

Australian Government Organ and Tissue Authority



ORGAN DONATION FOR TRANSPLANTATION

# The Australian Vigilance And Surveillance System 2022

**2022 Report** June 2023

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## Foreword

Transplant recipients, donors, and their families, as well as the Australian community trust that the organ donation and transplantation system is as safe and effective as possible. Any potential or actual failures in these systems must therefore be identified, analysed, and discussed so that actions can be taken to prevent reoccurrence, to keep patients safe and to strive for the best possible outcomes.

The Australian Vigilance and Surveillance System complements state and territory clinical incident management and reporting systems by providing a national reporting and evaluation process, to help inform future national advice, recommendations and guidelines.

In 2022 Australia saw the highest number of COVID-19 infections and hospitalisations across the pandemic which had a wide-ranging impact on the health system, the health workforce, and the community. Organ and tissue donation and transplantation is a complex process with many elements and interdependencies. As the healthcare sector continued to be under stress, it was no surprise the program was also affected.

Despite the impacts on the system, the lives of 1224 Australians were changed when they received an organ transplant in 2022. This was only possible thanks to the generosity of 454 deceased organ donors and their families who said yes to donation.

All health professionals across the donation and transplantation sector have continued to navigate a challenging healthcare and operational environment to achieve the best outcomes from organ donation and transplantation. There continues to be flexibility and improvement to clinical practices across the donation and transplantation sectors with the goal of keeping patients safe and providing quality care, while optimising donation and transplantation opportunities.

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**Professor Jeremy Chapman** AC FRACP FRCP Chair Vigilance Surveillance Expert Advisory Committee

**Associate Professor Helen Opdam** Deputy Chair

Vigilance Surveillance Expert Advisory Committee **National Medical Director** Organ and Tissue Authority

The Vigilance and Surveillance Expert Advisory Committee (VSEAC) are integral to further improving the quality and safety of the organ donation and transplantation system and continue to play a vital role in the sector. The Vigilance and Surveillance system continues to mature since its inception with improvements to the submission process for notifications, the database storing the notifications, and the provision of information and learnings to the clinical community through regular communiques.

The 2022 annual report contains an analysis of 32 serious adverse event and/or reaction (SAER) notifications reported to the VSEAC. This small dataset does not allow for detailed reporting, whilst maintaining de-identification and confidentiality. With the accumulation of four full years of data we can present some trends which will assist with insights into the types of events being reported and support positive practical changes.

Feedback on the Report or any VSEAC activities is welcomed and can be sent by email to the mailbox: SAEN@donatelife.gov.au



Transparency makes for a safer system, and the OTA and VSEAC continue to strongly encourage the reporting of actual or potential adverse events and reactions so that knowledge can be gained to help inform future advice, recommendations, and guidelines. This will improve the safety and quality of donation and transplantation and enhance Australia's system.

Lucinda Barry CEO Organ and Tissue Authority

## 2 Background, update and reporting

Vigilance and surveillance are an essential part of any health care system. For organ donation and transplantation, vigilance and surveillance systems are established to maintain quality and safety during organ donation and transplantation. Importantly these systems aim to review and avoid reoccurrence of SAERs.

SAERs are infrequent and when seen individually may appear as simple isolated occurrences, so it is important to have a central system to capture all incidents to gain a complete representation of all issues, as well as analyse and identify any trends. A national monitoring system enables the development of recommendations for system and process improvements, provides an opportunity for shared learning, identification of long-term trends and ultimately improves the functioning and safety of the overall organ donation for transplantation system.

Reporting de-identified information on SAERs for shared learning is a critical component of any vigilance and surveillance system. This reporting enables clinicians working in the donation and transplantation system to improve clinical practice and enhance patient outcomes.

Internationally vigilance and surveillance systems that monitor and trace the safety of donated and transplanted organs are at various stages of development and implementation. In 2010 the World Health Assembly endorsed a global mandate for



\*Australian Health Ministers Advisory Committee (AHMAC)

Member States to collect 'appropriate information on the donation, processing and transplantation of human cells, tissues, and organs, including data on severe adverse events and reactions<sup>(1]</sup>. This is aligned with the Organ Tissue Authority (OTA) strategy to enhance the safety of organ donation and transplantation in Australia<sup>[2]</sup>.

A brief history is presented in Figure 1 (below) illustrating how the Australian Vigilance and Surveillance System has developed over time.

### 2.1 Australian Vigilance and Surveillance System for Organ Donation for **Transplantation Reports**

The Australian Vigilance and Surveillance System has published three Reports since 2020, collating all notifications received since 2012. This 2022 annual report is the fourth release, reporting on all notifications received between 1 January and 31 December 2022. This also includes some events that occurred in 2021 but were reported in 2022. The system and its functions are described below. Each notification is assessed, reviewed, and classified into a notification type and category including, broader system issues, serious adverse events, and serious adverse reactions.

### 2.2 VSEAC communiques

In addition to the Annual Report, the VSEAC regularly dispatches communiques. The purpose of the VSEAC communiques are to raise awareness of current recommended clinical practices and convey new issues, risks, and recommendations to enhance patient safety, donation, and transplantation outcomes.

### 2.3 Clinical guidelines

Several SAER notifications prompted a review of current standard operating procedures and guidelines by The Transplantation Society of Australia and New Zealand (TSANZ). In the last year, the TSANZ Clinical Guidelines for Organ Transplantation from Deceased Donors Version 1.10 - October 2022 was updated because of SAER notifications, specifically to the kidney allocation process. Additionally, a new working group was formed to develop guidelines for donor coordinators related to organ retrieval surgery that will include procedures for the packaging of organs. This initiative is in response to a small but significant number of SAERs where consistency of packaging may have influenced the outcome of a donation/transplantation process.

### 2.4 International reporting

VSEAC is committed to contributing to the international Notify Library<sup>[3]</sup> database when Australian SAERs meet the criteria for submission. The Notify Library is an international database that is designed to capture adverse outcomes that occur during transplantation and assisted reproduction procedures. It is intended as a communication hub for organisations and institutions to collaborate on vigilance and surveillance information.

The VSEAC retrospectively reviewed all notifications received from 2012; the inception of reporting to the Australian Vigilance and Surveillance program, to 31 December 2021 to assess suitability for submission to Project Notify. Since 2021, all SAER notifications are assessed for suitability for submission to Project Notify as a part of the review by the VSEAC committee. In 2021, one notification met all criteria and was submitted to Project Notify. The submission was accepted and has been published on the Notify Library website in May 2022. A notification of passive transfer of Hepatitis B antibodies from 2022 is being considered for submission to Project Notify.



## **3** The Australian Vigilance and **Surveillance System**

### 3.1 The Australian Vigilance and Surveillance System

The Australian Vigilance and Surveillance System for organ donation and transplantation is designed to:

- ▶ work in parallel with state and territory clinical incident management systems and processes for deceased organ donation and transplantation
- provide a nationally and internationally coordinated notification function
- monitor, record and retrospectively analyse SAERs
- ▶ inform future processes in organ donation and transplantation, and
- ▶ improve the safety and quality of organ donation and transplantation thereby improving patient outcomes.



The Australian Vigilance and Surveillance System provides a nationally and internationally coordinated notification function.

The core elements of the Australian Vigilance and Surveillance System are the VSEAC and the SAER notification database.

Clinical response management and investigation of SAERs remain the responsibility of the hospitals and jurisdictions in which the incident occurred. States and territories continue to be responsible for:

- Iocal reporting and immediate clinical management of an incident
- communication with relevant clinicians and patients (including interstate where appropriate)
- ▶ investigation of the incident
- other aspects of a response to an incident including feedback on policy and clinical practice review
- reporting the incident to the national system.



The Australian Vigilance and Surveillance System works in parallel with State and Territory clinical incident management and reporting systems in deceased organ donation and transplantation.

The Australian Vigilance and Surveillance System complements state and territory clinical incident management and reporting systems. The System provides a national reporting and evaluation process where information obtained is shared between states and territories to help inform future national advice, recommendations, and guidelines. State and Territory DonateLife agencies are required to notify SAERs to the Australian Vigilance and Surveillance System. Transplant units are encouraged to report all SAERs through their local DonateLife agency.

### 3.2 Scope of the national system

The Australian Vigilance and Surveillance System applies to solid organs donated for transplantation from deceased donors. It does not apply to tissue and eye-only donation or living donation, with the exception of the Australian and New Zealand Paired Kidney Exchange (ANZKX) program, which is a living donation program supported by the OTA. The system encompasses all phases of the process from donation to transplantation and post-transplantation and extends beyond identifying donor derived infections or other diseases.

A key focus is to collate incidents related to potential infectious and malignant disease transmission, including issues with donor screening and assessment; the intra-operative or post-transplant discovery of potential or actual transmission of disease from a donor to recipient; or harm including death of a recipient that may be a result of donor-derived disease.

In setting up the Australian process it was considered that central reporting and review of other types of occurrences may also facilitate opportunities for process improvement, so the scope was broadened beyond possible donor to recipient disease transmission. These occurrences include the avoidable loss of a potential donor or donor organ for transplantation and those related to organ retrieval, perfusion, storage and transportation.

These process issues, are termed 'serious adverse event – broader system (SAE-BS), which are then considered at a national level to identify where improvements could occur to increase the safety, efficiency, and effectiveness of donation and transplantation.

SAER notifications arising from tissue and eye-only donation for transplantation continue to be reported under the Therapeutic Goods Administration (TGA) Biologicals Regulatory Framework and the appropriate jurisdictional incident reporting system. Reporting to the Australian Vigilance and Surveillance System is only required if the donor also donated solid organs for transplantation and the SAER has relevance to organ donation and/or transplantation.

# **3.3** Defining serious adverse events and reactions

The Australian Vigilance and Surveillance System reporting criteria are based on the 2013 'Communication and Investigation of Serious Adverse Events and Reactions Associated with Human Tissues and Cell (SOHO V&S) <sup>[4]</sup>'. In 2022 the 'European Directorate for the Quality of Medicines and Healthcare (EDQM) – 8th Edition Guide to the quality and safety of organs for transplantation (2022) <sup>[5]</sup>', in chapter 16, referenced the same document. The VSEAC has not changed the current definitions for serious adverse events/reactions or the assessment tools, as they remain aligned with international practice.

A **serious adverse reaction** is an 'unintended response, including a communicable disease in the recipient that might be associated with any stage of the chain from donation to transplantation **that is** fatal, life-threatening, disabling, incapacitating or which results in, or prolongs, hospitalisation or morbidity'.

A serious adverse event is any 'undesired and unexpected occurrence associated with any stage of the chain from donation to transplantation **that might** lead to the transmission of a communicable disease, to death or life-threatening, disabling or incapacitating conditions for patients or which might result in, or prolong, hospitalisation or morbidity'.

VSEAC have further broken down serious adverse events (SAEs) into two categories:

- ► SAE individual specific (SAE), and
- ► SAE broader system (SAE-BS).

### 3.4 Commonwealth Qualified Privilege

To strengthen and encourage reporting of adverse events and reactions, the VSEAC was granted Commonwealth Qualified Privilege in 2016 for an initial five-year period. After a renewal application in 2021, another five year period of Qualified Privilege was granted, taking effect from 14 December 2021.

### **3.5** The Vigilance and Surveillance Expert Advisory Committee (VSEAC)

The VSEAC comprises high level technical specialists with relevant expertise from key clinical, government and professional organisations. Membership is position or skills-based, meaning individuals may be a formal representative of their respective organisation or may be appointed based on their expertise to meet the essential skills of the VSEAC membership. The committee formally met four times in 2022, with a mixture of face to face and virtual meetings. The VSEAC membership between 1 January 2022 to 31 December 2022 is outlined in Appendix A.

# **3.6** The Vigilance and Surveillance System process

The Vigilance and Surveillance System process (as outlined in Figure 2) remained unchanged throughout 2022. The figure outlines the pathway that is followed when an adverse event or reaction occurs. The hospitals, states, and territories are responsible for the immediate and ongoing clinical management of the incident; concurrently the SAER notification is submitted to the Australian Vigilance and Surveillance System by the State Medical Director or delegate of the DonateLife Agency.

The SAER notification is initially reviewed by the OTA National Medical Director who assesses the notification and determines if any immediate actions are required. The notification is then reviewed by the VSEAC at the next meeting or out of session if a timely response is required. SAER notifications are assessed according to severity, imputability, recurrence likelihood, and impact of the event or reaction. Members are required to declare any conflicts of interest, for example if there is personal prior knowledge or involvement in an incident, prior to the consideration of each case.

### 3.7 SAER notification database

The SAER notification database is managed by the OTA and has been enhanced to enable collation, cross referencing, traceability, and trending of SAER notifications. The information contained includes the SAER notification form, all associated documents, and the VSEAC review outcomes including comments, categorisation, and follow up actions. In addition, any literature reviews, Notify Library searches, and correspondence is also stored with each SAER notification.

In 2022, modification to the portal that facilitates online submission of SAER notifications continued with the longterm goal of submission and associated correspondence being stored and edited in a centralised location.



4 Overview of all reported serious adverse events and/or reaction notifications

Nationally in 2022, there was an 8% increase in deceased organ donors and a 4% increase in the number of people receiving a transplant compared to 2021.

The COVID-19 pandemic has continued to negatively impact the program, following the decade of growth in donation and transplantation in Australia that occurred after the introduction of the national program in 2009. with activity in 2022 remaining approximately 15% lower than the peak year of 2019.

DonateLife Agencies and transplant teams have continued to work together, throughout this period to navigate the challenges facing hospitals and clinicians, impacting donation and transplantation practices.

In 2022, there were 32 notifications received, which were further classified by notification type and category. Of the 32 notifications received in 2022, two were out of scope; these were related to a data transcription issue and a community enquiry. Table 1 is a breakdown of the 30 notifications received in 2022, in to the types and categories used by the vigilance and surveillance system. Four of the events included in this assessment occurred in 2021.

### Table 1 SAER Notifications that occurred and were reviewed in 2022

### Notification type (total 30 notifications)

Serious adverse reaction	4	13%
Serious adverse event	14	47%
Serious adverse events – Broader system	10	33%
Other	2	7%

### Notification category (total 30 notifications)

Donation	14	47%
Retrieval	10	33%
Transplantation	6	20%

VSEAC strongly encourages early reporting. In the event that an incident requires local review and evaluation it is desirable that preliminary notification to VSEAC occurs with more complete information provided it becomes available.

8 The Australian Vigilance and Surveillance System for Organ Donation and Transplantation

The number of SAER notifications reported to VSEAC in 2022 remained steady compared to 2021 (32 notifications in 2022, 29 SAER notifications in 2021, 12 SAER notifications in 2020). This is encouraging and supports indications that the Vigilance and Surveillance system continues to become embedded as routine practice, strengthening the quality and safety of organ donation and transplantation processes.

VSEAC normally considers events that have an impact on the broader system (SAE-BS). As can be seen in Figure 3, there were 30 in scope SAER notifications, submitted to VSEAC during 2022. Two notifications were for potential donors who were deemed not medically suitable after a positive COVID-19 test result at a time when it was advised not to proceed with donation from COVID-19 positive individuals. This advice was provided by the COVID-19 - Australian Transplantation and Donation Rapid Response Taskforce. In one of these COVID-19 positive cases the kidneys, liver and lungs were deemed medically unsuitable due to the positive COVID-19 result, and additional hepatitis B and C viral risk. The heart was also considered and found to be unsuitable. In the second all transplant teams had accepted heart, lungs, liver, and kidneys, all organs were subsequently declined following the positive COVID-19 result. The remaining 28 notifications were reviewed and assessed by VSEAC and are discussed in this report.

Another 2 were related to external events outside the donation transplantation system, classified as "other". This category has been introduced as these two events are beyond the broader system. As reporting numbers increase this category may be required to capture events that cannot be classified at the broader system level.



Serious adverse events in organ donation and transplantation are extremely rare in Australia.

The increase in notifications each year reflects the evolution of the Australian Vigilance and Surveillance System and a greater transparency and willingness to report.



The number of SAER notifications remains low at 26 relative to overall donation and transplant activity. The proportion of patient specific SAERNs to transplant procedures is at 1.09%, a slight increase from previous years (Table 2). 14 patient specific notifications were received in 2022. Following on from implementation, there has been a progressive uptake and use of the

notification system. It should be noted that the numbers in Fig.3 correspond to Table 1, the difference in SAEs from the number recorded in Figure 3 of 12 to the number in table 1 of 14 are the two COVID-19 cases that are included under SAEs in Table 1 but are classified as Not Medically Suitable (NMS) in Figure 3.

Table 2 SAER Notifications in context of deceased organ donors, transplant procedures and transplant recipients: year of SAER occurrence - 2012 to 2022

							VSEA	C establi	shed		
Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Deceased Organ Donors	354	391	378	435	503	510	554	548	463	421	454
Transplant Recipients	1,049	1,121	1,107	1,239	1,447	1,400	1,544	1,444	1,270	1,174	1224
Transplant Procedures*	1,100	1,163	1,164	1,301	1,508	1,467	1,618	1,501	1,334	1,227	1281
SAERN Patient Specific*	1	2	6	5	2	3	5	12	4	13	14
SAEN Broader System	1	1	4	8	8	13	11	16	7	20	10
Proportion SAERN relative to transplant procedures*	0.09%	0.17%	0.52%	0.38%	0.13%	0.20%	0.31%	0.80%	0.30%	1.06%#	1.09%

\* Note, the 2021 percentage has been updated with SAERNs reported in 2022.

\*The percentage proportion of SAERNs relative to transplant procedures is calculated from SAERN Patient Specific over Transplant Procedures.

Figure 4, shows a comparison of the total 2022 incidents compared to SAER notifications in prior years, breaking down SAER notifications into five broad categories. For 2022 the number in each category is as follows:

- Serious adverse event = 14 Broader system issues = 10
- Serious adverse reaction = 4

COVID-19 Log = 3

As in 2021 the OTA continued to record and monitor cases involving COVID-19. Please note that these cases were logged because they're COVID-19 related but were not reported as SAER notifications. As COVID-19 infection levels decreased, logging of cases ceased and any notifications involving COVID-19 were incorporated into routine reporting.



► Other = 2

## 5 Analysis of serious adverse events and/or reaction notifications

The incidents reported via the SAER notification process and reviewed by VSEAC have sufficient detail to enable analysis and categorisation. This is done according to the part of the donation and transplantation continuum they relate to, their classification and their impact. The following sections provide information about the 28 SAER notifications reviewed by VSEAC in 2022. The two events categorised as "Other" were isolated incidents where environmental controls in a theatre were compromised and flooding prevented a transplant opportunity. There has also been a significant decrease in COVID-19 related SAERs from 2021 to 2022.

### **5.1** Analysis of SAER notification categories for 2022

The SAER notifications can be categorised according to whether they relate to donation, retrieval, or transplantation (Figure 5). For 2022, out of the 30 notifications, there were:

Notification category		
Donation	14	47%
Retrieval	10	33%
Transplantation	6	20%

Figure 6 opposite shows the notifications according to the four types of classifications (serious adverse event, serious adverse reaction, broader system, or other) and the categories of donation, retrieval, and transplantation. As the notifications are submitted by the DonateLife State Medical Director or delegate it is more likely that notifications are made within the donation and retrieval categories although reporting from the transplant sector, through the DonateLife Agency is encouraged.

Notifications can be further classified into the following sub-categories: donor assessment; donor management; information/data transcription as well as offer and allocation; retrieval surgery; perfusion and preservation; storage and transport; post-transplant; transplant surgery; possible donor derived infection; and donor malignancy.

Figure 7 shows the number of notifications in each sub-category in 2022. In 2022, the retrieval surgery sub-category had the most notifications, followed by offer and allocation (7) and possible donor derived infection (4). It should be noted that 2 of the 10 retrieval surgery events were due to storage and other issues. Eight events were specifically related to the surgical procedure.

A more in-depth overview of SAER notifications reviewed by the VSEAC by category, from 1 January 2022 to 31 December 2022, is outlined below.



Figure 5 SAER notifications by Donation,



Notifications detailed here have been de-identified to ensure confidentiality.



Donation

Figure 7 SAER notifications by sub-category in 2022





### Retrieval

Transplantation

# 5.1.1 SAER notifications relating to donation

SAER notifications relating to the donation category made up 47% of the total number of notifications from 1 January 2022 to 31 December 2022. This was 1% lower than 2021 data and 4% higher than the overall average of 43% of all SAER notifications relating to the donation category.

Figure 8 Percentage of SAER notifications related to Donation.



For 2022, these notifications included the following sub-categories:

### 5.1.1.1 Donor assessment

The notifications in this category are related to assessment of a potential donor. The work up of a potential donor involves gathering extensive health information, a detailed consent process with the next of kin that specifies each organ and/or tissue to be donated, further screening tests and assessments. Then provision of this information to transplant units who have potential recipients. There were two notifications in the donor assessment category. One notification related to a weather event which impacted the ability to offer donation and one notification where the additional information required could not be provided due to technical issues.

### 5.1.1.2 Offer and Allocation

There were seven notifications related to offering and allocation of organs. Five notifications were related to the allocation of organs, in one of these notifications the organ was able to be reallocated. One notification was a kidney offer declined as the donor was hepatitis C positive and one notification in which a kidney offer was declined due to the health of the recipient.

'The presence of HIV, Hepatitis B and Hepatitis C is not necessarily a contraindication to donation. Decisions about whether to proceed with donation and transplantation will depend on recipient informed consent, the nature of the infection, other recipient clinical factors and the availability of effective treatment' (TSANZ Clinical Guidelines, page 13).

### 5.1.1.3 Information/transcription issues

In 2022, there were three notifications related to discrepancies in the registration status of individuals when checking the Australian Organ Donor Register (AODR).

Figure 9 Total number of Australian Organ Donor Register (AODR) SAER notifications.



### 5.1.2 SAER notifications relating to retrieval

SAER notifications relating to the retrieval category made up 33% of the total number of notifications from 1 January 2022 to 31 December 2022.



40%



For 2022, these notifications included the following sub-categories:

### 5.1.2.1 Retrieval surgery

There were eight notifications within the retrieval surgery category. Five notifications related to surgical retrieval challenges, including surgical technique and donor physiology. Three notifications were related to the broader system pertaining to hospital or local level issues, including workforce resourcing.

### 5.1.2.2 Perfusion and Preservation

There was one notification in relation to storage and transport of donated organs. The organ was found to have hypothermic injury although was able to be successfully transplanted.

These notifications have prompted a review of local and international storage and transportation processes.

### 5.1.2.3 Storage and Transportation

There was one notification relating to a logistics issue. Many donated organs are transported around the country using domestic flights and there are occasions when the timing of surgery, couriers and availability of flights create challenges for the donation and transplantation process.



# 5.1.3 SAER notifications relating to transplantation

SAER notifications relating to the transplantation category made up 20% of the total number of notifications from 1 January 2022 to 31 December 2022. For 2022, these notifications included the following sub-categories:

# 5.1.3.1 Possible Donor Derived Infection or other disease

There are four notifications within the category of possible donor derived infection or other disease transmission. In all four notifications the organs were transplanted, and the possible donor derived infection or other disease transmission was managed appropriately. In all four cases it relates to hepatitis B or C transmission risk, with two instances of actual hepatitis C transmission of infection.

### 5.1.3.2 Possible donor malignancy

Two notifications were submitted relating to a possible donor malignancy. The organ transplant recipients from the same donor have been informed and no further reports of donor-derived malignancies have been reported.

The role of VSEAC is to monitor and trend serious adverse events and reactions. The identification of any trends can and will result in VSEAC making recommendations to improve clinical practice, and to make organ donation and transplantation safer for all Australians.

## **Appendix A VSEAC membership 2022**

The Vigilance and Surveillance Expert Advisory Committee (VSEAC) comprises high level technical specialists with relevant expertise from key clinical, government and professional organisations. Membership is position or skills based, meaning individuals may be a formal representative of their respective organisation or may be appointed based on their expertise to meet the essential skills of the VSEAC membership.

The table below outlines all VSEAC members between 1 January 2022 to 31 December 2022.

Position	Committee role (representative and expertise based)	Held by
Chair (OTA CEO appointed)	Editor in Chief Transplantation Journals, Chairman Australian Bone Marrow Donor Registry	Prof Jeremy Chapman
Deputy Chair	National Medical Director, Organ, and Tissue Authority	A/Prof Helen Opdam
Member	Infectious Disease Physician, Microbiologist	Dr Peter Boan
Member	DonateLife State Medical Director/s	Dr Elena Cavazzoni – NSW Dr Stewart Moodie – SA
Member	Donation Nurse Specialist, DonateLife Queensland	Ms Niamh Farrell
Member	Communicable Diseases Network Australia representative	Dr Louise Flood
Member	Transplant Nurses Association representative (New)	Ms Julie Pavlovic
Member	Senior Medical Virologist	Prof William Rawlinson
Member	Surgeon representative, Transplantation Society of Australia, and New Zealand	Dr Handoo Rhee
Member	Australasian Transplant Coordinators Association representative	Mr Paul Robertson
Member	Oncology expertise	Dr Brian Stein
Member	Physician representative, Transplantation Society of Australia, and New Zealand	Prof Angela Webster
Member	Epidemiologist	A/Prof Germaine Wong

# **Reference List**

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