SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Stream Director, Critical Care and Emergency Medicine
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FUNCTIONAL GROUP(S)	Critical Care and Emergency Medicine
KEY TERMS	Organ and Tissue Donation, Brain death, Neurological death
SUMMARY	To inform staff of the process and requirements for organ and tissue donation after neurological determination of death within South Eastern Sydney Local Health District.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

1. POLICY STATEMENT

The purpose of this policy is to outline the process of facilitating Organ and Tissue Donation via the Donation after Neurological Determination of Death pathway. This policy is consistent across SESLHD sites, inclusive of St George Hospital, Calvary Health Care Kogarah, The Sutherland Hospital, Prince of Wales Hospital and Sydney/Sydney Eye Hospital, and has been developed in accordance with the NSW Ministry of Health (MoH) and the Australian Organ and Tissue Authority (OTA) guidelines.

2. BACKGROUND

SESLHD supports the facilitation of Organ and Tissue Donation as an option for terminally ill patients that are cared for in critical care areas. The principles in this document are aligned with the Australian New Zealand Intensive Care Society (ANZICS) Statement on Death and Organ Donation (Ed 4.1), *NSW Human Tissue Act 1983*, National Health and Medical Research Council – Ethical guidelines on organ and tissue donation and transplantation.

Donation of organs and tissues after death is governed by laws. In 1977, the Australian Law Reform Commission addressed the absence of a definition of death in Australian law, recommending that a statutory definition of death should be introduced. They recommended that death be defined as:

- Irreversible cessation of all function of the brain of the person; or
- Irreversible cessation of circulation of blood in the body of the person.

In Australia, neurological determination of death, formerly known as brain death, cannot be determined unless there is evidence of severe brain injury sufficient to cause death. Such injury is associated with an increase in the pressure inside the skull cutting off the blood supply to the brain. Blood flow to the brain ceases and the entire brain, including the brainstem, dies.

In accordance with the ANZICs Statement for Death and Organ Donation, this document provides a framework for best practice in end-of-life care of the neurologically deceased patient and providing support for families in their decision surrounding organ and tissue donation. The fundamental principles for organ and tissue donation within SESLHD include:

A) Donation of organs and tissues is an act of altruism and human solidarity that potentially benefits those in medical need and society.

B) Organ and tissues for transplantation should be obtained in ways that:

- demonstrate respect for all aspects of human dignity, including the worth, welfare, rights, beliefs, perceptions, customs, and cultural heritage of all involved
- respect the wishes, where known (with reference to the Australian Organ Donor Registry (AODR) or family discussion, of the deceased
- give precedence to the needs of the potential donor and the family over the interests of organ recovery surgery for transplant
- recognise the needs of all those directly involved, including the donor, recipient, families, carers, friends, and health professionals.

C) Organs and tissues should be allocated according to just and transparent processes.

D) The choice not to donate should be respected and the family shown understanding for the decision.

2.1 Definitions

Australian Organ Donor Register: The Australian Organ Donor Register (AODR) is a government register, recording individuals who have indicated a wish for, or objection to, donation of organs and tissues in the event of their death. The register is administered by Medicare Australia. Australian Government policy requires that the AODR be consulted to ascertain the potential donor's registration status and any recorded wishes, and that the potential donor's family or senior available next-of-kin be informed of these. The AODR is accessed by authorised clinical personnel only.

Brain death: See Neurological Determination of Death definition.

Circulatory death: Death defined by irreversible cessation of circulation of blood in the person's body. Formerly known as donation following cardiac death**.**

Delegate: Somebody who is chosen to represent or has been given the authority to act on behalf of the SANOK. The delegate must be of the same level in the order of hierarchy (as per NSW Human Tissue Act 1983) as the person who authorised him or her to exercise the functions of a next of kin. The Authorisation to Delegate Responsibilities of Senior Available Next of Kin form (SMR020.031 appendix 2) must be completed.

Designated Officer: A person responsible for authorising removal of organs and tissues for transplantation or other therapeutic, medical, or scientific purposes. The designated

officer is also responsible for the performance of non-coronial postmortem examination and the release of a body for anatomical examination.

Designated Specialist: A person appointed by the Governing Authority as an appropriately qualified, and experienced medical specialist with '*specialist registration'* for the purposes of certifying brain death.

Specialist registration means a person who holds a specialist registration in a recognised specialty in a health profession in accordance with Division 2 of Part 7 of the Health Practitioner Regulation National Law (NSW). For the purposes of this act a person who holds a specialist registration in one of the following specialties as prescribed:

- Emergency Medicine.
- Anaesthetists.
- Intensive Care Medicine.
- Physicians.
- Surgery
- Obstetricians and Gynaecologists

As outlined by the Human Tissue Regulation 2020 [2020-454]

Donation Specialist Nurse (DSN): A Clinical Nurse Consultant Working within SESLHD who is a member of the NSW Organ and Tissue Donation Service (OTDS).

Donation State Coordinator (DSC): A Clinical Nurse consultant employed by the NSW Organ and Tissue Donation service (OTDS).

Donation Specialist Medical (DSM): An intensive care medical specialist dedicated to the facilitation and management of potential organ and tissue donors working within the SESLHD.

Family: Recognising the collaborative nature of end-of-life decision-making, the term 'family' is used to refer to a person or persons who have a close, ongoing, personal relationship with the patient, whom the patient may have expressed a desire to be involved in their treatment decisions, and who have indicated a preparedness to be involved in such decisions. This may or may not include biological family and may include extended relatives, a partner (including same sex and de facto), friend, or 'person responsible' according to an expressed wish of the patient.

Intensive Care Specialist: Refers to an Intensive care physician.

Life-sustaining treatment: Life-sustaining treatment is any medical intervention, technology, procedure, or medication that is administered to forestall death, whether the

treatment is intended to ameliorate life-threatening diseases or biological processes. These treatments may include, but are not limited to, artificial airways, mechanical ventilation, artificial hydration and nutrition, cardiopulmonary resuscitation, or medication to support circulatory function.

Neurological Determination of Death (NDD): refers to death determined by 'irreversible cessation of all function of the brain'. (ANZICS_2019_4 ED) This was previously known as brain death. Donation via the neurological determination of death pathway can be referred to via the accepted abbreviated acronym **DNDD**.

NSW Organ and Tissue Donation Service (NSW OTDS): The NSW agency responsible for the coordination of organ and tissue donation for transplantation based at Kogarah: SESLHD hosted service.

NSW State Coroner: An independent, appointed government official who holds jurisdiction over all reportable deaths as defined by the Coroners Act 2009 No 41.

NSW Tissue Bank: The NSW Tissue Bank incorporating the Lions NSW Eye Bank and NSW Bone Bank, is a state-wide service for the identification and coordination of eye, musculoskeletal, skin, and amnion donors.

Principal Care Officer (PCO): A PCO of the designated agency, which has full case management responsibility for the child or young person, automatically becomes the person responsible for consent for organ and tissue donation for transplantation.

Routine referral/ Notification: Notification by hospital staff to the OTDS staff whereby there is a consensus that the patient is at end of life and further treatment is not in the patients' best interests.

Senior Available Next-of-kin: as defined in the NSW Human Tissue Act 1983.

In relation to a deceased adult:

- Spouse of the deceased (which includes de facto and same sex partner)
- Son or daughter of the deceased (18 years of age or over), where above is not available
- Parent of the deceased where none of the above is available
- Sibling of the deceased (18 years of age or over), where none of the above is available.

And

- In relation to a deceased child:

- Parent of the child (both parents have equal standing)
- Sibling of the child (18 years of age or over), where a parent is not available
- Guardian of the child at the time of death where none of the above is available.

3. RESPONSIBILITIES

This procedure applies to all clinical staff working within areas related to organ and tissue donation in SESLHD:

- Hospital Network Executive
- Stream/Site/Service Executive
- Senior Nurse Managers
- Donation Specialist Medical (DSM)
- Donation Specialist Nurse (DSN)
- Donation Specialist Coordinator (DSC)
- Intensive Care units Nursing and Medical staff
- Emergency departments Nursing and Medical staff
- Operating theatre nursing and medical staff
- Social Work, and other Allied Health Staff
- Aboriginal Liaison Officers

3.1 Employees will:

- Ensure that the needs and values of the dying person are always prioritised.
- Ensure best practice end of life care is delivered to all patients, regardless of their intention (or otherwise) to become an organ donor
- Support DNDD organ donation initiatives where these are consistent with the patient's wishes, and where they align with the priority commitment to end of life care. This includes recognising potential donors and facilitating access to organ donation carefully and in strict accordance with local, state and national best practice guidelines
- Familiarise themselves with the donor referral criteria and management of potential donors as outlined in these guidelines
- Approach all activities related to DNDD in a sensitive and thoughtful manner.

3.2 District Managers/ Service Managers will:

The Ministry monitors the performance of the NSW Organ and Tissue Donation Service, Local Health Districts, Specialty Health Networks, and other agencies. The Ministry also maintains policy and legislative frameworks to ensure that human tissue is used safely, ethically, and effectively.

The SESLHD Organ and Tissue Donation Governance Committee ensures engagement of senior clinicians and the relevant departments, including Senior Hospital Executive,

Operating Theatre, Emergency Department, Intensive Care Unit, Social Work and specialist Organ and Tissue Donation staff. This committee oversees the development, coordination, implementation, and ongoing monitoring of best practice surrounding organ and tissue donation.

3.3 General Medical staff in Critical Care will:

- Familiarise themselves with the donor referral criteria, see item 4.2
- Maintain their required level of knowledge regarding organ donation and end of life care as per the College of Intensive Care Medicine (CICM) and Australian New Zealand Intensive Care Society (ANZICS) guidelines
- Refer to the Donation Specialist Nurse (DSN) and Donation Specialist Medical (DSM) for consideration of organ donation in all patients where withdrawal of life sustaining treatment is planned, and end of life care is the focus of management
- Participate in education and training to remain up to date with local guidelines and protocols.

3.4 OTDS STAFF will:

Donation Specialist Medical (DSM)

The Donation Specialist Medical is responsible for all processes aimed at optimising organ and tissue donation for transplantation across SESLHD. They are responsible for providing consultancy in all procedures that are associated with donor identification, donor management and organ retrieval at their hospital and across the district when required.

In some cases, the DSM may be in a position of potential or perceived duality or conflict of interest, if required to act in both their role as the treating intensive care specialist and the DSM simultaneously. This should be avoided where possible, but where not practicable, this potential conflict should be assessed on a case-by-case basis. An additional trained specialist should be contacted to be present for any donation conversations, if available, to minimise any potential conflict of interest.

The role of the Donation Specialist Medical in DNDD is:

- To support local hospital staff during the process of donation by making sure local and best practice guidelines are followed.
- Ensure that the patient's best interests remain the priority during end-of-life care.
- Where possible, ensure that there is a separation between the clinical team managing the patient's end of life, and any clinical personnel engaged in the transplant retrieval process or potential recipient's care.
- Answer inquiries by the family, nursing, and medical staff regarding the DNDD process, including related ethical and legal issues.

- Provide training and education to local staff surrounding guidelines around organ donation.
- Assist in the updating of local guidelines as State and Federal guidelines change as well as reporting to governance committees.

Donation Specialist Nurse (DSN):

The Donation Specialist Nurse is to provide an expert patient centred consultancy practice for the clinical management of potential organ and tissue donors and their families via the DNDD pathway. This consultancy care is delivered in collaboration with patients, families, and other health professionals, while always ensuring the SESLHD core values are upheld.

The DSN role is aligned with the donor and the donor's family and is primarily concerned with the dying person's best interests. They provide the necessary conduit to the Donation Specialist Coordinators; however, they are always expected to be an advocate for the donor's end of life care.

The role of the Donation Specialist Nurse in DNDD is:

- To provide a conduit between the patient and their treating team, and the local and state transplant infrastructure.
- Always ensure respect for the dignity of the dying patient; inclusive of psychological, physical, emotional, and spiritual needs of the patient and their family/support people.
- Provide support for the grieving family and loved ones, ensuring this occurs throughout all phases of dying, before during and after cessation of life sustaining treatments.
- Ensure sound communication between all relevant teams, adopting a collaborative and inclusive team-work approach to enable smooth facilitation of the DNDD process. This includes:
    - Critical Care staff
    - OT Staff
    - Social Worker, Chaplains, Indigenous leaders
    - Porter

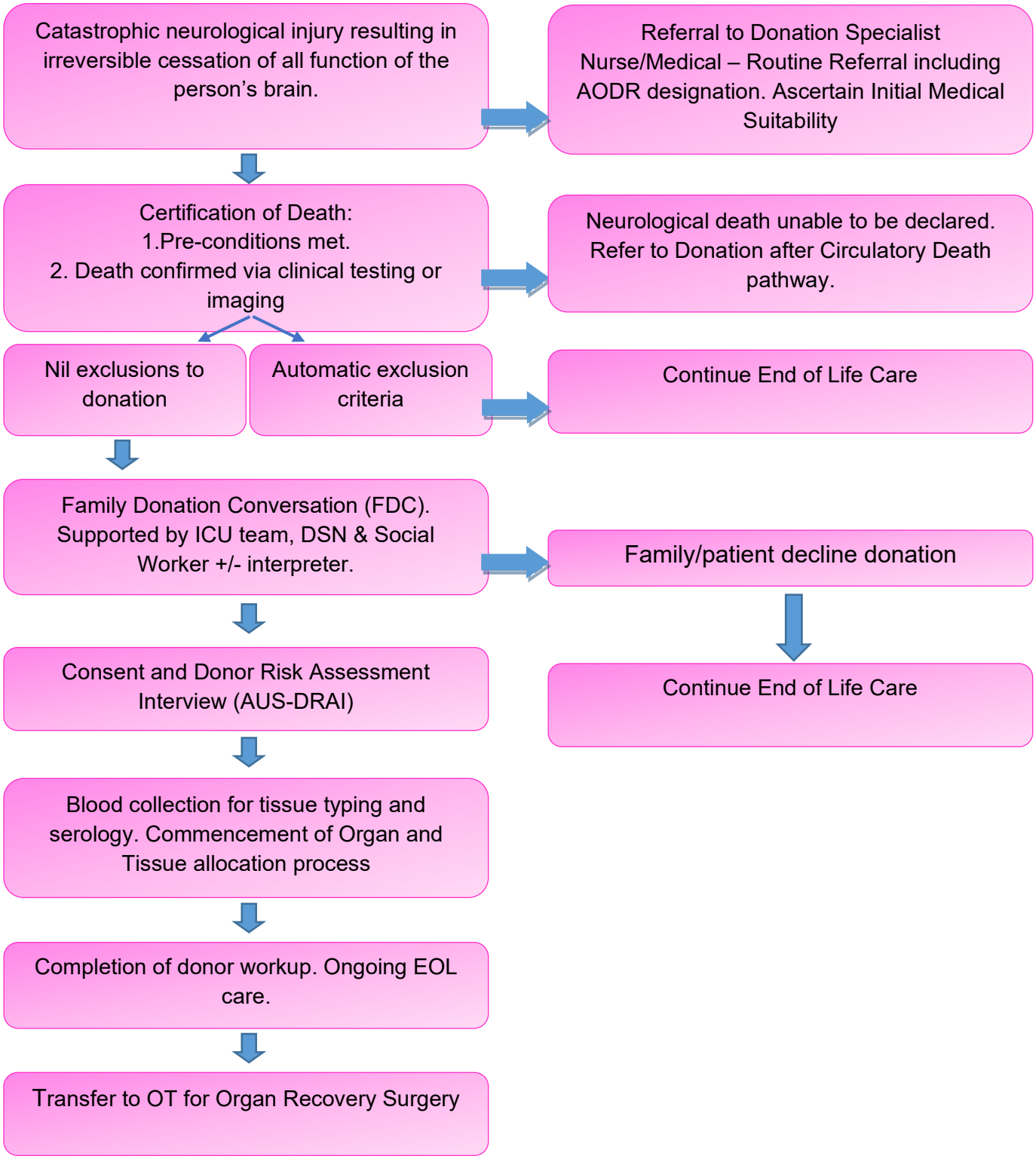
Donation Specialist Coordinator (DSC) in DNDD:

The DSC acts as the conduit between the donor and the transplant services, responsible for coordinating aspects of the surgical donation procedure, ensuring legal and ethical requirements are adhered to throughout the process. This includes:

- Education and support for all staff
- Ongoing communication and liaison with the transplant teams
- Clinical leadership within the OT
- Appropriate and respectful care of the deceased post donation surgery

4. PROCEDURE

4.1 Pathway to Organ Donation following Neurological Determination of Death



4.2 Identification of a potential organ donor

In critical care areas, Routine **Referral** or a routine **Notification** is made to consult donation staff when there is medical consensus that a patient is near end of life or when current/future treatment is deemed to be futile and would be burdensome to the patient. A routine referral can be made by anyone who is in direct care of the patient, including medical, nursing, social work, allied health etc. Local donation staff will conduct a preliminary assessment at the time regarding the appropriateness of offering donation based on the specific patient profile. In circumstances where either the patient themselves or family members raise the possibility of donation directly with hospital staff, the same referral process to local DSN should apply.

Contacts for SESLHD Donation Specialist staff can be made directly 24/7 via hospital switchboards or NSW OTDS paging service.

St George & Sutherland Hospitals	Prince of Wales Hospital	NSW OTDS Service
SGH Switchboard: (02) 9113 1111 TSH Switchboard: (02) 9540 7111 Ask for transfer to on-call DSN	POWH Switchboard: (02) 9382 2222 Ask for transfer to on-call DSN	Paging service: 02 9963 2801 Ask to page the DSC on call.

4.3 Donor referral and coordination:

Referral of all potential organ donors and notification or consultation with the relevant DonateLife hospital team/ DonateLife Agency should occur as early as possible. This enables preliminary assessment of the potential donor and facilitates the timely involvement of an FDC Trained Specialist to assist the clinical team in the planning and provision of patient care, family care and communication. End of life care and the family donation conversation are best managed in the ICU rather than the ED and should be provided by a trained specialist in collaboration with a Donation Specialist Nurse.

4.4 End-of-Life Conversations and Planning

It is the responsibility of the Intensive Care team to ensure that they have discussed the likely prognosis and the plan for end-of-life care and neurological testing with the patient and their family. This should be conducted separately from any discussion regarding the possibility of organ donation. The DSN may be encouraged to attend end of life discussions at the request of the treating team where appropriate.

Decision making should align with the patient's values and preferences wherever possible, and end of life care is and will remain the principle focus regardless of organ donation preferences and eligibility. For treating medical teams, management should be consistent with the ANZICS Statement on Death and Organ Donation.

4.5 Determination of Neurological Death *as outlined by the ANZIC Statement on Organ Death and Organ Donation*

- Permanent loss of brain function should always be determined whenever it has occurred and determination regardless of whether donation is being considered. The rigour of neurological determination of death provides certainty to the patient's family that an individual who meets criteria is dead, irrespective of organ donation.
- For neurological determination of death to be conducted, there must be definite clinical or neuroimaging evidence of acute brain pathology consistent with deterioration to permanent loss of all neurological function. In cases of hypoxic-ischaemic encephalopathy, clinical history alone may provide sufficient explanation of the acute brain pathology and not require neuroimaging prior to neurological determination of death by clinical examination.

4.6 Preconditions to clinical examination

Physicians should adhere to the ANZICS Statement on Death and Organ Donation and ensure that all preconditions and observational periods are met prior to clinical testing.

If any of these preconditions cannot be met, brain perfusion studies should be used to inform neurological determination of death.

4.7 Observation & Waiting periods.

There is a minimum 4-hour observation period prior to neurological determination of death using clinical examination alone. Throughout this observation period, all preconditions are met, the patient has a Glasgow Coma Scale of 3, with pupils nonreactive to light, absent cough/tracheal reflex, and apparent apnoea on a ventilator. Following an acute hypoxic-ischaemic encephalopathy or hypothermia (<35^{o}C) of duration greater than 6 hours, there should be a waiting period of 24 hours before determination of death using clinical examination alone. The four-hour observation period and the 24-hour waiting period can end simultaneously.

4.8 Process of Clinical Examination

Guidance for undertaking the clinical examination of determining neurological death can be found by referring to the ANZICS Statement on Death and Organ Donation.

Confirmation of death is documented on the NSW Health Neurological Determination of Death form (Appendix 1). The official time of death is recorded as the time when the ***second*** clinical examination has been completed or at the time when second clinician has reviewed the absence of intracranial blood flow on imaging.

4.9 Family presence during clinical examination

The opportunity to observe the clinical examination of brain function should be offered to family members. If the family are to be present, the intensive care specialist should explain the tests and responses, particularly forewarning them of the possibility of spinal reflexes. There must be someone available (e.g. a nurse, SW) to support the family.

4.10 Demonstrating absence of brain perfusion via medical imaging.

In situations where the clinical examination cannot be solely relied upon for neurological determination of death, it is essential to undertake imaging to demonstrate the absence of brain perfusion. When imaging is required, it must be preceded by undertaking those parts of the clinical examination that are possible. Testing for brain perfusion should be deferred until responsiveness, examinable brainstem reflexes and breathing effort are all absent.

Imaging tests must have a high sensitivity and, most importantly, a specificity of 100% to avoid the false conclusion that brain perfusion is absent in a person who does not meet neurological criteria for death. The three acceptable imaging techniques for demonstrating absent brain perfusion are:

- intra-arterial catheter angiography,
- radionuclide imaging and,
- computed tomography angiography (CTA)

Although the absence of brain perfusion is determined by a radiologist or nuclear physician, ***it is the responsibility of two medical practitioners*** who have clinically examined the patient to determine that the patient has died.

4.11 Family Donation Conversation (FDC)

All discussions surrounding Organ and Tissue donation should be conducted in accordance with the Best Practice Guideline for offering Organ and Tissue donation in Australia.

Raising donation with a family must be part of a considered process that best meets the needs of the family. Organ and tissue donation occurs at a time of grief and distress, and the donation process must be sensitive to the needs of the patient and the family at this time. Ideally, family conferencing should be conducted in a suitable private place, with consideration to the balance of clinical staff present in relation to family members. Families should be afforded the necessary time and space to process all information and ask questions in order to make a considered decision.

In SESLHD, donation will be raised by a clinician who has completed the Core Family Donation Conversation (cFDC) workshop. This is done as a collaborative approach, with involvement from Donation Specialist nursing, medical and allied health staff.

Inquiries should be made to find out if the patient has appointed an enduring guardian and if so, what functions the patient has assigned to them.

Inquiries should be made to find out if the patient has an Advance Care Directive, and if so, whether the patient expressed specific views about end-of-life care or organ donation.

5. CONSENT

Deceased organ donation is governed by the *NSW Human Tissue Act 1983*. The *NSW Human Tissue Act 1983* specifies the provisions for obtaining consent and authorisation for the removal of organs and tissues for the purposes of donation, and subsequent transplantation to a living person, or for other therapeutic, medical or scientific use of those donated organs and tissues. Further information related to obtaining consent for the purposes of deceased organ and tissue donation can be found in the NSW Health Policy Directive PD2024_002 - Organ and Tissue Donation, Use and Retention.

5.1 Seeking consent

The process of authorisation for organ and tissue donation requires consent from the following:

- The patient (where possible), via the AODR and/or Advanced Care Directive
- Senior Available Next-of-Kin (SANOK) or Delegate
- NSW State Coroner (where applicable)
- Designated Officer
- Principle Care Officer (PCO) if the patient is a child under the care of the state

5.2 The Patient

Registration of a prior wish to be an organ donor on the AODR supports organ and tissue donation to take place once verified by the Designated Officer of the hospital site. This may also be in the form of a documented Advanced Care Directive.

NOTE: A registered refusal does not necessarily mean organ and tissue donation cannot proceed under NSW Legislation. The designated officer may authorise the removal of tissue of the deceased patient, but only if the family/SaNOK have expressed with certainty more recent wishes of the potential donor.

5.3 SANOK and Delegate

Detailed, and informed consent from the SANOK is completed by signing the Consent and Authority for Removal of Tissue after Death form (SMR020.030 - Appendix 3), or by a taped verbal consent if obtained over the phone by the DSN. Refer to definitions for the hierarchy of people eligible to be the SANOK.

If a deceased person had documented their wish to be an organ donor and a health practitioner determines that the removal of tissue should not proceed due to the objection of the deceased person's family, then the relevant health practitioner must document the reasons for not proceeding and complete the Documenting Family Objection to Organ Donation Contrary to Known Wishes Of the Donor form (SMR010.516_Appendix 5).

5.4 Coronial consent

In cases where death is reportable to the Coroner, donation requires the prior authorisation of the Coroner. It is the responsibility of the DSC to seek authorisation for organ and tissue donation from the Coroner following SANOK consent. Initially this requires a discussion with the investigating Police and Duty Forensic Pathologist (FP). The Coronial Checklist should be utilised to determine if a death is reportable to the Coroner. Where doubt exists as to whether a death should be reported, the treating intensive care specialist should contact the Duty FP to discuss.

Donation surgery cannot commence until authorisation from the Coroner and Designated Officer is obtained. For further information please see the following link: PD2010_054 - Coroners Cases and the Coroners Act 2009.

5.5 DO consent.

A Designated Officer is responsible for authorising the release of a body for anatomical examination, non-coronial post-mortem examination and the removal and use of organs and tissue from a deceased body for medical, scientific, or therapeutic purposes (including transplant). They must do so in accordance with the *Anatomy Act 1977 (NSW)* and the *Human Tissue Act 1983 (NSW)*. Designated Officers within SESLHD are appointed in accordance with section 5 of the *Human Tissue Act 1983 (NSW)*.

When issuing authorisations under the *Human Tissue Act 1983 (NSW)* or the *Anatomy Act 1977 (NSW),* a Designated Officer:

- in coronial cases, cannot authorise the removal or use of tissue for any purpose unless the Coroner has given permission
- may make reasonable inquiries in order to be satisfied of the relevant criteria before authorising procedures (or not authorising)
- may rely on inquiries made by others
- must never sign an incomplete form and their authority must be in writing
- cannot act in any case where they have had a clinical or personal involvement
- must not disclose the deceased's identity to the public as per PD2024_023 - Designated Officer.

6. PREPARING FOR ORGAN PROCUREMENT SURGERY

The patient is transported to OT by anaesthetic personnel in conjunction with hospital and donation specialist staff (if required).

Documentation required to accompany the patient to the peri-operative suite is based on local polices and can include, but is not limited to:

- Certification of brain death
- Consent and authority for removal of tissue after death,
- Death certificate or Form A,
- Coronial Checklist
- Authorisation to delegate responsibilities of NOK and all available patient notes. (Appendix 2)

6.1 Care of the patient post operatively:

Operating staff and the DSC will attend to the care of the deceased's body after the completion of donation surgery. This is to be conducted as per local policy. Special consideration is taken into account when there are specific requests made by the donor family. Please note that the patient may be transferred back to the ICU for a viewing and care of the deceased will be the responsibility of staff taking over care in the ICU.

Refer to the following local business rules:

- POWH CLIN118 CBR Deceased Patient-Care of the
- SGH-TSH CLIN086 CBR DEATH-CARE OF THE BODY AFTER

6.2 Family viewing

At the completion of surgery, the family have the option to see their loved one prior to transfer to the mortuary. This time can be important for some families and significant others. Ongoing support of the family may be required, from ICU doctors and nurses, donation staff, social work, religious or cultural leaders, or other relevant support persons where appropriate.

6.3 Care for staff:

Debriefing for all staff involved in donor care should be offered following every donation case. Attendance is voluntary and at the discretion of the staff involved. Similarly, staff members who were in the direct care of the potential donor should have the opportunity to receive information regarding the donation outcomes. Correspondence must align NSW privacy legislation. If further support is required for staff, professional counselling is encouraged and available from SESLHD Employee Assistance Program (EAP).

Other organisational strategies used to mitigate staff grief and distress should be facilitated through local initiatives. Examples of these include debriefing after the event.

7. DONOR FAMILY FOLLOW-UP

Following organ and tissue donation the DSN ensures that the following steps are completed to support the wellbeing of donor families:

- Ascertain if the family would like to complete an NSW OTDS Memory Book (handprints, lock of hair, photos of hands), if not already done by the local ICU team.
- Identify the family members requesting follow up, and confirm their contact details
- Briefly outline the Family Support Program

8. DOCUMENTATION

Bedside Guide for Organ Donation – Appendix 4

9. AUDIT

Donation Specialist Nurse at each site conducts daily audit of hospital deaths to identify instances where donation could have been considered. Reported daily to Organ & Tissue Authority.

Monitoring organ and tissue donation best practice guidelines for offering organ and tissue donation in Australia. Results are tabled ICU M & M (monthly).

10. REFERENCES

This procedure document should be read in conjunction with the following NSW Health policies and guidelines:

- ANZICS The Statement on Death and Organ Donation. Edition 4.1 2021 https://www.anzics.org/wp-content/uploads/2022/04/ANZICS-Statement-on-Death-and-Organ-Donation.pdf
- ANZICS Statement on Care and Decision-Making at the End of Life for the Critically Ill Edition 1.0 2014 https://www.anzics.com.au/wp-content/uploads/2018/08/ANZICS-Statement-on-Care-and-Decision-Making-at-the-End-of-Life-for-the-Critically-Ill.pdf
- Best Practice Guideline for Offering Organ and Tissue Donation in Australia https://donatelife.gov.au/resources/clinical-guidelines-and-protocols/best-practice-guideline-offering-organ-and-tissue
- *Human Tissue Act 1983 No. 164* https://legislation.nsw.gov.au/view/html/inforce/current/act-1983-164
- NSW Legislation - *Human Tissue Regulation 2020* Human Tissue Regulation 2020 - NSW Legislation
- GL2021_004 - End of Life Care and Decision-Making https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_004
- PD2010_054 - Coroners Cases and the Coroners Act 2009 https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2010_054
- PD2024_022 - Organ and Tissue Donation, Use and Retention https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2024_022
- PD2024_023 - Designated Officer https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2024_023

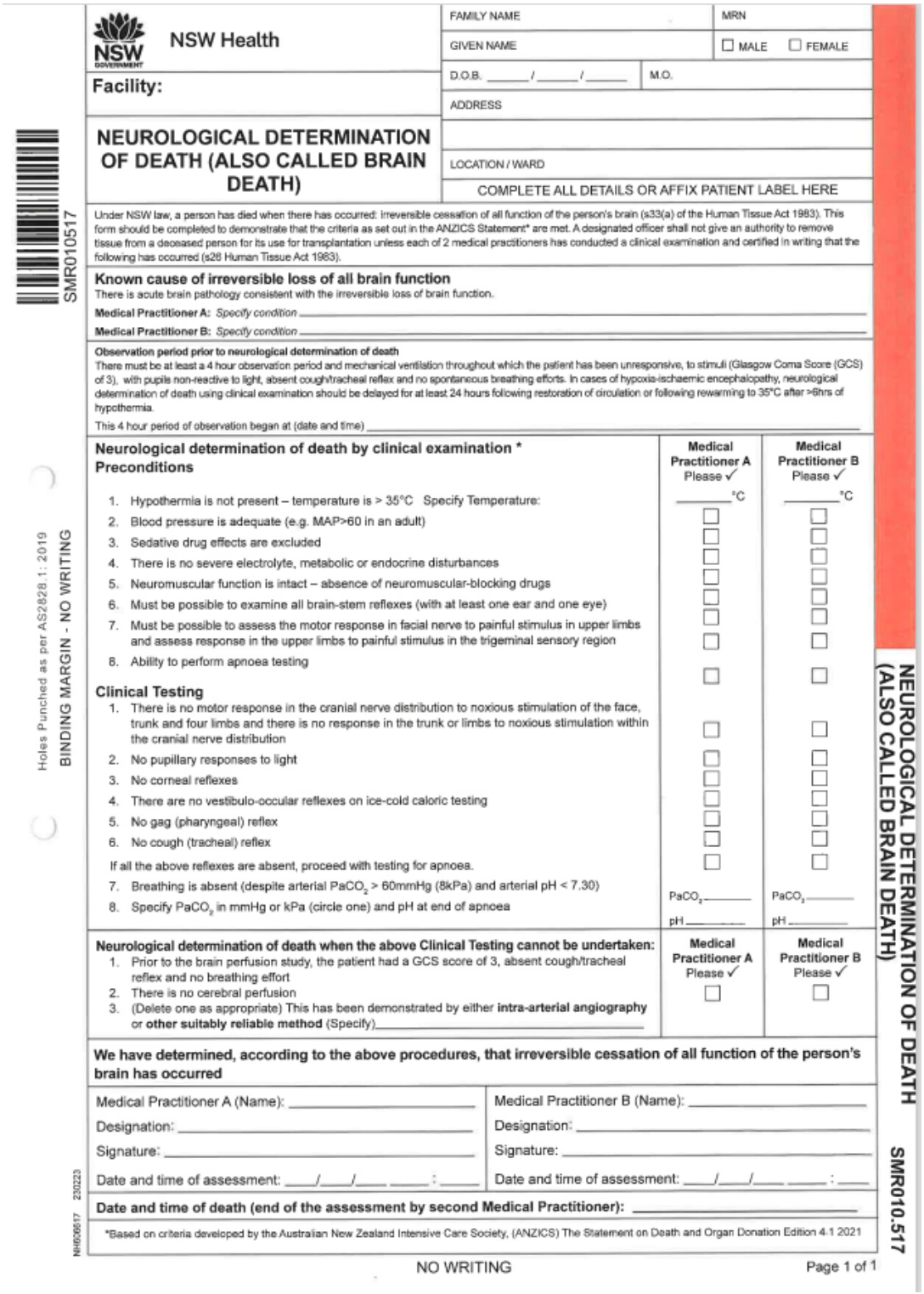
11. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
February 2013	1	Eleni Zahou and Lisa O'Reilly
March 2013	2	Reviewed by Christine Maree Ross
April 2013	3	Reviewed and approved by Dr Gordon Flynn
July 2016	4	Written by Eleni Zahou Document reviewed by Dr Tejo Kapalli and Dr Gordon Flynn (ICU Staff Specialist and Donation Specialist Medical) Document reviewed by Suzanne Schacht (Nurse Manager - Cardiac and Respiratory and Critical Care Clinical Streams)

November 2016	4	Draft for Comment
March 2016	4	SESLHDPR/231 updated and published on SESLHD Policy webpage – minor update
November 2020	5	Minor review: Change to terminology – Brain Death now referred to 'Neurological Death'; updated information to align with new ANZICS statement on death and organ donation Completed review by DSNs CVR, LOR, CB
May 2021	5	Completed Review by DSMs
21 October 2024	5.1	Review and updates: Change in GIVE trigger to routine referral/notification. Updated clinical forms and policies.

12. APPENDICES

Appendix 1



NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

NEUROLOGICAL DETERMINATION OF DEATH (ALSO CALLED BRAIN DEATH)

SMR010517

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

Under NSW law, a person has died when there has occurred: irreversible cessation of all function of the person's brain (s33(a) of the Human Tissue Act 1983). This form should be completed to demonstrate that the criteria as set out in the ANZICS Statement* are met. A designated officer shall not give an authority to remove tissue from a deceased person for its use for transplantation unless each of 2 medical practitioners has conducted a clinical examination and certified in writing that the following has occurred (s26 Human Tissue Act 1983).

Known cause of irreversible loss of all brain function

There is acute brain pathology consistent with the irreversible loss of brain function.

Medical Practitioner A: *Specify condition* _____

Medical Practitioner B: *Specify condition* _____

Observation period prior to neurological determination of death

There must be at least a 4 hour observation period and mechanical ventilation throughout which the patient has been unresponsive, to stimuli (Glasgow Coma Score (GCS) of 3), with pupils non-reactive to light, absent cough/tracheal reflex and no spontaneous breathing efforts. In cases of hypoxia-ischaemic encephalopathy, neurological determination of death using clinical examination should be delayed for at least 24 hours following restoration of circulation or following rewarming to 35°C after >6hrs of hypothermia.

This 4 hour period of observation began at (date and time) _____

Neurological determination of death by clinical examination * Preconditions	**Medical Practitioner A** Please ✓	**Medical Practitioner B** Please ✓
1. Hypothermia is not present – temperature is > 35°C Specify Temperature:	_____°C	_____°C
2. Blood pressure is adequate (e.g. MAP>60 in an adult)	☐	☐
3. Sedative drug effects are excluded	☐	☐
4. There is no severe electrolyte, metabolic or endocrine disturbances	☐	☐
5. Neuromuscular function is intact – absence of neuromuscular-blocking drugs	☐	☐
6. Must be possible to examine all brain-stem reflexes (with at least one ear and one eye)	☐	☐
7. Must be possible to assess the motor response in facial nerve to painful stimulus in upper limbs and assess response in the upper limbs to painful stimulus in the trigeminal sensory region	☐	☐
8. Ability to perform apnoea testing	☐	☐
Clinical Testing		
1. There is no motor response in the cranial nerve distribution to noxious stimulation of the face, trunk and four limbs and there is no response in the trunk or limbs to noxious stimulation within the cranial nerve distribution	☐	☐
2. No pupillary responses to light	☐	☐
3. No corneal reflexes	☐	☐
4. There are no vestibulo-ocular reflexes on ice-cold caloric testing	☐	☐
5. No gag (pharyngeal) reflex	☐	☐
6. No cough (tracheal) reflex	☐	☐
If all the above reflexes are absent, proceed with testing for apnoea.		
7. Breathing is absent (despite arterial $PaCO_2$ > 60mmHg (8kPa) and arterial pH < 7.30)		
8. Specify $PaCO_2$ in mmHg or kPa (circle one) and pH at end of apnoea	$PaCO_2$ _____ pH _____	$PaCO_2$ _____ pH _____

Neurological determination of death when the above Clinical Testing cannot be undertaken:	**Medical Practitioner A** Please ✓	**Medical Practitioner B** Please ✓
1. Prior to the brain perfusion study, the patient had a GCS score of 3, absent cough/tracheal reflex and no breathing effort		
2. There is no cerebral perfusion		
3. (Delete one as appropriate) This has been demonstrated by either **intra-arterial angiography** or **other suitably reliable method** (Specify)_____	☐	☐

We have determined, according to the above procedures, that irreversible cessation of all function of the person's brain has occurred

Medical Practitioner A (Name): _____	Medical Practitioner B (Name): _____
Designation: _____	Designation: _____
Signature: _____	Signature: _____
Date and time of assessment: ____/____/____ ____ : ____	Date and time of assessment: ____/____/____ ____ : ____

Date and time of death (end of the assessment by second Medical Practitioner): _____

*Based on criteria developed by the Australian New Zealand Intensive Care Society, (ANZICS) The Statement on Death and Organ Donation Edition 4.1 2021

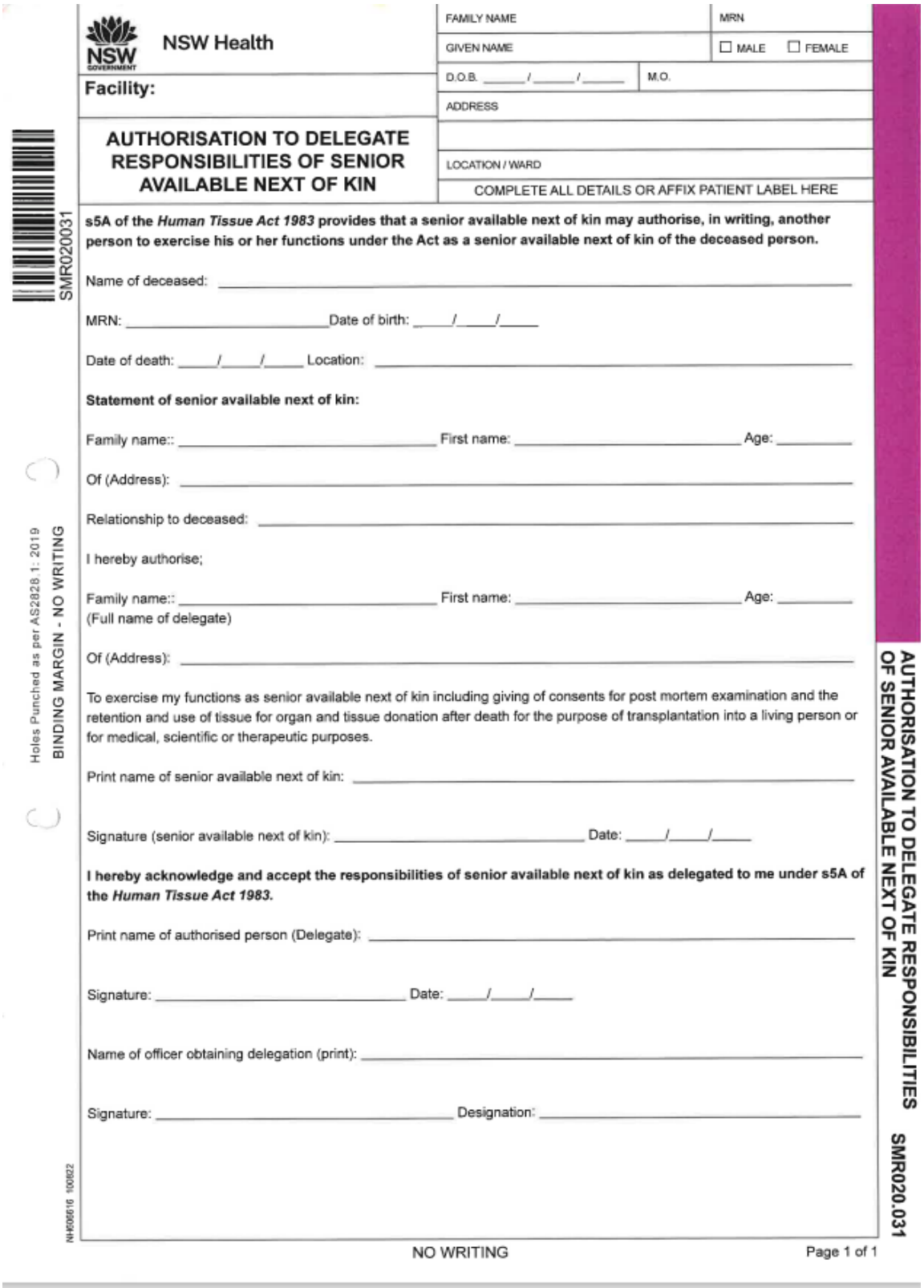
NH506617 230223

NO WRITING

Page 1 of 1

NEUROLOGICAL DETERMINATION OF DEATH (ALSO CALLED BRAIN DEATH) SMR010.517

Appendix 2



NSW Health

Facility:

AUTHORISATION TO DELEGATE RESPONSIBILITIES OF SENIOR AVAILABLE NEXT OF KIN

SMR020031

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

s5A of the *Human Tissue Act 1983* provides that a senior available next of kin may authorise, in writing, another person to exercise his or her functions under the Act as a senior available next of kin of the deceased person.

Name of deceased: _____

MRN: _____ Date of birth: ____/____/____

Date of death: ____/____/____ Location: _____

Statement of senior available next of kin:

Family name:: _____ First name: _____ Age: _____

Of (Address): _____

Relationship to deceased: _____

I hereby authorise;

Family name:: _____ First name: _____ Age: _____
(Full name of delegate)

Of (Address): _____

To exercise my functions as senior available next of kin including giving of consents for post mortem examination and the retention and use of tissue for organ and tissue donation after death for the purpose of transplantation into a living person or for medical, scientific or therapeutic purposes.

Print name of senior available next of kin: _____

Signature (senior available next of kin): _____ Date: ____/____/____

I hereby acknowledge and accept the responsibilities of senior available next of kin as delegated to me under s5A of the *Human Tissue Act 1983*.

Print name of authorised person (Delegate): _____

Signature: _____ Date: ____/____/____

Name of officer obtaining delegation (print): _____

Signature: _____ Designation: _____

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AUTHORISATION TO DELEGATE RESPONSIBILITIES OF SENIOR AVAILABLE NEXT OF KIN SMR020.031

NH#005616 100822

NO WRITING

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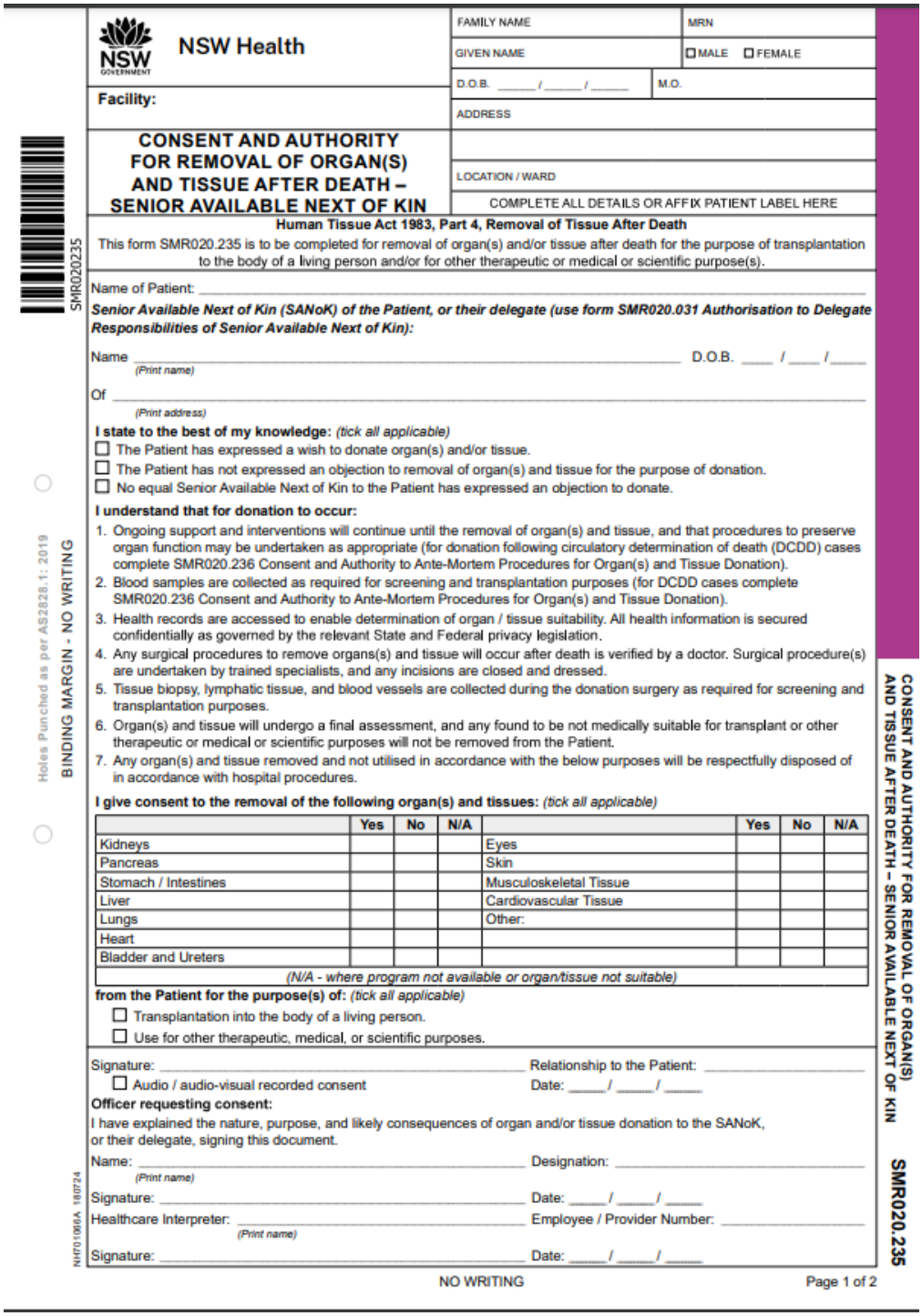
Appendix 3



NSW Health

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONSENT AND AUTHORITY FOR REMOVAL OF ORGAN(S) AND TISSUE AFTER DEATH – SENIOR AVAILABLE NEXT OF KIN

SMR020.235

Human Tissue Act 1983, Part 4, Removal of Tissue After Death

This form SMR020.235 is to be completed for removal of organ(s) and/or tissue after death for the purpose of transplantation to the body of a living person and/or for other therapeutic or medical or scientific purpose(s).

Name of Patient: _____

Senior Available Next of Kin (SANoK) of the Patient, or their delegate (use form SMR020.031 Authorisation to Delegate Responsibilities of Senior Available Next of Kin):

Name _____ D.O.B. ____/____/____
(Print name)

Of _____
(Print address)

I state to the best of my knowledge: *(tick all applicable)*

- ☐ The Patient has expressed a wish to donate organ(s) and/or tissue.
- ☐ The Patient has not expressed an objection to removal of organ(s) and tissue for the purpose of donation.
- ☐ No equal Senior Available Next of Kin to the Patient has expressed an objection to donate.

I understand that for donation to occur:

1. Ongoing support and interventions will continue until the removal of organ(s) and tissue, and that procedures to preserve organ function may be undertaken as appropriate (for donation following circulatory determination of death (DCDD) cases complete SMR020.236 Consent and Authority to Ante-Mortem Procedures for Organ(s) and Tissue Donation).
2. Blood samples are collected as required for screening and transplantation purposes (for DCDD cases complete SMR020.236 Consent and Authority to Ante-Mortem Procedures for Organ(s) and Tissue Donation).
3. Health records are accessed to enable determination of organ / tissue suitability. All health information is secured confidentially as governed by the relevant State and Federal privacy legislation.
4. Any surgical procedures to remove organs(s) and tissue will occur after death is verified by a doctor. Surgical procedure(s) are undertaken by trained specialists, and any incisions are closed and dressed.
5. Tissue biopsy, lymphatic tissue, and blood vessels are collected during the donation surgery as required for screening and transplantation purposes.
6. Organ(s) and tissue will undergo a final assessment, and any found to be not medically suitable for transplant or other therapeutic or medical or scientific purposes will not be removed from the Patient.
7. Any organ(s) and tissue removed and not utilised in accordance with the below purposes will be respectfully disposed of in accordance with hospital procedures.

I give consent to the removal of the following organ(s) and tissues: *(tick all applicable)*

	Yes	No	N/A		Yes	No	N/A
Kidneys				Eyes			
Pancreas				Skin			
Stomach / Intestines				Musculoskeletal Tissue			
Liver				Cardiovascular Tissue			
Lungs				Other:			
Heart							
Bladder and Ureters							

(N/A - where program not available or organ/tissue not suitable)

from the Patient for the purpose(s) of: *(tick all applicable)*

- ☐ Transplantation into the body of a living person.
- ☐ Use for other therapeutic, medical, or scientific purposes.

Signature: _____ Relationship to the Patient: _____

☐ Audio / audio-visual recorded consent Date: ____/____/____

Officer requesting consent:

I have explained the nature, purpose, and likely consequences of organ and/or tissue donation to the SANoK, or their delegate, signing this document.

Name: _____ Designation: _____
(Print name)

Signature: _____ Date: ____/____/____

Healthcare Interpreter: _____ Employee / Provider Number: _____
(Print name)

Signature: _____ Date: ____/____/____

NO WRITING

Page 1 of 2

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BINDING MARGIN - NO WRITING

CONSENT AND AUTHORITY FOR REMOVAL OF ORGAN(S) AND TISSUE AFTER DEATH – SENIOR AVAILABLE NEXT OF KIN SMR020.235

NH701006A 180724

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONSENT AND AUTHORITY FOR REMOVAL OF ORGAN(S) AND TISSUE AFTER DEATH – SENIOR AVAILABLE NEXT OF KIN

Coronial Consent:

☐ Not required (as per SMR010.513 Coronial Checklist)

☐ The death has been reported to the NSW State Coroner (via draft Coronial Pro Forma – organ donation cases only)

The Duty Coroner _____ has provided consent for the removal and use of organ(s) and tissue subject to the following condition(s) (if any):

☐ No conditions specified

☐ Conditions: _____

Consent obtained by: _____ **Designation:** _____
(Print name)

Authorisation by Designated Officer:

I, _____
(Print name)

as a Designated Officer for _____
(Facility / Local Health District)

hereby state, at the time of assessing this consent and authority request: *(tick all applicable)*

☐ I have had no direct clinical or personal involvement with the Patient during their lifetime.

☐ I am satisfied the particulars of the Patient are correct as recorded on this consent and authority, and on all records accompanying this request.

☐ I am satisfied the purposes and consequences of removal of the organ(s) and tissue after death have been explained and understood by the person providing consent, and this decision was made freely, without coercion or expectation of financial gain.

☐ There is no other Senior Available Next of Kin of the same or higher standing who objects.

☐ The Patient has not expressed an objection nor revoked a previously documented consent for the removal of organ(s) or tissue following their death.

☐ A Senior Available Next of Kin has not been identified, despite reasonable inquiries. I am satisfied the Patient has provided written intent or consent on their own behalf.

☐ Coronial consent is granted contingent on the conditions recorded above.

and, having reviewed the consent and authority request, I authorise the removal of the specified organ(s) and/or tissue from the body of the Patient after death in accordance with the terms and conditions of this consent.

Signature: _____ Date: _____/_____/_____

Designation: _____

Secondary Designated Officer Authorisation:
(Where the Patient has been transferred to a facility outside the jurisdiction of the Designated Officer named above)

Having reviewed the consent and authority request, I authorise the removal of the specified organ(s) and/or tissue from the body of the Patient after death in accordance with the terms and conditions of this consent.

Name: _____ Designation: _____
(Print name)

Signature: _____ Date: _____/_____/_____

Donation Facility: _____

Hierarchy of Senior Available Next of Kin:

1. a person who was a spouse or de-facto (including same sex partner) of the deceased immediately before the person's death
2. where the deceased person has no spouse, or the spouse is not available, a son or daughter of the deceased person, who has attained the age of 18 years
3. where no person referred to in 1 or 2 is available, a parent of the deceased person
4. where no person referred to in 1, 2, or 3 is available, a brother or sister of the deceased person, who has attained the age of 18 years

Senior Available Next of Kin of a deceased child means, in the following order of seniority:

1. a parent of the child
2. where a parent of the child is not available, a brother or a sister of the child, who has attained the age of 18 years
3. where no person referred to in 1 or 2 is available, a person who is guardian of the child immediately before the child's death

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SMR020235

Page 2 of 2 NO WRITING

Appendix 4

Health
NSW Organ & Tissue Donation Service

Incorporating:
NSW Bone Bank
Lions NSW Eye Bank
Australian Ocular Biobank

Part of the DonateLife network

Donor Management Guidelines

Cardiovascular Management **MAP 60-80mmHg** **HR <120bpm** **CVP 6-10mmHg**

Hypertension MAP >110mmHg	Short acting beta blocker (esmolol 0.1 – 0.3mcg/kg/min) Vasodilator (sodium nitroprusside 1-5mcg/kg/min)
Hypotension MAP <60mmHg	Hypovolemia Replace volume – Avoid hyperchloremia and hypernatremia and starch based colloids Blood transfusion- if Hb <70g/L Vasopressors – (preference) Noradrenaline if >0.2mcg/kg/min then commence vasopressin (1-2.4unitrs/hr.) may allow for reduction of Noradrenaline requirements.
Arrhythmias	Normalise physiology – maintain serum electrolytes (optimise K+, Mg+ Ca^{2+}), optimise fluid status, normalise temperature. SVT & VT arrhythmia management – Standard arrhythmia management should be initiated (amiodarone, cardioversion) Bradycardia – Adrenaline, Isoprenaline or pacing. Normally resistant to atropine or glycopyrolate.
Hypothermia	Ensure temperature is maintained >36°C bair hugger for temp <36°C
Hormonal replacement therapy	Unstable patients when MAP<60mmHg, CVP>12mmHg, Noradrenaline >0.2mcg/kg/min or LVEF<45 or major LV wall motion abnormality T3 4mcg/hr. Methylprednisolone 15mg/kg

Respiratory Management **Aim ph. 7.35- 7.45** **pCO2 35-45mmHg** **pO2 >80mmHg** **Sats >95%**

Hypoxaemia	TV 6-8mls/kg PEEP 5-10mmHg Plateau PIP <30cmH20 Normocapnia = pCO2 35-45 normal pH FiO2= lowest possible to maintain PaO2 >100mmHg and SaO2>95% Head Of Bed > 30 degrees Add broad spectrum antibiotics if clinically indicated **Lung Recruitment** Early and continuous physiotherapy 4/24, suctioning and repositioning to promote alveolar recruitment **Optimisation of fluid management** Aim for a negative fluid balance if cardiovascular stability allows this to occur.

Fluid Management

Diabetes Insipidus (DI)	Commence a vasopressin infusion or DDAVP if U.O. >3mls/kg for 2 consecutive hours associated with rising plasma sodium. Urine Osmolality Vasopressin infusion – max 2.4 units/hr. DDAVP 2-4 micrograms every 2-6 hours Fluid replacement – use low Na concentration as free water is lost & hypernatremia develops. Use 5% dextrose or 0.45% Saline or Hartman's
Hypernatremia Na>155mmol/L	Remove all sources of sodium in IV solutions
Hyperglycaemia	Insulin infusion recommended aim BSL 6-10mmol/L

Ministry of Health, NSW. Management of the Adult Brain Dead Potential Organ and Tissue Donor
http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2016_008.pdf

Draft v.2 Potential donor requirements 2017

Bedside Guide For Organ Donation

Health NSW Organ & Tissue Donation Service | Incorporating: NSW Bone Bank, Lions NSW Eye Bank, Australian Ocular Biobank | Part of the DonateLife network

Continuous monitoring of ECG, invasive BP, CVP, Sp02, intake, inotrope support and output.

Positioning, chest physiotherapy, mouth and eye care to be carried out as per ICU protocols

Investigations	√
Weight Kg Height cm Girth cm	
Group and hold ordered/printed	
Subtype if A or AB ordered/printed	
HbA1C (pre-diabetics/diabetics only)	
BHCG (females <50yrs C.O.D ICH)	

Test	Freq.	Due	Due	Due	Due	Due
EUC/CMP/LFT/FBC/COAGS	6/24					
Lipase and Amylase	once					
CK and Troponin	once					
ABG on FiO2 1.0 PEEP 5 (20 mins)	4/24					
ABG on vent settings	once					

Box 1 & Box 2 bloods	Time bloods taken:	Time courier departs:
T3 commencement – repeat echo 4 hours post	T3 Start time:	Repeat echo time

Investigations	√
Urinalysis	
CXR and report	
ECHO and report	
ECG and Report	
Cultures-Urine/Sputum/Blood	
Routine MRSA/VRE swabs if not done	
Chest CT	
Coronary Angiogram	
Bronchoscopy	

Other requests	

Pre Op preparation	√
Cease feeds @	
Pre Op checklist	
2 ID bands	
1 page pt. labels (min 30)	
Admission front sheet	
Pre Op wash and shave	
Death Cert or Form A	
Formal Police ID prior to OT (BD only)	
Coronial checklist	
Cremation certificate	
Memory items for family	

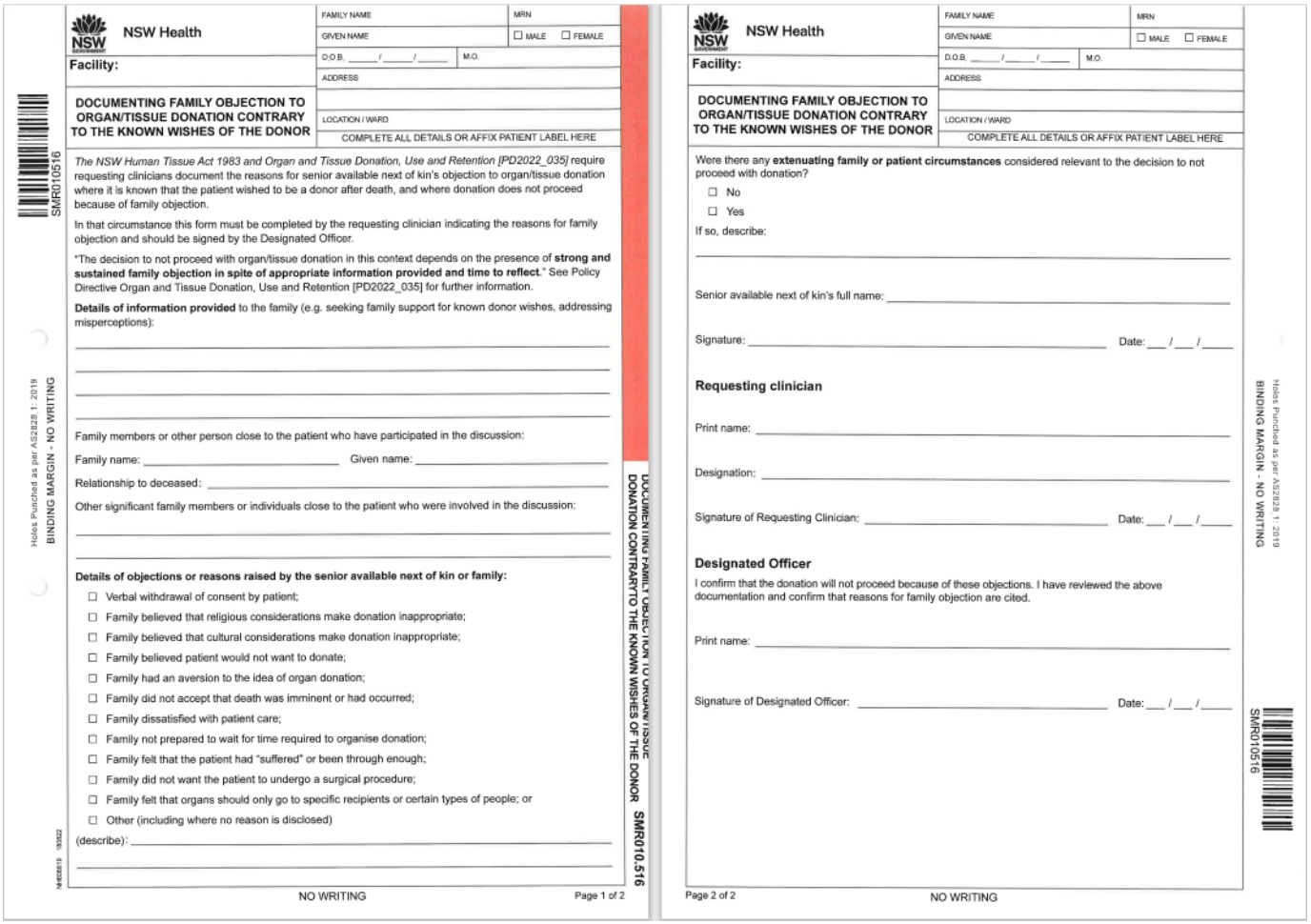
N.B Strike through the investigations/procedures that are not required.

Donation Specialist Contact:

02.18

NSW GOVERNMENT Health South Eastern Sydney Local Health District

Appendix 5



NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DOCUMENTING FAMILY OBJECTION TO ORGAN/TISSUE DONATION CONTRARY TO THE KNOWN WISHES OF THE DONOR

SMR010516

The NSW Human Tissue Act 1983 and Organ and Tissue Donation, Use and Retention [PD2022_035] require requesting clinicians document the reasons for senior available next of kin's objection to organ/tissue donation where it is known that the patient wished to be a donor after death, and where donation does not proceed because of family objection.

In that circumstance this form must be completed by the requesting clinician indicating the reasons for family objection and should be signed by the Designated Officer.

"The decision to not proceed with organ/tissue donation in this context depends on the presence of **strong and sustained family objection in spite of appropriate information provided and time to reflect**." See Policy Directive Organ and Tissue Donation, Use and Retention [PD2022_035] for further information.

Details of information provided to the family (e.g. seeking family support for known donor wishes, addressing misperceptions):

_____

_____

_____

_____

Family members or other person close to the patient who have participated in the discussion:

Family name: _____ Given name: _____

Relationship to deceased: _____

Other significant family members or individuals close to the patient who were involved in the discussion:

_____

_____

Details of objections or reasons raised by the senior available next of kin or family:

- ☐ Verbal withdrawal of consent by patient;
- ☐ Family believed that religious considerations make donation inappropriate;
- ☐ Family believed that cultural considerations make donation inappropriate;
- ☐ Family believed patient would not want to donate;
- ☐ Family had an aversion to the idea of organ donation;
- ☐ Family did not accept that death was imminent or had occurred;
- ☐ Family dissatisfied with patient care;
- ☐ Family not prepared to wait for time required to organise donation;
- ☐ Family felt that the patient had "suffered" or been through enough;
- ☐ Family did not want the patient to undergo a surgical procedure;
- ☐ Family felt that organs should only go to specific recipients or certain types of people; or
- ☐ Other (including where no reason is disclosed)

(describe): _____

_____

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DOCUMENTING FAMILY OBJECTION TO ORGAN/TISSUE DONATION CONTRARY TO THE KNOWN WISHES OF THE DONOR SMR010.516

NO WRITING

Page 1 of 2

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DOCUMENTING FAMILY OBJECTION TO ORGAN/TISSUE DONATION CONTRARY TO THE KNOWN WISHES OF THE DONOR

Were there any **extenuating family or patient circumstances** considered relevant to the decision to not proceed with donation?

- ☐ No
- ☐ Yes

If so, describe:

_____

Senior available next of kin's full name: _____

Signature: _____ Date: ___ / ___ / ____

Requesting clinician

Print name: _____

Designation: _____

Signature of Requesting Clinician: _____ Date: ___ / ___ / ____

Designated Officer

I confirm that the donation will not proceed because of these objections. I have reviewed the above documentation and confirm that reasons for family objection are cited.

Print name: _____

Signature of Designated Officer: _____ Date: ___ / ___ / ____

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SMR010516

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