



**Australian Government**  
**Organ and Tissue Authority**



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

**2020 Report**  
June 2021

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# 1 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 holes or gaps in our systems must thus be identified, analysed, and considered so that actions can be taken to prevent recurrence and to keep our patients safe to ensure the best possible outcomes.**

In years to come, we will look back on 2020 and reflect on how rapidly the world changed as a result of COVID-19. Organ donation and transplantation were substantially impacted, especially in the early stages when the world was learning about how the 'new' virus was behaving and its impact on different populations, especially the vulnerable immunosuppressed people with transplants.

Members of the Vigilance and Surveillance Expert Advisory Committee (VSEAC) have played a role in the donation and transplantation sector's response to COVID through contributing to key national forums: the '[COVID-19 - National Transplantation and Donation Rapid Response Taskforce](#)' (the Taskforce) and the '[Communicable Diseases Network Australia \(CDNA\) 'Coronavirus Disease 2019' \(COVID-19\)](#)'. The inclusion of VSEAC members in these forums illustrates the maturity and confidence the community have in the 'Australian Vigilance and Surveillance System for Organ Donation for Transplantation' and VSEAC.

The 2020 Australian Vigilance and Surveillance System for Organ Donation for Transplantation Report (report) has some differences to the inaugural 2019 report:

- 1 The absolute number of notifications reported is small (11) compared to the 2019 report and is focused on notifications received between 1 January and 31 December 2020

- 2 The number of notifications is correlated with missed donation opportunities as a result of COVID-19 related incidents. Consequently, the small numbers do not allow for much in-depth analysis in the report.
- 3 There were two notifications that pertained to the eye and tissue sector, which is out of scope for VSEAC and managed through the Therapeutic Goods Administration (TGA) processes, and
- 4 Inclusion of notifications of COVID-19 related incidents. These incidents illustrate the challenges faced by the donation and transplant sectors in delivering the national organ donation for transplantation program in 2020. VSEAC reviewed but did not rank the COVID-19 incidents, as they were 'unavoidable events' secondary to COVID-19.

As in 2019 report, the 2020 report is targeted in two formats to firstly communicate effectively with clinicians working in the organ donation and transplantation sector to promote practice improvements and to also report to the public in an open, transparent, and appropriate way.

We will continue to enhance our reporting for shared learning through VSEAC quarterly communiques to clinicians working in the system and if needed also immediate reporting, depending on the nature and severity of events. VSEAC have implemented a new process, in which each notification is considered for international reporting to Project NOTIFY and currently there is one such notification under consideration for submission. The OTA and VSEAC continue to maintain strong relationships with Project NOTIFY and are exploring virtual platforms for ongoing communication and sharing of information.

If you wish to provide feedback on the report or any VSEAC activities, you can send an email to the SAEN mailbox – [SAEN@donatelife.gov.au](mailto:SAEN@donatelife.gov.au).



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## 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 safeguard a better quality and safety in organs donated and used for transplantation. Importantly these systems aim to review and avoid reoccurrence of a serious adverse event and/or reaction (SAER).**

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 full picture and identifying trends. A national monitoring system enables the development of recommendations for system and process improvements, provides an opportunity for shared learnings, 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 to further enhance patient safety.

Internationally, vigilance and surveillance systems to 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'<sup>(1)</sup>. This is aligned with a strategy of the Organ and Tissue Authority (OTA) to enhance the safety of organ donation and transplantation in Australia.<sup>(2)</sup>

A brief history at Figure 1 illustrates how the Australian vigilance and surveillance has matured over time.

### 2.1 Inaugural 2019 Australian Vigilance and Surveillance System for Organ Donation for Transplantation Report

On 15 May 2019, the Vigilance and Surveillance Expert Advisory Committee (VSEAC) published the inaugural 'Australian Vigilance and Surveillance System for Organ Donation for Transplantation Report (Report)<sup>(3)</sup>'.

The inaugural report included all notifications submitted to between 2012 and 2019, a total of 99 notifications were classified in the report. Each notification was classified by notification type and notification category:

Notification type	
Broader system issue	63 (64%)
Serious adverse event	18 (18%)
Serious adverse reaction	18 (18%)

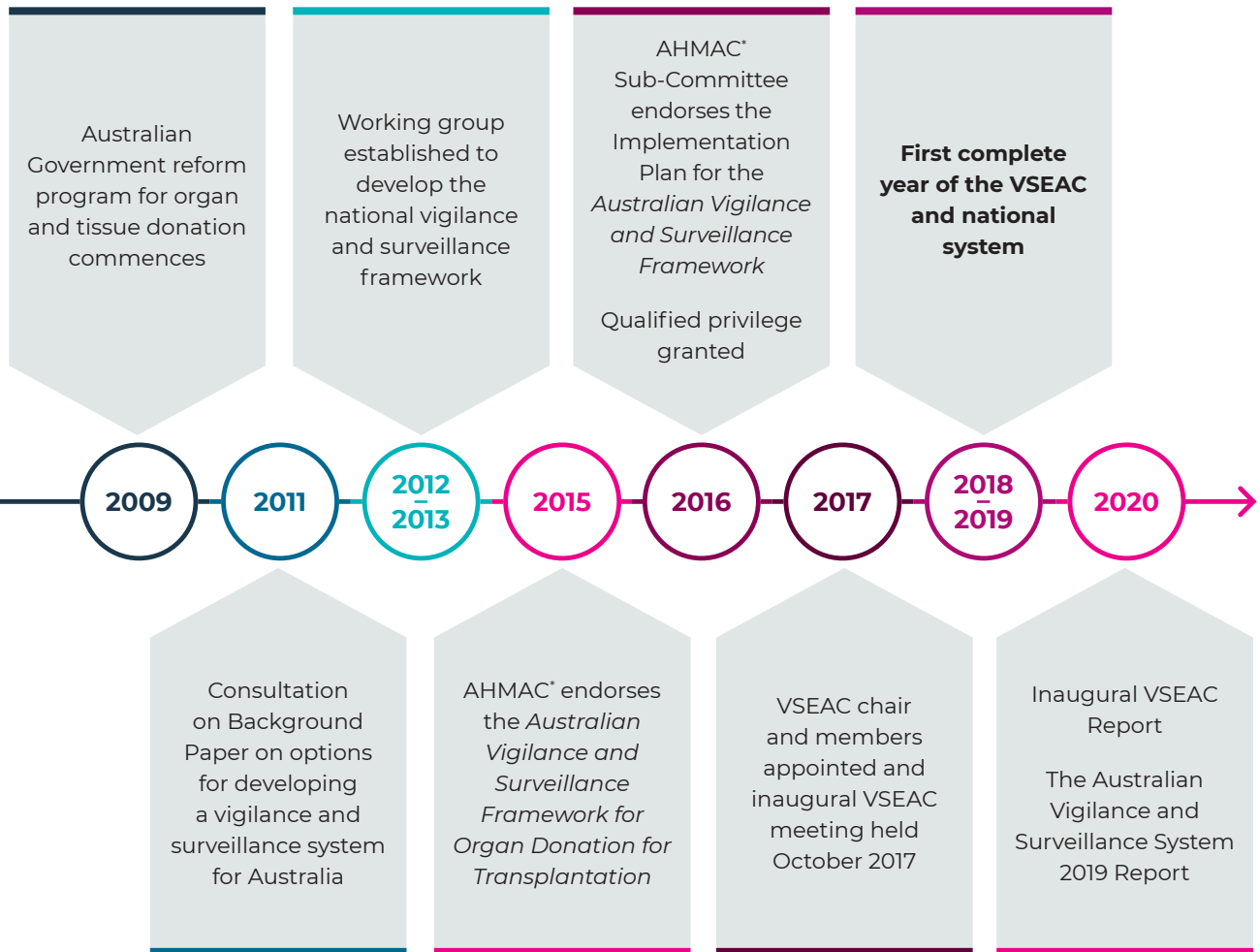
Notification category	
Donation	42 (43%)
Retrieval	33 (33%)
Transplantation	24 (24%)

The VSEAC did not begin reviewing, assessing, or ranking of notifications until January 2017, therefore the analysis of notifications, by VSEAC, only occurred for notifications received between 1 January 2017 and 31 December 2019.



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.

**Figure 1 Development and implementation of the Australian Vigilance and Surveillance System**



Throughout the development and implementation phases, states and territories were and continue to be responsible for individual management of SAERs that occur within their jurisdiction.



Reporting all events makes for a safer system.

\*Australian Health Ministers Advisory Committee (AHMAC)

## 2.2 VSEAC quarterly communiques

In addition to the inaugural annual Report, the VSEAC committed to regular communication with the donation and transplant sector through VSEAC quarterly communiques. The purpose of the VSEAC quarterly communique is to provide information and learnings to the sector in a timely fashion to enable changes to clinical practice in order to prevent similar future events.

## 2.3 Updates to clinical guidelines

A number of SAER notifications led to updates being made to the [TSANZ Clinical Guidelines for Organ Transplantation from Deceased Donors](#). A new section titled **“Risks related to other donor conditions”**. As well as a sub-section on **“Allergy and anaphylaxis,”** the new section includes information on diseases other than infection or malignancy.



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, save more lives, and enhance Australia's donation and transplantation system.

## 2.4 International reporting

The VSEAC is committed to contributing to the international NOTIFY Library<sup>(4)</sup> database when Australian SAERs meet the criteria for submission.

The VSEAC have reviewed all notifications received from 2012 at the inception of reporting to the Australian Vigilance and Surveillance system to 31 December 2020, to assess if any notifications are suitable for submission to the NOTIFY Library.



## 3 The Australian Vigilance and Surveillance System

### 3.1 The Australian Vigilance and Surveillance System

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

- ▶ work in parallel with state and territory clinical incident management systems in deceased organ donation and transplantation
- ▶ provide a coordinated national and international notification function
- ▶ monitor, record and retrospectively analyse serious adverse events / reactions (SAERs)
- ▶ inform future processes in organ donation for transplantation, and
- ▶ improve the safety and quality of organ donation and transplantation thereby improving patient outcomes.



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

The core elements of the Australian Vigilance and Surveillance System are the Vigilance and Surveillance Expert Advisory Committee (VSEAC) and the serious adverse events and reactions (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:

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



The Australian Vigilance and Surveillance System works in collaboration 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 by providing a national reporting 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-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.

A key focus is indeed 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 a 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.

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 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 were originally based on the 2013 'Communication and Investigation of Serious Adverse Events and Reactions Associated with Human Tissues and Cells (SOHO V&S)<sup>(5)</sup>.

In 2018 the European Directorate for the Quality of Medicines and Healthcare (EDQM) published the same criteria in the *7th Edition Guide to the quality and safety of organs for transplantation (2018)*<sup>(6)</sup> (Chapter 15 and appendix 19). Consequently, VSEAC has not changed the current definitions for serious adverse events/ reactions and assessment tools, as it remains aligned with international practice.

A **serious adverse event** is any 'undesired and unexpected occurrence associated with any stage of the chain from the 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'.

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'.

In line with internationally definitions of serious adverse events and reactions, the Australian Vigilance and Surveillance System include notifications of broader system issues where practice improvements could be made. These are unexpected or undesired occurrences that fall within EDQM serious adverse event – category C international definitions, and may have consequences for potential transplant recipients, such as:

- ▶ communication delays or miscommunications
- ▶ resource or logistic constraints related to surgical retrieval, transportation of organs, donation, or transplantation services
- ▶ the process of retrieval and perfusion of organs, and
- ▶ the storage and transportation of organs and vessels.

The above issues can then be considered at a national level to identify where process improvements could occur in the system to improve safety, efficiency, and effectiveness of donation for transplantation.

### 3.4 Commonwealth Qualified Privilege

To strengthen and encourage reporting of adverse events and reactions, the VSEAC was granted Commonwealth Qualified Privilege in 2016 and will be applying for renewal in 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 VSEAC membership at 31 December 2020 is as outlined in Appendix A.

During 2020 the VSEAC met three times, either face-to-face or via, videoconferencing, and also progressed matters out of session and through email correspondence.

### 3.6 The VSEAC process

The VSEAC process (as outlined in Figure 2) continued unchanged throughout 2020 despite the challenges of the COVID-19 pandemic. The figure outlines the pathway that is followed when an adverse event or reaction occurs. It demonstrates that hospitals and states and territories are responsible for the immediate and ongoing clinical management of the incident and that concurrently the SAER notification is submitted to the Australian Vigilance and Surveillance System by the State Medical Director of the DonateLife Agency.

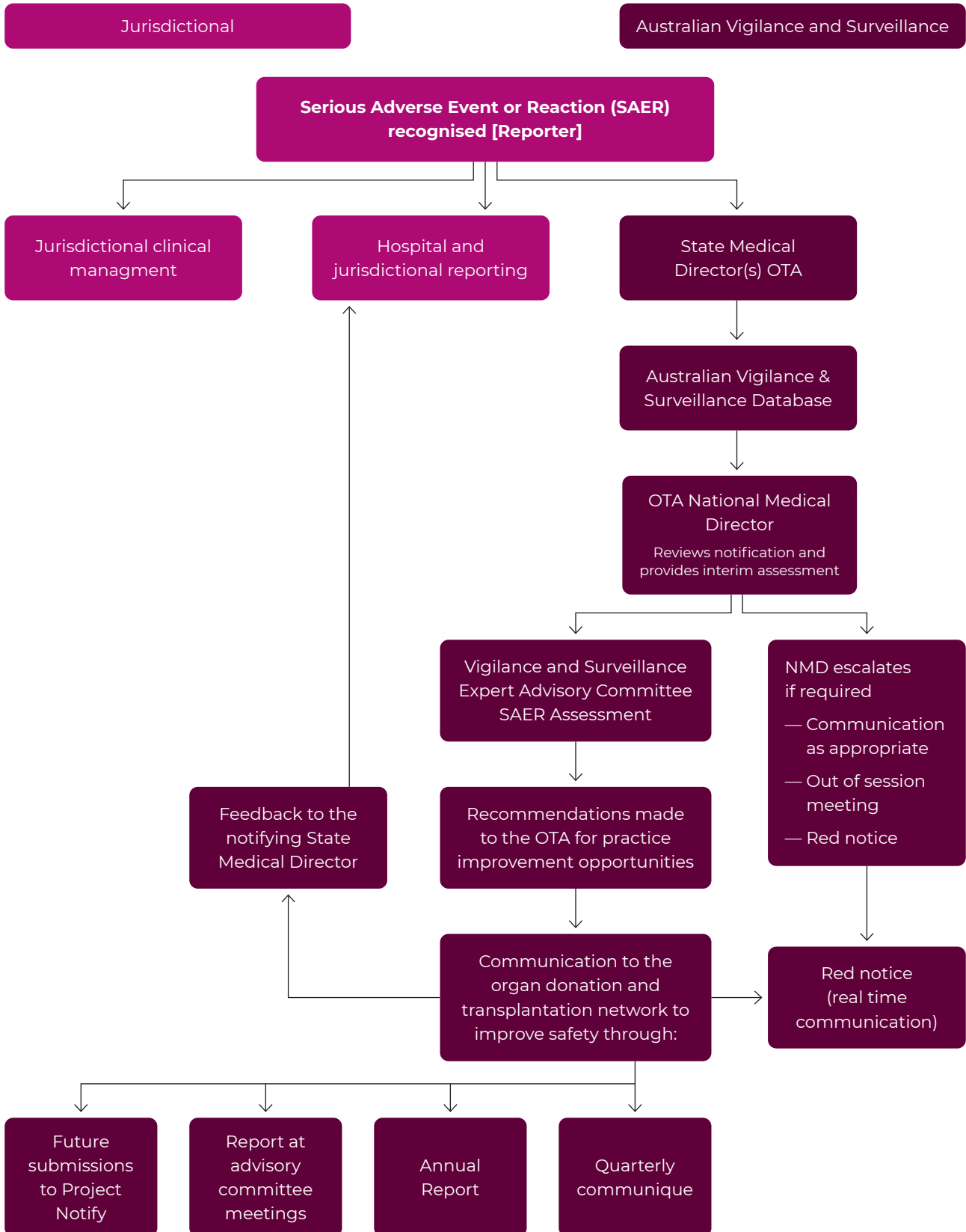
The SAER notification is initially reviewed by the OTA National Medical Director who assesses the notification and determines if any immediate actions are required. The notification is then reviewed by the VSEAC at the next meeting or out of session if a more timely response is required. SAER notifications 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 any literature review, NOTIFY Library searches, and correspondence which is also stored with each SAER notification.



**Figure 2 Communication pathway for SAER notifications**



## 4 Overview of reported serious adverse event and/or reaction notifications and COVID-19 log

In 2020, donation and transplantation activity in Australia declined due to the COVID-19 pandemic. There was a 12% decrease in the number of people receiving a transplant and a 16% decrease in the number of donors compared to 2019. This reduction in activity and other factors related to the pandemic are likely to have affected the number of SAER notifications reported to VSEAC, with 58% fewer notifications received as compared to the prior year (13 SAER notifications in 2020 compared with 31 SAER notifications in 2019).

Due to initial uncertainty about patient safety and risks to transplant recipients from COVID-19, the transplant sector took the precautionary step of suspending the adult kidney and pancreas transplant programs from the 24 March through to mid-May when the data became clear. The decision to suspend programs was primarily due to concern about the risk of COVID-19 infection during the early post-transplant phase in hospital when patients are most vulnerable and heavily immunosuppressed. Liver, heart, lung, and urgent paediatric kidney transplantation continued a selective basis based on the different risk-benefit assessment of delaying transplantation in these patients.

As a result of COVID-19, 2020 was a challenging year for the national program, with direct impact on the organ and tissue donation and transplantation numbers. The DonateLife teams worked hard with transplant teams to navigate the challenges facing hospitals and logistics, including with COVID-19 restrictions, flight reductions, and border closures, so that patients received the best possible transplantation outcomes.

VSEAC normally considers issues that have impact on the broader system, where practice improvements could be made. It was agreed that the extraordinary COVID-19 issues be captured separately in the COVID-19 log, an overview of this COVID-19 log has been included in this report.

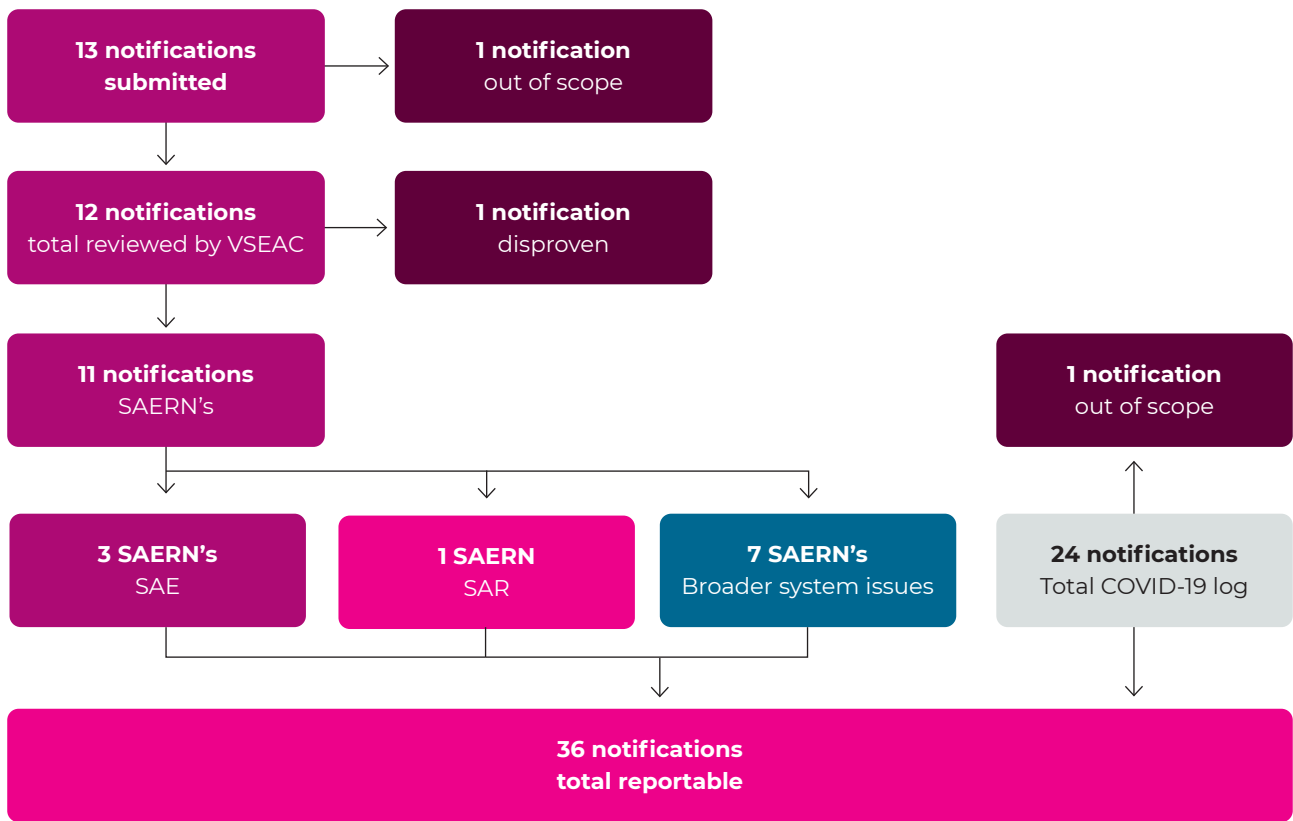
As can be seen in Figure 3, there were 13 SAER notifications submitted to VSEAC, with one notification that was out of scope, resulting in 12 notifications reviewed by VSEAC. There was one notification submitted to VSEAC, which on further assessment was found not to be a case of donor-derived transmission and subsequently is not included in the analysis. A total of 36 incidents (combined SAER notifications and COVID-19 log incidents) are included in the 2020 Report.

The number of SAER notifications (11) relative to overall donation and transplant activity (transplant procedures) remained small as can be seen in Table 1 at 0.82%, similar to 2019.



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

**Figure 3 SAER notifications reviewed in 2020**



**Table 1 SAER Notifications in context of deceased organ donors, transplant procedures and transplant recipients: 2012 to 2020**

Year	2012	2013	2014	2015	2016	VSEAC established			
						2017	2018	2019	2020
Deceased Organ Donors	354	391	378	435	503	510	554	548	463
Transplant Recipients	1,049	1,121	1,107	1,239	1,447	1,400	1,544	1,444	1,270
Transplant Procedures	1,100	1,163	1,164	1,301	1,508	1,467	1,618	1,501	1,334
Serious adverse event and/or reaction notifications submitted	1	2	6	5	2	3	5	12	11
Proportion of serious adverse event and/or reaction notifications relative to Transplant Procedures (percent)	0.09%	0.17%	0.52%	0.38%	0.13%	0.20%	0.31%	0.80%	0.82%

Figure 4, shows a comparison of the total 2020 incidents compared to SAER notifications in prior years, breaking down SAER notifications into three broad categories. For 2020 the number in each category is as follows:

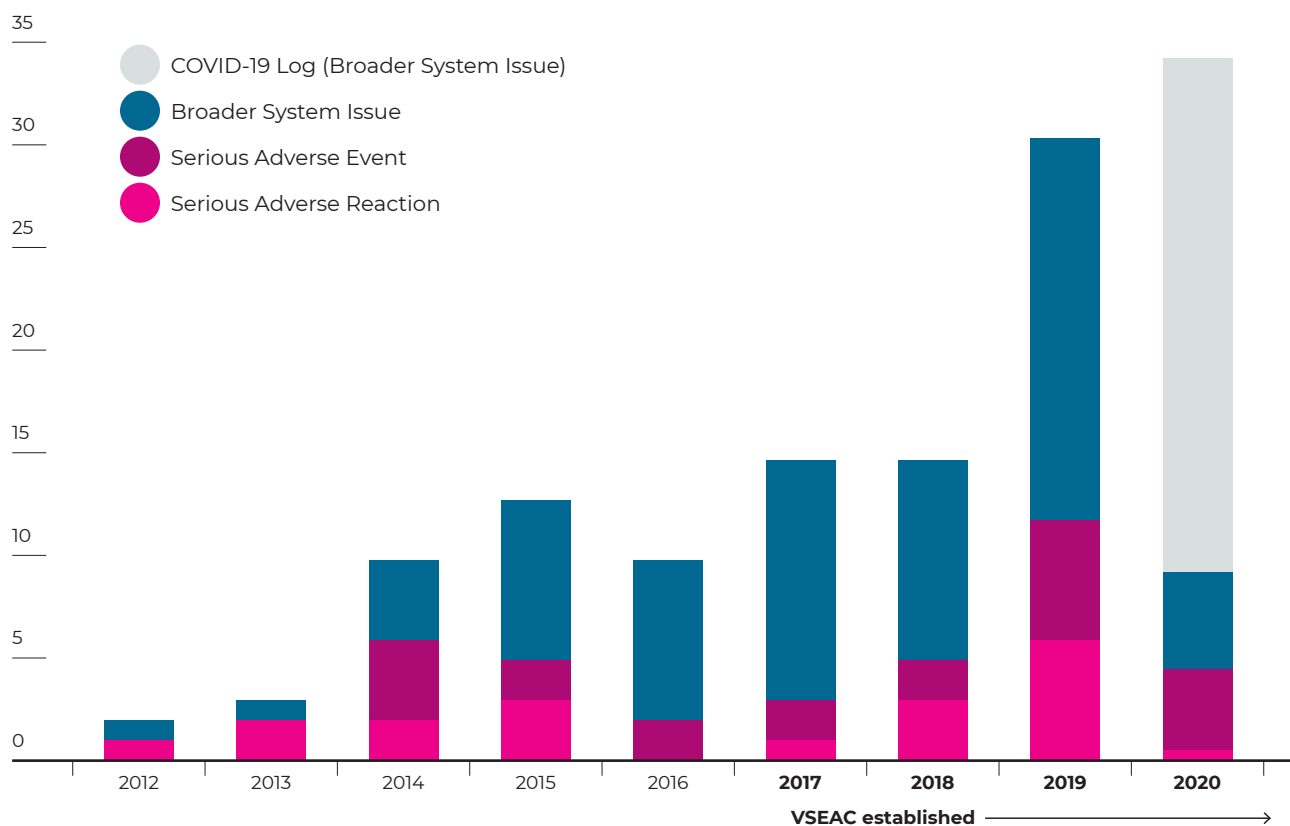
Notification category	
Serious adverse event	3
Serious adverse reaction	1
Broader system issues	7
COVID-19 log incidents	24



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 COVID-19 log reports are shown separately, although can be considered to be broader system issues (grey).

**Figure 4 SAER notifications by year: 2012 to 2020**



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

The incidents reported via the SAER notification process and reviewed by VSEAC have sufficient granular detail to enable analysis and categorisation according to the part of the donation and transplantation continuum they relate to, and also their impact. The following sections provide detailed information about the 12 SAER notifications reviewed by VSEAC in 2020.

The number of notifications to VSEAC during 2020 was small, only 11 notifications were formally ranked. This small number may be attributed to the impact of the COVID-19 pandemic on donation and transplantation activity and processes.

### 5.1 Analysis of SAER notification categories for 2020

The SAER notifications can also be categorised according to whether they relate to donation, retrieval, or transplantation (Figure 5, see page 12).

For 2020, out of the 11 notifications, there were:

Notification category	
Donation	4
Retrieval	4
Transplantation	3

Figure 6. (see page 12) show the notifications according to the three types of notifications (serious adverse event, serious adverse reaction, or broader system issues) and the categories of donation, retrieval, and transplantation. As the notifications are submitted by DonatLife State Medical Directors it is more likely that notifications are made within the donation and retrieval categories although reporting from the transplant sector, through DonatLife was encouraged.

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

Figure 7. (see page 12) shows the number of notifications in each sub-category in 2020. It shows the donor assessment sub-category had the most notifications followed by retrieval surgery and storage/ transport.

A more in-depth overview of SAER notifications reviewed by the VSEAC by category, from 1 January 2020 to 31 December 2020, is therefore included in this report.



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

#### 5.1.1 SAER notifications relating to donation

SAER notifications relating to the donation category made up 36.5% of the total number of notifications from 1 January 2020 to 31 December 2020. These notifications include the following sub-categories:

##### Donor assessment

There were two notifications related to donor assessment, specifically in regard to donor screening for diseases and the clinical accuracy of the screening test results.

Following the two notifications in 2020, VSEAC recommended that the advice in the TSANZ Clinical Guidelines be strengthened with respect to real-time involvement of other experts when assessing risk of disease transmission and in correlation with the screening test results.



The TSANZ Clinical Guidelines for Organ Transplantation from Deceased Donors were updated in 2020 to strengthen the recommendation to seek infectious disease advice on a positive HTLV result in relation to the donors known risk factors and likelihood of a false positive.

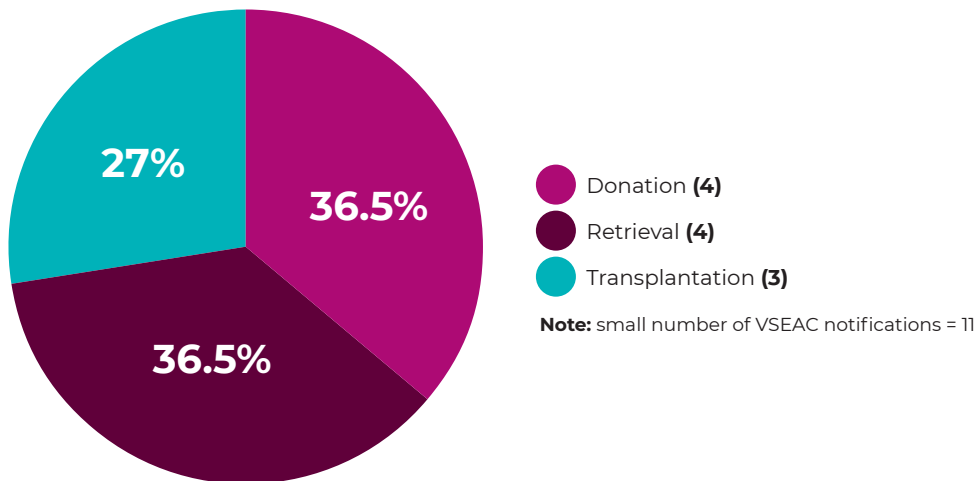
##### Information/ transcription issues

In 2020, there was one SAER notification related to the Australian Organ Donor Register (AODR), in comparison to four both in 2018 and 2019. The VSEAC continue to rate these notifications seriously as a registration to donate on the AODR is associated with a high rate of family consent.

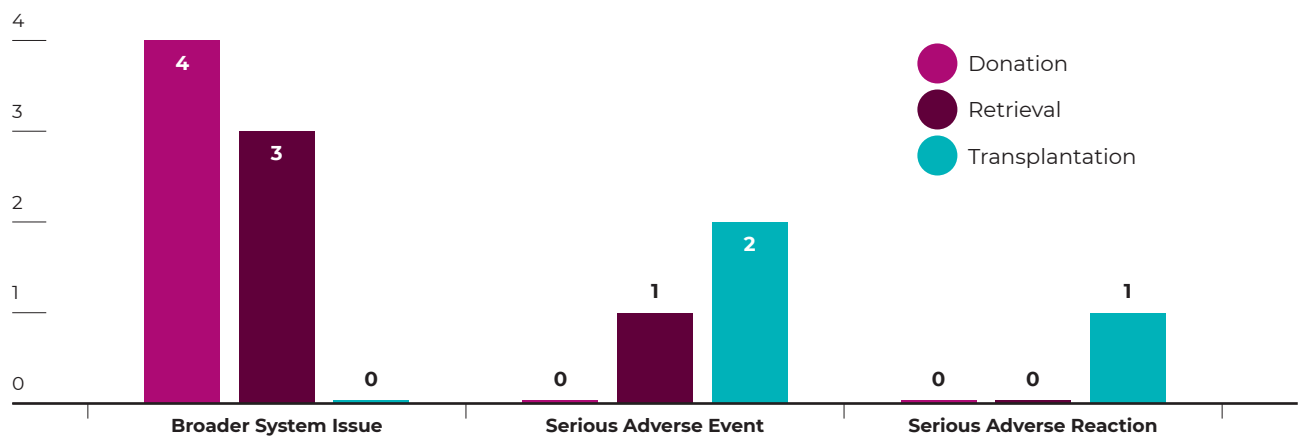


In 2020, 89% of families agreed to donation when their family member was registered to donate on the Australian Organ Donor Register (AODR).

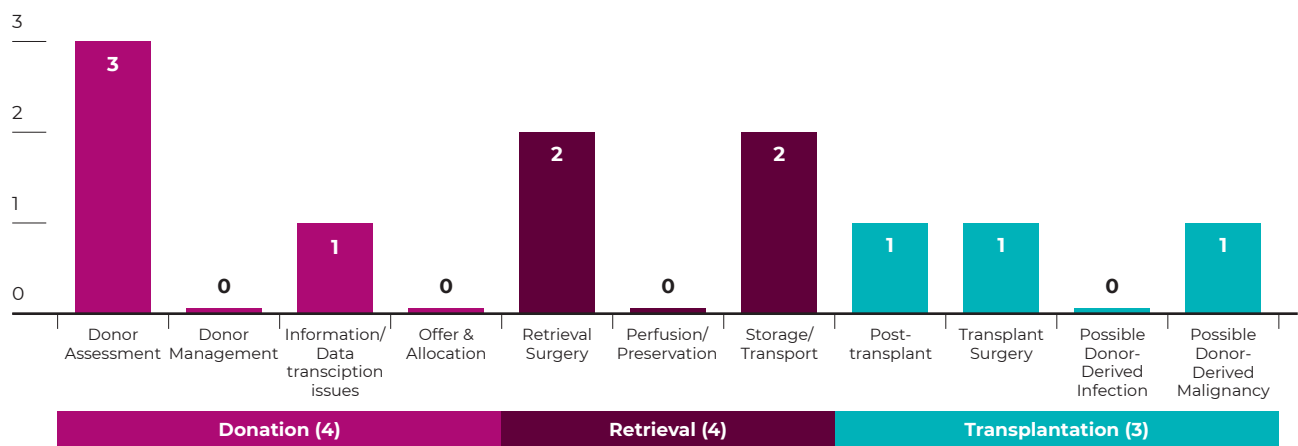
**Figure 5 SAER notifications by Donation, Retrieval and Transplantation categories in 2020**



**Figure 6 SAER notifications by category and notification type in 2020**



**Figure 7 SAER notifications by sub-category in 2020**



The AODR registration status is routinely provided to the family at the time of offering organ donation and inaccurate information may influence the family's final decision about donation.

### 5.1.2 SAER notifications relating to retrieval

SAER notifications relating to the retrieval category made up 36.5% of the total number of notifications from 1 January 2020 to 31 December 2020. These notifications include the following sub-categories:

#### ► Retrieval surgery

Two notifications were reviewed that relate to surgical retrieval challenges that may have contributed to the organ being ultimately unsuitable for transplantation. Each notification prompted a review of relevant surgical technical approaches, including by the relevant TSANZ Advisory Committee.

#### ► Storage/Transport

There were two notifications in which there were issues with storage and transport of the donated organs. In one instance, an organ was not able to be utilised for transplantation. Regardless of the issue, they were both rare unforeseen events which did not require any changes to practices or processes.

### 5.1.3 SAER notifications relating to transplantation

SAER notifications relating to the transplantation category made up 27% of the total number of notifications from 1 January 2020 to 31 December 2020. These notifications include the following sub-categories:

#### ► Transplant surgery

In one notification a transplant procedure was abandoned due to an unexpected rare event during the transplant surgery. Due to the timing of the event, there was no time for re-allocation and the organ was not transplanted.

#### ► Possible donor-derived malignancy

One notification was submitted following the receipt of information of a significant finding by the coroner. The findings were shared with all recipient transplant units, and at the time of this report, there have been no reports of donor-derived malignancies.

#### ► Post-transplant issues

One notification related to the accuracy of communication from the donation agency to the relevant transplant units with respect to a final donor pathology results.

Donation agencies must have robust mechanisms in place for timely follow up of donor information. Clear documentation and communication of donor information post donation to transplant units is important.



It is critical that communication is accurate and timely in all phases of the donation and transplantation processes. Clinicians are reminded to follow local protocols and follow-up any outstanding results.

### 5.1.4 Notification reviewed by VSEAC and disproven

There was one notification to VSEAC, which through further analysis and investigation was excluded, due to conclusive evidence the case was proven not to be a case of donor-derived transmission to the recipient and was not a classified or ranked by VSEAC.

## 6 Analysis of COVID-19 log reports

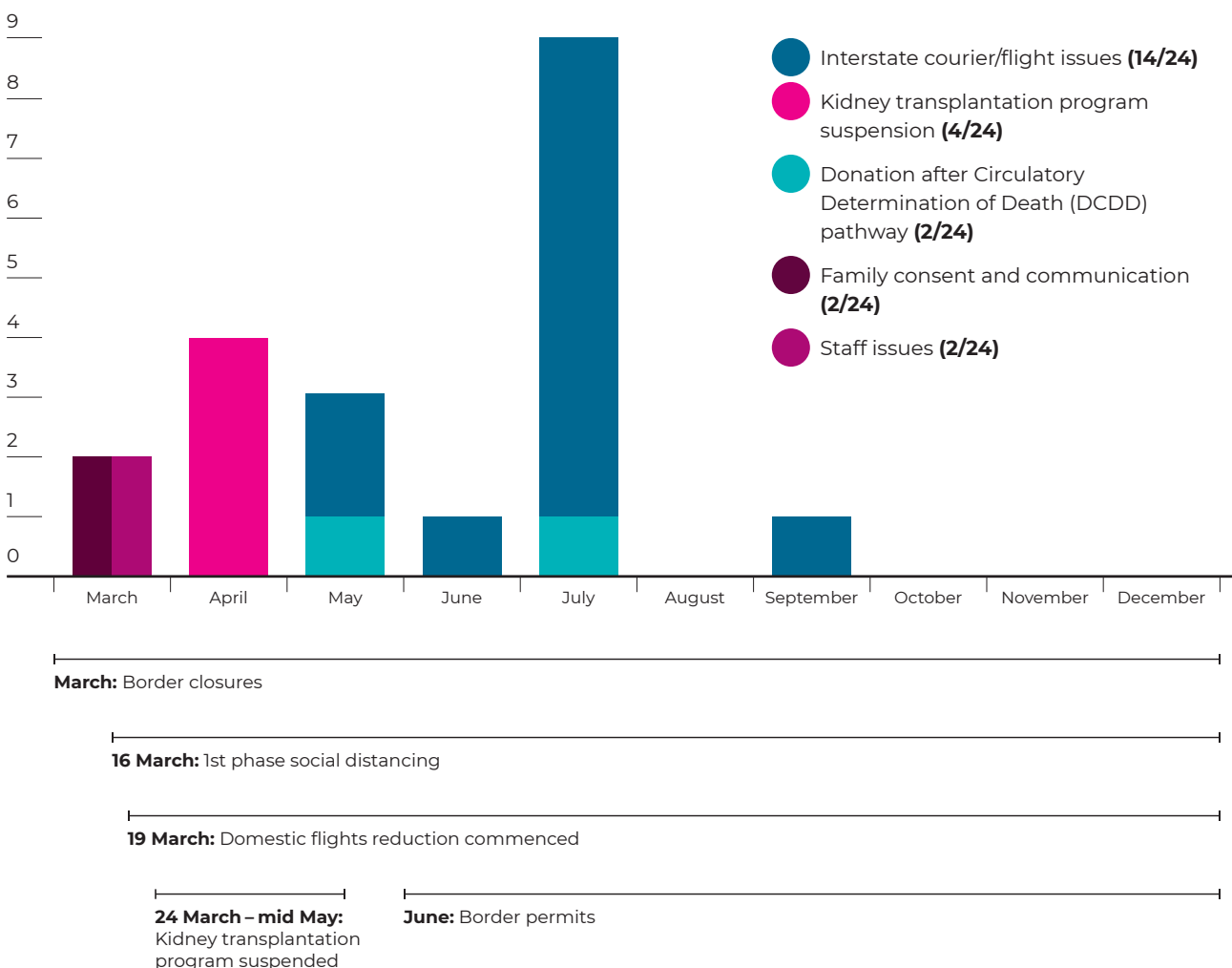
It was discussed and agreed to establish a COVID-19 log to capture any incidents that prevented or delayed donation. With the focus on process and logistic issues, and an opportunity to capture any impact on being able to facilitate donation and transplantation. The expectation was that this real-time collection of information could be used to improve safety in the ongoing provision of donation and transplantation services and address arising challenges in order to sustain donation and transplantation activity.

The process was to complement existing systems, including local reporting systems and the VSEAC SAER notification process. It was also considered that the

impact of COVID-19 on existing systems and practices, including the potential for staff deployment and changed working practices.

Real-time notification of relevant incidents were submitted to the COVID-19 – National Transplantation and Donation Rapid Response Taskforce (the Taskforce) for immediate action and resolution. Therefore, VSEAC has not undertaken a detailed review of these incidents given the nature of the COVID-19 log, lack of specific and granular information and real-time actions of the COVID-19 Taskforce.

**Figure 10 COVID-19 Log mapped against key events in 2020**





A high-level summary of the incidents are provided in the figure below. The temporal relationship of these incidents is shown along with key events related to the COVID-19 pandemic in Australia in figure 10 (left).

The COVID-19 log resulted in a total of 24 reported incidents – which provides an indication of the impact that COVID-19 had on donation and transplantation activity. However, it is highly likely that there were additional incidents, not reported, and as such this report provides only insight to the overall issues faced.

The incidents have been grouped into six categories, with interstate courier/ flight issues being the predominate issue with 14/24 notifications made:

Notification category	
Interstate courier/ flight issues	14 (58%)
Kidney transplantation program suspension	4 (17%)
Donation after Circulatory Determination of Death (DCDD) pathway	2 (8.3%)
Donor family support and communication	2 (8.3%)
Staff issues	2 (8.3%)

Interstate courier/ flight issues were the most common issue with 14 incidents documented in the COVID-19 log. The vast majority of these occurred during the period when domestic commercial flights and border closures were most restricted.

The introduction of state border and permit requirements were navigated by the DonateLife Agencies to facilitate donation and transplantation across borders.

Figure 10 illustrates that the challenges were addressed and quickly overcome by the donation and transplantation sectors which if left not addressed, would have resulted in many more lost donation and transplantation opportunities.

## Appendix A

### VSEAC membership 2020

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.

In 2020, VSEAC expanded the membership to include three additional positions which will bolster the VSEAC skill mix matrix. With the addition of a microbiologist, virologist, and a donation nurse, VSEAC has the required skills, knowledge, and experience to perform VSEAC duties as well as contributing to other national and international forums.

The membership of VSEAC at 31 December 2020:

Position	Committee role (representative and expertise based)	Held by
Chair (CEO appointed)	Vigilance and surveillance	Prof Jeremy Chapman
Deputy Chair	National Medical Director, Organ and Tissue Authority	A/Prof Helen Opdam
Member	Chief Executive Officer, Organ and Tissue Authority	Ms Lucinda Barry
Member	Infectious diseases physician, Microbiologist	Dr Peter Boan
Member	DonateLife State Medical Director (VIC)	Dr Rohit D'Costa
Member	Representative of the Communicable Diseases Network Australia	A/Prof Paul Dugdale
Member	DonateLife Donation Nurse representative	Ms Niamh Farrell
Member	Surgeon representative, Transplantation Society of Australia and New Zealand	Mr Michael Fink
Member	Infectious disease physician	Prof Lindsay Grayson
Member	Representative of the Australasian Transplant Coordinators Association	Mr Paul Robertson
Member	Physician representative, Transplantation Society of Australia and New Zealand	Prof Nicholas Shackel
Member	Oncology expertise	Dr Brian Stein
Member	Senior medical virologist	Prof William Rawlinson
Member	Epidemiologist	A/Prof Germaine Wong

# Reference List

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