NHS Blood and Transplant

Liver Advisory Group
OTDT Patient Safety Report November 2025

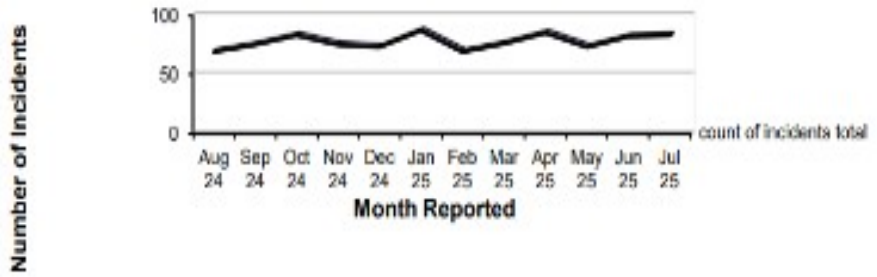
1. Status – Confidential

2. Action Requested

LAG is requested to note this report.

3. Data

Incidents reported and requiring investigation



4. Learning from reports

Below is a summary of the findings and learning from key clinical incident reports submitted to OTDT:

Date reported: 22.05.2025
Reference: INC 8998

What was reported
Liver accepted for complex recipient that required daytime transplant. For this reason, the decision was made to put the liver on OrganOx overnight. After the liver went on OrganOx one of the cannulas became dislodged. This was dealt with surgically and the liver went back onto the perfusion device. On further assessment the liver was declined for transplant on function. On re-offering the organ was not accepted by any other centres.
Investigation findings
The transplant centre fed back that it had not been possible to definitively say that the liver was transplantable prior to the cannula being dislodged. The cannula became dislodged at 40 mins perfusion which was too early to make a clear decision about the function of the liver. The lactate was 10.2 mmol/litre and the first ALT sample was processed at 60 minutes. The centre highlighted that at 40 minutes into the perfusion the recirculation pump was constantly running. The reservoir emptied 73 seconds after that. The perfusion was

stopped at this point. According to the recipient centre this is likely when the arterial cannula became dislodged. It was reported to have not been properly secured and became dislodged over that time. There was also a significant amount of air entrainment in the liver circuit, most likely due to persistently low pressures. The bench work surgeon was asked to investigate, the cannula was reinserted, and perfusion recommenced. There was little to no flow through the liver for 13.5 minutes. Following review and analysis of the downloaded machine data the clinical team reported no concern regarding the functioning of the OrganOx.
Learning
The transplant centre reviewed and discussed this case with their transplant surgeons who involved in placing livers on the perfusion device and also with their perfusion practitioner team. As a result of this case the centre has subsequently implemented additional training sessions and are reviewing their training processes for the future. They are also writing a local 'troubleshooting quick guide' for all users.

Date reported: 19.06.2025
Reference: INC 9103

What was reported
A liver centre expressed interest in a fast-track (FT) paediatric liver offer. The centre was 6th in the offering sequence. OTDT Hub Operations (HO) clarified with the liver centre if the expression of interest was for an adult or a paediatric patient. If for a paediatric patient, then the centre would be higher in the offering sequence than the centres who had expressed interest for an adult patient (multiple centres had expressed interest). As the centre had expressed interest for a paediatric patient the liver offer then went to them; they accepted. A little while later HO re-contacted the centre after consulting with the on-call OTDT Operations Manager. It was believed an error had been made with the FT offering sequence, the offer was to be retracted from this centre and given back to the original centre. The reporter requested further clarity around these circumstances and whether there should be separate FT sequences for adult and paediatric listed liver patients.
Investigation findings
This was an unusual scenario. The donor was a 15-year-old female DBD who died following a hypoxic brain injury (HBI) after a possible illicit drug overdose. On referral to the Specialist Nurse (SN) team the patient had deranged liver function and clotting, was in acute renal failure and on CVVH with rhabdomyolysis. For this reason, the SN screened suitability of the liver to transplant centres as per agreed process – the liver was screened out and

therefore would not be offered out. The donation process proceeded as kidney-only and the donor family was consented for this. In theatre, the attending NORS surgeon commenced surgery on the understanding they were retrieving kidneys only, however they deemed the liver looked very good and should be offered. As the liver function had improved this was discussed with NHSBT's on-call OTDT Operations Manager to discuss how to proceed. As cross-clamp was imminent it was agreed to FT the organ and not offer via the named patient route. The FT trigger as agreed is if cross-clamp is imminent which the SN and retrieval team agreed was the case. All actions were taken with the intention for the organ to be utilised.
Learning
NHSBT's Clinical Statistics Lead for the Liver Advisory Group (LAG) reviewed the FT allocation and whether this was being looked at for paediatrics and adults and if there had been similar cases before. They confirmed the incident reporter had attended the LAG Core Group in June 2025 at their invitation to discuss this case. A paper requesting clarity on the FT sequence was shared. Splitting the zones into adult and paediatric zones has been raised and agreed by LAG as an IT change. This however will be a large piece of work and further planning with the LAG chair, the paediatric subgroup chair and relevant NHSBT teams is planned and will be followed up via LAG.

5. Requirement from LAG

Note the details of this report.

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