Australian Government

Organn and Tissue Authority

Australian Vigilance & Surveillance System

ORGAN DONATION FOR TRANSPLANTATION

# The Australian Vigilance and Surveillance System

## 2024 REPORT

# Contents

# 1 Foreword

**Transplant recipients, donors, donor families, and the Australian community trust that the organ donation and transplantation system is as safe and effective as possible. Ideally, all potential issues should be identified and corrected before they become actual failures in this complex system. Issues should be identified, analysed, and discussed so that preventive actions can be taken to keep patients safe and to strive for the best possible outcomes.**

The Australian Vigilance and Surveillance System complements the state and territory clinical incident management and reporting systems for deceased organ donation and transplantation. It provides a national reporting and evaluation process to monitor trends and help inform national advice, recommendations, and guidelines.

The lives of 1328 Australians were changed when they received an organ transplant in 2024. This was only possible thanks to the generosity of 527 deceased organ donors and their families who said yes to donation. In addition, there were 253 living kidney donations in Australia of which 66 were facilitated through the Australian and New Zealand Paired Kidney Exchange (ANZKX) Program.

Organ donation and transplantation involves many different people, organisations, and protocols, making it a very complex process. All health professionals across the donation and transplantation sectors have continued to navigate a challenging healthcare and operational environment in the last few years, to achieve the best possible outcomes from organ donation and transplantation. There continue to be improvements to clinical practices across the donation and transplantation system with the goal of keeping patients safe, providing quality care and optimising donation and transplantation.

The Australian Vigilance and Surveillance system plays a vital role in improving the quality and safety of organ donation and transplantation in Australia. The Vigilance and Surveillance Expert Advisory Committee (VSEAC) is integral to this system. It has continued to review reported events and refer identified issues and trends to the appropriate governing committees with the aim of improving practices and access to transplantation. During the past year, this work has resulted in updates to key clinical practices and guidelines and notification of key trends to jurisdictions and relevant committees where recurring events were identified. In addition, regular communiques have been issued to the clinical sector that have highlighted key practices and learnings, as well as information from international publications considered relevant to safe donation and transplantation practice.

This report contains an analysis of 76 serious adverse event and/or reaction (SAER) notifications reported to the VSEAC. Events and reactions are rare, for context there were 1,387 transplant procedures performed in 2024, with 50 of the SAER notifications directly related to the donor or recipient processes equating to 3.6% of all transplant procedures. The remaining 26 notifications related to broader system issues. In this report we provide the collated information and trends to provide insights into the types of events being reported and that have led to positive practice changes.

There has been an increase in the total number of events in 2024 due to the targeted introduction of new avenues for reporting, better engagement with the sector regarding the importance of reporting and an increase in the number of Australian Organ Donor Register (AODR) events reported.

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.

**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

**Lucinda Barry AM**
**CEO**
Organ and Tissue Authority

# 2 Background, update and reporting

## Vigilance and surveillance are an essential part of any health care system.

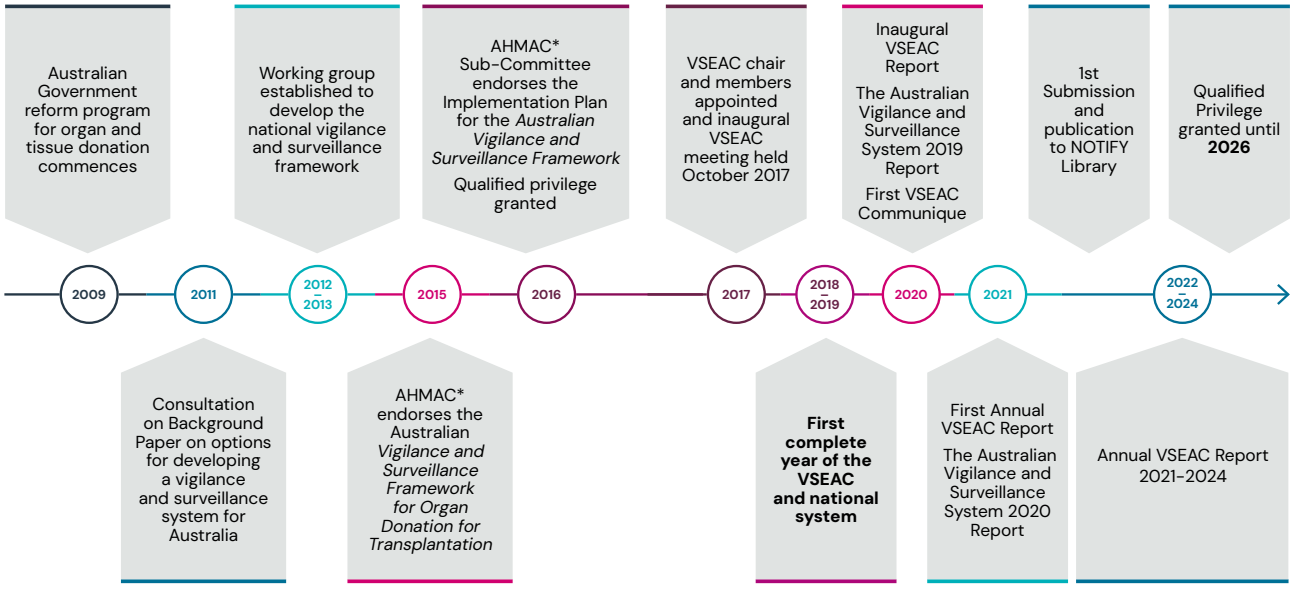
For organ donation and transplantation, vigilance and surveillance systems are established to maintain quality and safety throughout the process of:

- donor evaluation
- organ allocation
- retrieval, storage and transport
- transplantation surgery, and
- post-transplant care.

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. A national monitoring system for detection, analysis and reporting provides an invaluable component of a feedback and improvement cycle, leading to recommendations for practice improvements, an opportunity for shared learning, identification of long-term trends and ultimately a more effective and safer organ donation and transplantation system.

**Figure 1** Overview of the evolution of the Australian Vigilance and Surveillance System for organ donation and transplantation.




States and territories are responsible for management of SAERs that occur within their jurisdiction.

*AHMAC = The Australian Health Ministers' Advisory Committee, a former committee comprised of the heads of the federal, state and territory government health authorities with the role of considering matters related to co-ordinating health services across the nation.

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.

International 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 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' [1]. This is aligned with the Organ and Tissue Authority (OTA) strategy to enhance the safety of organ donation and transplantation in Australia [2].

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

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

The Australian Vigilance and Surveillance System has published five reports since 2020, collating all notifications received since 2012. This 2024 annual report covers all notifications received between 1 January and 31 December 2024. 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 as well as consideration towards improvement and prevention of recurrence.

## 2.2 VSEAC communiques

In addition to the Annual Report, the VSEAC regularly dispatches communiques. The purpose of the VSEAC communiques is 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

The VSEAC provides advice and recommendations regarding the potential need for review of clinical guidelines and standard operating procedures, where inconsistencies in clinical practice are identified. Since its inception, notifications from the VSEAC have prompted several reviews and updates to the standard operating procedures and guidelines by The Transplantation Society of Australia and New Zealand (TSANZ).

## 2.4 International reporting

The VSEAC is committed to contributing to the international Notify Library [3] database when Australian SAERs meet the criteria for submission. The Notify Library is an international database that is designed to capture adverse occurrences that take place during organ donation, 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 System, 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 at the time of review of the notification by the VSEAC. In 2021, one notification met all criteria and was submitted to Project Notify. The submission was accepted and was published on the Notify Library website in May 2022.[3]

**"If we know something important that no one else knows, it is important to share this"**

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

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

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:

- local 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 and Tissue Typing laboratories have been encouraged to report all SAERs through their local DonateLife agency. In 2024, to enable greater access for reporting, notifications can now be submitted directly to the OTA Vigilance and Surveillance team or by the National OrganMatch Office.

## 3.1 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. The exception is 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, post-transplantation outcomes, 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 events may also facilitate opportunities for process improvement. As a result, the scope was broadened beyond possible donor to recipient disease transmission. These events 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). They 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.

## 3.2 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)'* [4]. In 2025 the *'European Directorate for the Quality of Medicines and Healthcare (EDQM) - 9th Edition Guide to the quality and safety of organs for transplantation (2025)* [5]', 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).

## 3.3 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. A renewal was applied for in 2021 and another five-year period of Qualified Privilege was granted, taking effect on 14 December 2021.

The Australian Commonwealth Privilege Scheme grants qualified privilege for eligible quality assurance activities. It prohibits the release of information that may identify a person, including patients and health professionals and protects those taking part in the activity from civil liability and legal action [6]. This is important, as these protections encourage health professionals to take part in the Vigilance and Surveillance System.

## 3.4 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 2024, with a mixture of face to face and virtual meetings. The VSEAC membership from 1 January 2024 to 31 December 2024 is outlined in **Appendix A**.

## 3.5 The VSEAC process

The Vigilance and Surveillance System process (as outlined in Figure 2) expanded its mechanisms for reporting of SAERNs in 2024. 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 or the National OrganMatch Office or by an individual directly to the OTA Vigilance and Surveillance team.

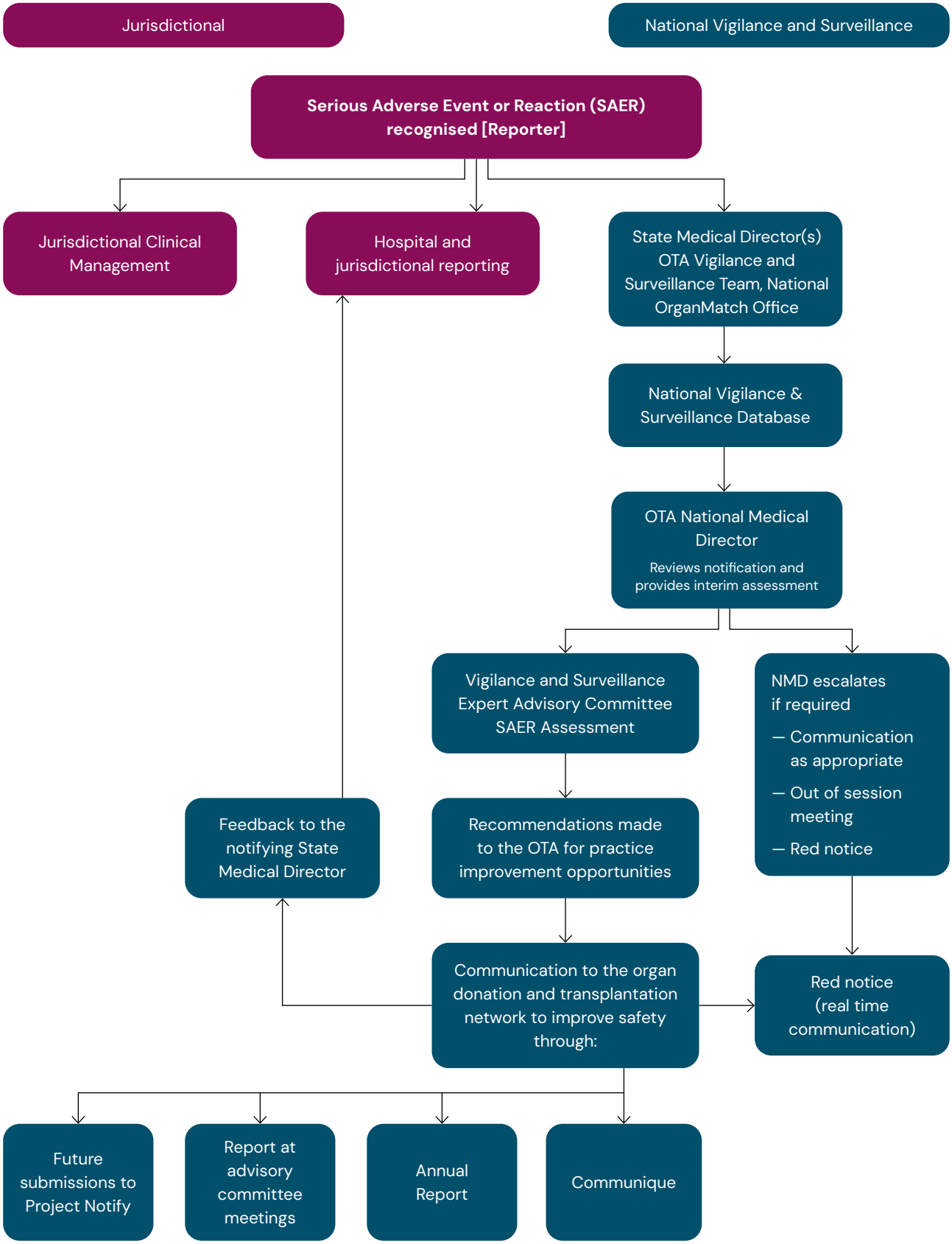
The SAER notification is initially reviewed by the OTA National Medical Director who assesses the notification and determines if any immediate actions are required. The notification is then reviewed by the VSEAC at the next meeting or out of session if a more timely response is required. SAER notifications are assessed according to severity, imputability, recurrence likelihood, and impact. 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.

## 3.6 SAER notification database

The SAER notification database and its IT infrastructure is managed by the OTA in partnership with its IT provider. It 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 2024, modification to the portal that facilitates online submission of SAER notifications continued with the long-term goal of submission and associated correspondence being stored and edited in a centralised location.

**Figure 2** Notification, communication, review and reporting process for serious adverse event and/or reaction (SAER) notifications.



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

The National Donation Program continued to see an increase in the number of deceased organ donors, with a 2.6% increase nationally in 2024. However, this resulted in a 5% decrease in the number of organ transplant recipients compared to 2023, due to a greater proportion of donors after circulatory determination of death and extended criteria donors, from whom there are on average fewer transplantable organs per donor.

DonateLife Agencies and transplant teams continue to work together throughout this period to navigate the challenges facing the health system. This includes hospital pressures and staff shortages which can impact donation and transplantation practices.

In 2024, there were 77 notifications received, which were classified by notification type and category.
A duplicate SEAR notification was identified related to a potential donor derived malignancy. This was classified as a single event and the notifications were combined. Thus, this report provides advice regarding 76 notifications. Events and reactions are rare, for context there were 1,387 transplant procedures performed in 2024, with 50 of the SAER notifications directly related to the donor or recipients' processes, with the remaining 26 related to broader system issues - this equates to 3.6% of all transplant procedures. Table 1 is a breakdown of the 76 notifications reviewed in 2024, classified according to the types and categories used by the Vigilance and Surveillance System.

**Table 1** SAER Notifications that occurred and were reviewed in 2024

| | | |
|---|---|---|
| **Notification type (total 76 notifications)** | | |
| Serious adverse reaction | 5 | 7% |
| Serious adverse event | 45 | 59% |
| Serious adverse events – Broader system | 26 | 34% |
| **Notification category (total 76 notifications)** | | |
| Donation | 45 | 59% |
| Retrieval | 16 | 21% |
| Transplantation | 15 | 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 when it becomes available.

The number of SAER notifications reported to VSEAC in 2024 (76) has increased compared to prior years (43 SAER notifications in 2023, 32 SAER notifications in 2022, 29 SAER notifications in 2021). This is considered likely due to the targeted introduction of new avenues for reporting, better engagement and awareness of the role and value of VSEAC and an increase in the number of Australian Organ Donor Register (AODR) events reported.

In Figure 3 the 76 SAER notifications submitted to and assessed by VSEAC during 2024 are shown, and also the subcategories according to whether they were reactions or events (individual specific or broader system).

Serious adverse events in organ donation and transplantation are 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.

**Figure 3** SAER notifications reviewed in 2023

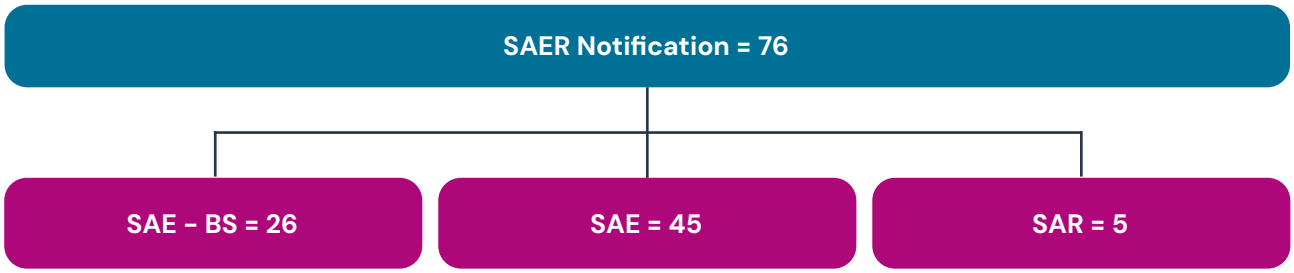



Table 2 demonstrates an increase in the proportion of SAER notifications relative to overall transplant procedures, from 1.92% in 2023 to 3.6% in 2024. The 76 notifications received in 2024 is an increase from the 43 notifications received in 2023. Five notifications in 2024 were serious adverse reactions involving possible donor derived diseases. These included notifications of infection, malignancy and other diseases with potential transmission to a recipient. There has been progressive increase in the submission of notifications to VSEAC since the implementation of the Australian Vigilance and Surveillance System.

**SAER:** Serious adverse event and/or reaction.

**SAE:** Serious adverse event.

**SAE-BS:** Serious adverse event - Broader system.

**SAR:** Serious adverse reaction.

**Table 2** SAER Notifications in context of deceased organ donors, transplant procedures and transplant recipients: year of SAER occurrence - 2015 to 2024

| | | | VSEAC established | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Deceased organ donors | 435 | 503 | 510 | 554 | 548 | 463 | 421 | 454 | 513 | 527 |
| Transplant recipients | 1,239 | 1,447 | 1,400 | 1,544 | 1,444 | 1,270 | 1,174 | 1,224 | 1,396 | 1328 |
| Transplant procedures* | 1,301 | 1,508 | 1,467 | 1,618 | 1,501 | 1,334 | 1,227 | 1,281 | 1,458 | 1387 |
| SAER notifications | 5 | 2 | 3 | 5 | 12 | 4 | 13 | 14 | 28 | 50 |
| SAE-BS notifications | 8 | 8 | 13 | 11 | 16 | 7 | 20 | 10 | 15 | 26 |
| Proportion of SAER notifications relative to transplant procedures* | 0.38% | 0.13% | 0.20% | 0.31% | 0.80% | 0.30% | 1.06%# | 1.09% | 1.92% | 3.6% |

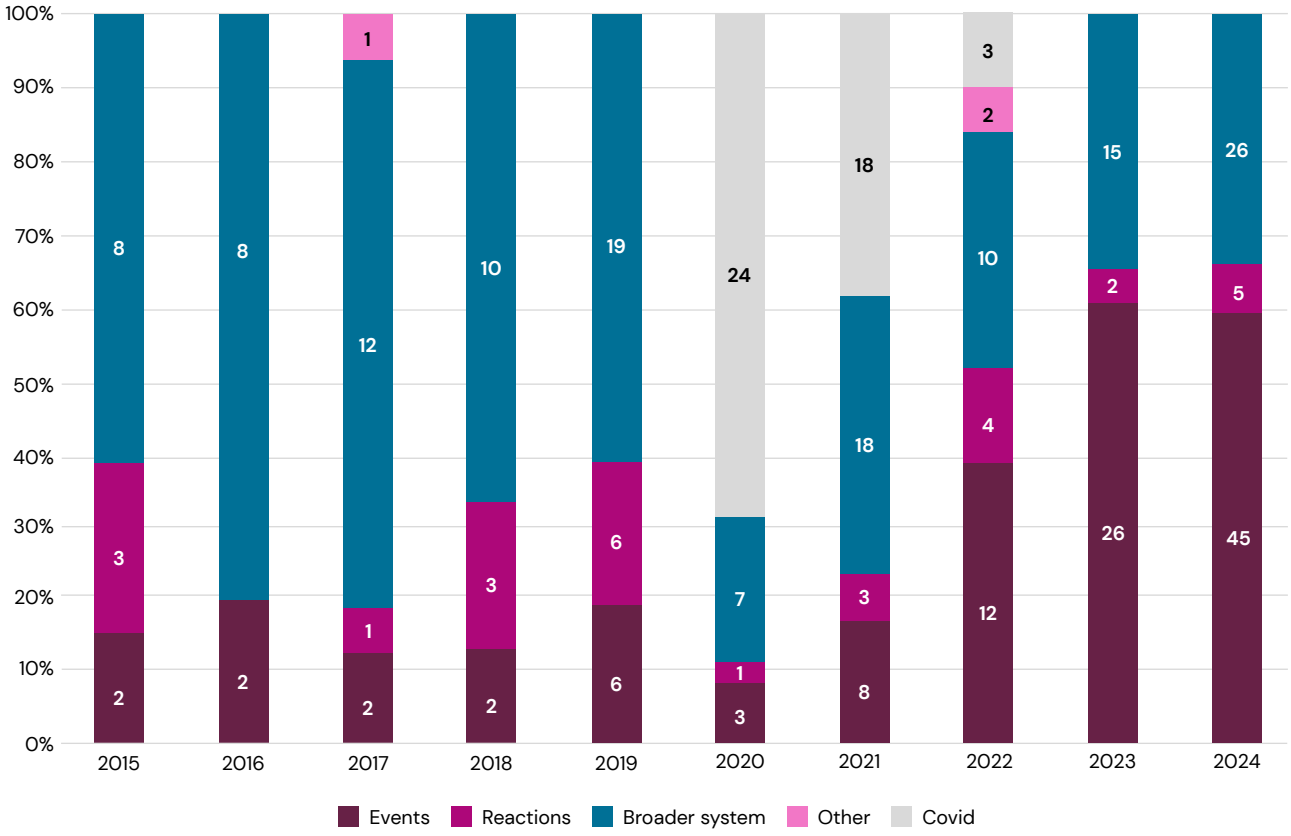
# Note, the 2021 percentage has been updated with SAER notifications reported in 2022.
*The percentage proportion of SAER notifications relative to transplant procedures is calculated from SAER notifications divided by Transplant Procedures.

Figure 4 shows a comparison of the total 2024 incidents compared to SAER notifications in prior years, breaking down SAER notifications into the reported categories.

For 2024 the number in each category is as follows:

- Serious adverse event – Individual specific = 45
- Serious adverse event – Broader system = 26
- Serious adverse reaction = 5
- COVID-19 Log = 0
- Other = 0

**Figure 4** SAER notifications by category from 2015 to 2024



# 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 76 SAER notifications reviewed by VSEAC in 2024.

## 5.1 Analysis of SAER notification categories for 2024

The SAER notifications can be categorised according to whether they relate to donation, retrieval, or transplantation (Figure 5). For 2024, the 76 notifications were categorised as:

| Notification category | | |
|---|---|---|
| Donation | 45 | 59% |
| Retrieval | 16 | 21% |
| Transplantation | 15 | 20% |

Figure 6 shows the 2024 notifications according to the three types of classifications (serious adverse event, serious adverse reaction and broader system) and the categories of donation, retrieval, and transplantation.

Notifications can be further classified into the following sub-categories:

- donor assessment
- donor management
- information/data transcription
- offer and allocation
- retrieval surgery
- perfusion and preservation
- storage and transport
- post-transplant
- transplant surgery
- possible donor derived infection
- malignancy or other diseases.

**Figure 5** SAER notification by category

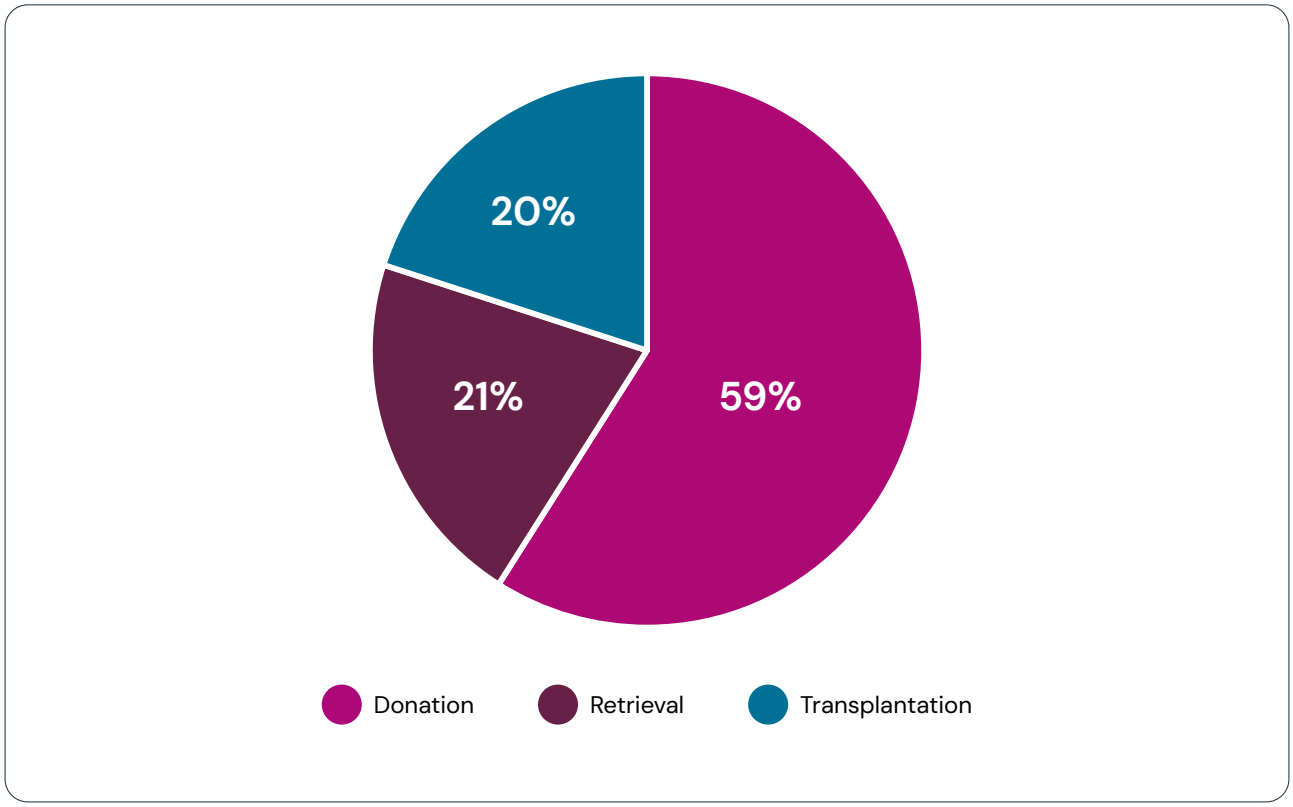
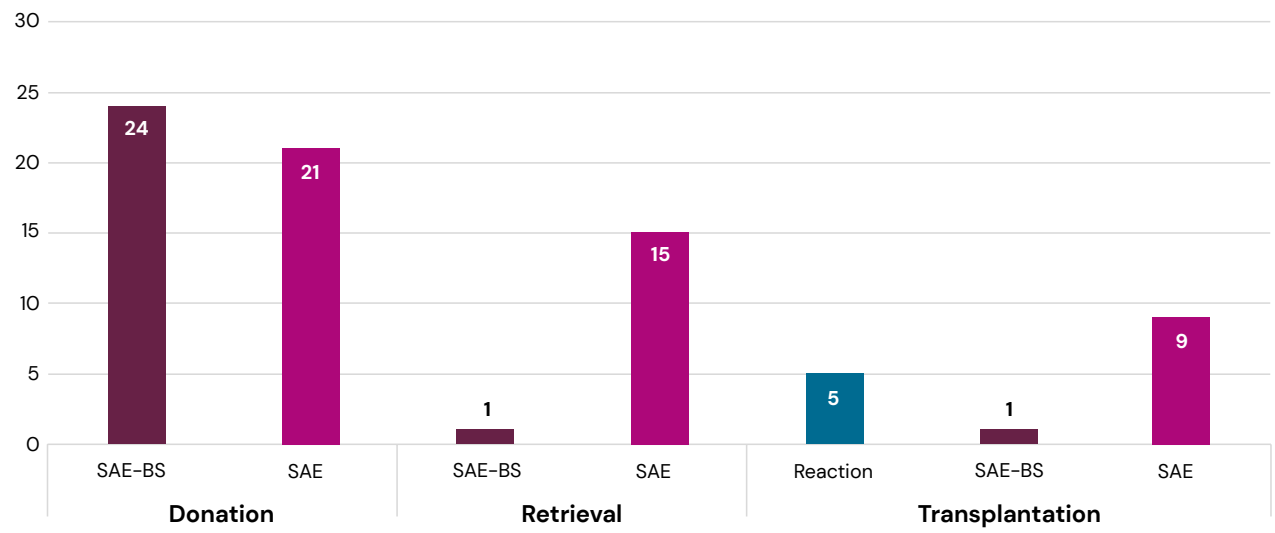


**Figure 6** SAER notifications by classification and category

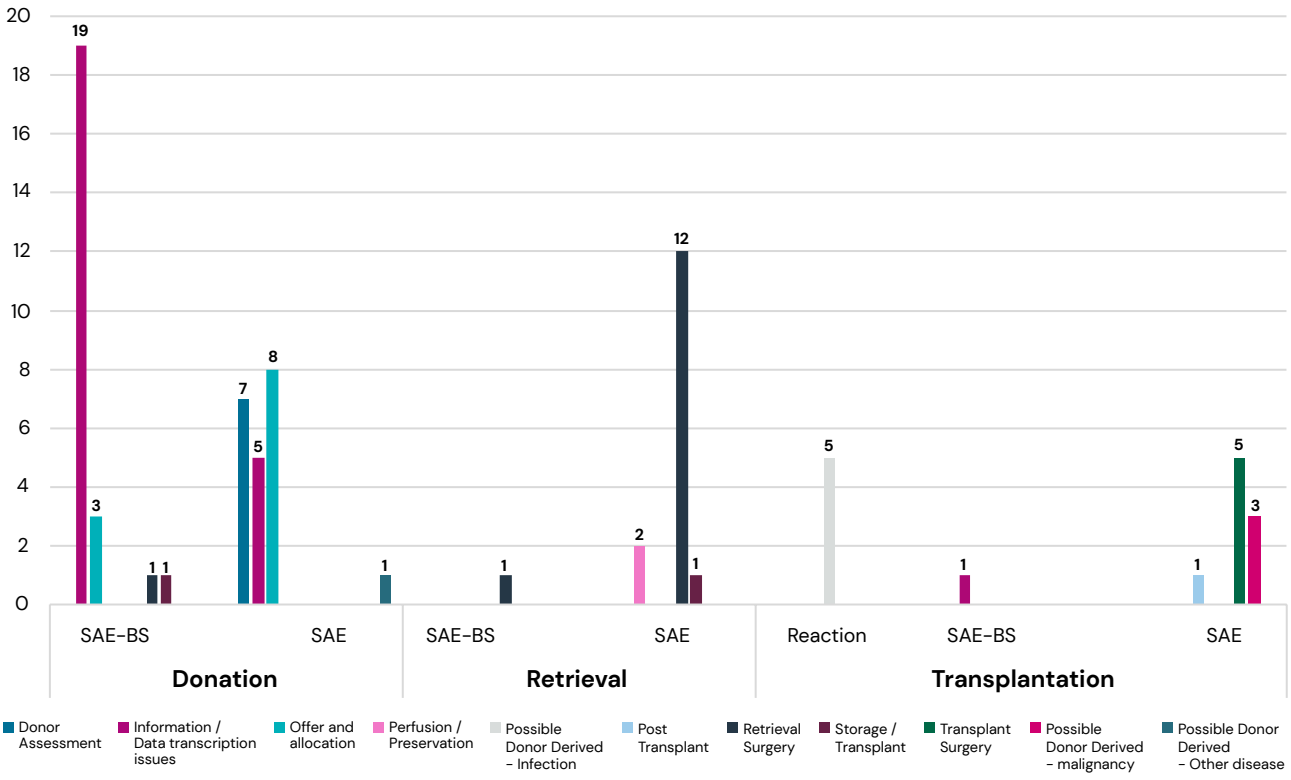



Notifications can be further classified into the following sub-categories:

- donor assessment
- donor management
- information/data transcription
- offer and allocation
- retrieval surgery
- perfusion and preservation
- storage and transport
- transplant surgery
- post-transplant
- possible donor derived infection, and
- donor malignancy.

Figure 7 shows the number of notifications in each sub-category in 2024. In 2024, the Information/ Data transcription sub-category had the most notifications (25), followed by retrieval surgery (14) and offer and allocation broader system (11).

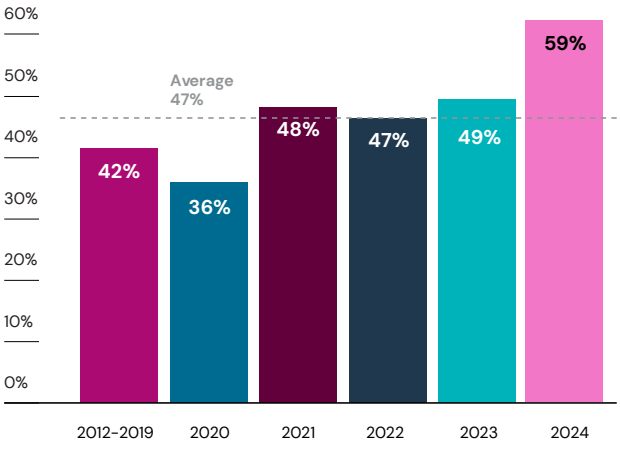
**Figure 7** SAER notifications by sub-category in 2024



### 5.1.1 SAER notifications relating to donation

Figure 8 shows SAER notifications relating to the donation category accounted for 59% of the total number of notifications from 1 January 2024 to 31 December 2024. This was 10% higher than 2023 data and 12% higher than the overall average of all SAER notifications relating to the donation category from 1 January 2012 to 31 December 2024 (47%).

**Figure 8** SAER notifications related to Donation.




For 2024, these notifications included the following sub-categories:

#### 5.1.1.1 Donor assessment

The notifications in this category relate to the assessment of a potential donor that requires a comprehensive evaluation to determine their suitability for organ donation. This involves a detailed consent process with the next of kin, an extensive medical history review, and additional medical tests and assessments. Donor assessment information is provided to transplant units who assess this information in relation to potential recipients.

There were seven notifications in the donor assessment category and 19 notifications related to the Australian Organ Donor Register (AODR), which are discussed in section 5.1.1.3. There were seven notifications related to patient-specific events, including a complaint regarding the Australian Donation Risk Assessment Interview (AUS-DRAI) and incidental findings during donor evaluation resulting in potentially suitable organs not being transplanted.

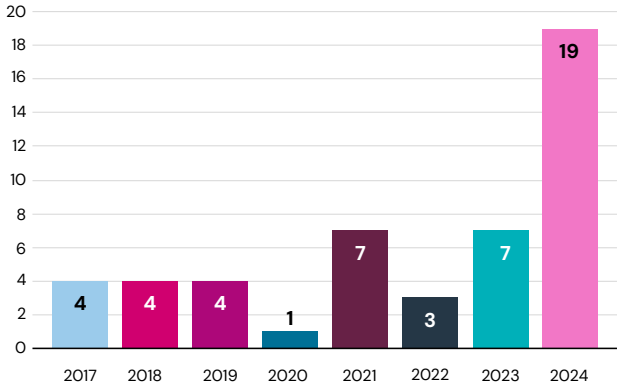
#### 5.1.1.2 Offer and allocation

There were 11 notifications related to the offering and allocation of organs. These notifications were related to logistical issues and organ allocation processes, including tissue typing processes.

#### 5.1.1.3 Information/transcription issues

In 2024, there were 25 notifications related to information/transcription errors, with 19 involving the AODR (Figure 9). Of the remaining reported incidents there were varied transcription/ documentation issues.

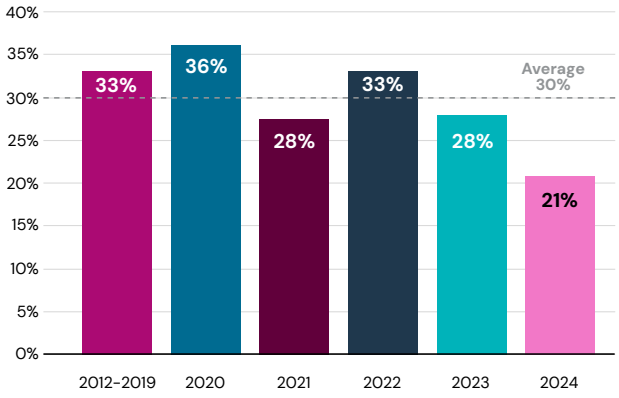
**Figure 9** Australian Organ Donor Register (AODR) SAER notifications.



### 5.1.2 SAER notifications relating to retrieval

SAER notifications relating to the retrieval category made up 21% of the total number of notifications from 1 January 2024 to 31 December 2024 (Figure 10).

**Figure 10** SAER notifications related to Retrieval.




In 2024, these notifications included the following sub-categories:

#### 5.1.2.1 Retrieval surgery

There were 14 notifications within the retrieval surgery category. These notifications related to surgical retrieval challenges and injuries, including surgical technique, donor physiology and surgical retrieval team logistics.

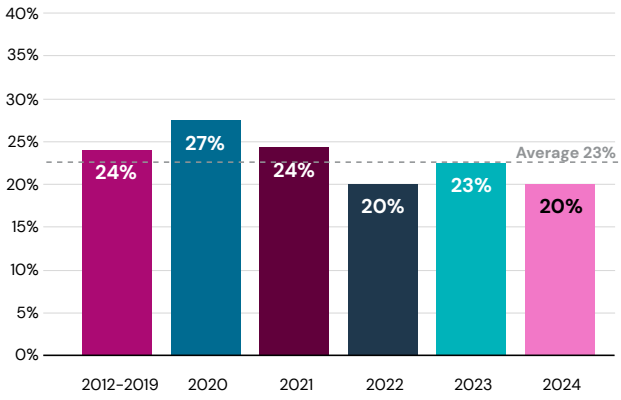
#### 5.1.2.2 Perfusion and preservation

There were two notifications related to the perfusion and preservation of organs. These cases involved an ex-situ perfusion machine failure and access to organ cold static perfusion fluid.

### 5.1.3 SAER notifications relating to transplantation

SAER notifications relating to the transplantation category accounted for 20% of the total number of notifications from 1 January 2024 to 31 December 2024 (Figure 11).

**Figure 11** SAER notifications related to Transplantation.




In 2024, these notifications included the following sub-categories:

#### 5.1.3.1 Possible Donor Derived Infection or other disease

There were nine notifications within the category of possible donor derived disease in 2024. These notifications encompassed infection, malignancy or other disease. In eight of the notifications an organ was transplanted, and the possible donor derived disease transmission was managed appropriately.

#### 5.1.3.2 Transplant surgery

There were five notifications related to issues occurring or identified during the transplant surgery. These involved equipment malfunction, logistics relating to recipient availability or condition of the organ, and recipient management.

The role of VSEAC is to monitor trends of serious adverse events and reactions. Identifying trends results in the VSEAC making recommendations for improved clinical practice to make organ donation and transplantation safer for all Australians.

# Appendix A
# VSEAC membership 2024

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 2024 to 31 December 2024.

| 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<br>Dr Stewart Moodie - SA |
| Member | Donation Nurse Specialist, DonateLife Queensland | Ms Niamh Farrell |
| Member | Donation Nurse Specialist, DonateLife Victoria | Ms Erin Bryen |
| Member | Communicable Diseases Network Australia representative | Dr Louise Flood |
| Member | Transplant Nurses Association representative | Ms Julie Pavlovic |
| Member | Senior Medical Virologist | Prof William Rawlinson |
| Member | Surgeon representative, Transplantation Society of Australia & New Zealand | A/Prof Handoo Rhee |
| Member | Australasian Donation and Transplant Coordinators Association representative | Mr Paul Robertson |
| Member | Australasian Donation and Transplant Coordinators Association representative | Ms Nicola Seifert |
| 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 |
| Member | Chair – National Tissue Typing Advisory Committee | Ms Rhonda Holdsworth |

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