement **WITN0563001**).

6. Reading through the statement, I can feel the loss and upset his whole illness caused his sister, along with the unexpected loss of her husband and parents in such a short time. The process of re-living it must have been traumatic, although it is positive that she has contributed to the Inquiry.

7. Perhaps I can explain why I may have requested Witness W0563's late brother to use less Factor 8 and possibly said that that Factor 8 was expensive. Unfortunately, his medical records were destroyed some years after his death (which is standard hospital practice) so I cannot look back at the notes. The annual Haemophilia Returns were retained until my retirement in 2015, but no longer seem to be available. However, blood products were issued by Transfusion and there is a record on the computer system from mid-1989. I have been able to obtain a printout of this record, (exhibit WITN7632002) which shows that he was issued with:

1989	134,500 units (annualised 249,940 units)
1990	278,000 units
1991	222,000 units
1992	172,000 units
1993	153,000 units
1994	60,000 units

All the Factor 8 he received was 8Y intermediate heat-treated concentrate, made with UK plasma by BPL. Witness W0563's late brother 's levels of use were much higher

than other severe haemophilia patients under our care. To give some context of cost, 200,000 units cost around £30,000 in 1994.

8. Witness W0563's late brother was slim and assuming he was around 70kgs, this is the kind of usage you would expect with regular prophylactic (preventative doses) which would raise the basal factor eight levels from very low levels (<1% F VIII, seen in severe haemophilia) to around 3% F VIII seen in milder forms. As I recall, we received the supply of F actor 8 from BPL. This was subject to production delays from time to time. As custodians of the blood products, we had to make sure that all the patients who needed it, had a supply. We also needed to have a reserve to treat emergencies, such as when Witness W0563's late brother was injured outside the pub. In these circumstances we had to use large doses, particularly for head injuries. I may have said that it was expensive, to drive home the message that it was a limited supply.

9. As can be seen from the figures that I refer to in paragraph 7, the units that he received were relatively consistent and so it appears that he was receiving what he needed and that is my recollection. It was not my intention that Witness W0563's late brother should have less Factor VIII than he needed nor that he should think that he should not ask for the supplies he needed. If this was the impression he took from what I said, I apologise.

10. I hope that my explanation is helpful to Witness W 0563 .

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 13/03/2023

Table of Exhibits

Date	Notes / Description	Exhibit Number
2022	Transfusion Summary and Printout	WITN7632002