FERTILITY SOCIETY
OF AUSTRALIA AND NEW ZEALAND

MEDIA STATEMENT

Statement on behalf of the Fertility Society of Australia and New Zealand (FSANZ)

01 September 2025 – The Fertility Society of Australia and New Zealand (FSANZ) acknowledges an online article published today by the ABC regarding an administrative error by a United States based sperm bank, which led to an IVF patient in Australia receiving sperm from a donor other than the one they selected.

As reported by the ABC, the patient was treated at a Queensland Fertility Group (QFG) clinic and the error resulted in the birth of a baby of a different ethnicity than expected, alerting the family to the mistake.

The Reproductive Technology Accreditation Committee (RTAC), a subcommittee of FSANZ, can confirm that there is no record of any notice or report made by QFG to RTAC in relation to this incident, which took place in 2014. At the time, the Code of Practice did not require such reporting. Mandatory notification of Serious Adverse Events was introduced on 1 October 2014.

Any inference within media stories that RTAC had prior knowledge of the incident is not correct, current members of RTAC had no prior formal or informal knowledge of this incident. Informal knowledge came as a direct result of enquiries made to RTAC by the ABC, at which time RTAC immediately approached QFG for clarification.

RTAC remains committed to upholding the Code of Practice, maintaining the highest standards of safety, accountability, and continuous improvement in assisted reproductive technology (ART) to protect patient welfare.

FSANZ has consistently advocated for structural, legislated reform in the IVF sector, including an independent regulatory body with powers to improve oversight, compliance and future transparency while protecting patient privacy. FSANZ continues to call for:

- A **National Fertility Plan** and uniform laws
- Transparent, **publicly accessible reporting of adverse events**
- A **National Donor Registry**
- A **10-Year MRFF Fertility Mission**
- Expanded access to genetic carrier screening and preimplantation genetic testing (PGT)

“Our primary concern is for the family affected and protecting their privacy,” said FSANZ President, Dr Petra Wale. “We recognise this news may cause concern for patients and the wider community. FSANZ remains committed to working with governments and the IVF sector to ensure patient welfare, privacy and public confidence remain at the centre of fertility care”.

“While this error was the responsibility of an overseas sperm bank, incidents such as these show why stronger, nationally consistent regulation is vital for Australia. Patients deserve transparency, accountability, and the assurance that lessons are learned at a system level. Fragmented state-by-state oversight will not deliver this.”

While the sector awaits the outcomes and recommended actions from the current IVF rapid review, Australian and New Zealand clinics using overseas donor banks should conduct due diligence on donor bank procedures and must act in accordance with the applicable state or national legislation, and relevant national standards.

Timeline of RTAC Code of Practice reforms

From 2014 to 2021, the Code of Practice (CoP) for ART clinics has progressively expanded and tightened requirements for reporting serious adverse events:

2014 - Introduction of Serious Notifiable Adverse Events (SNAEs):

From 1 October 2014, ART clinics were required to notify both RTAC and the Certifying Body of SNAEs. These were defined as events associated with ART treatment that:

- Cause or potentially cause harm, loss, or damage to patients or their reproductive tissues.
- Result in hospitalisation following (and as a result of) treatment.

2017 - Expanded Scope and Accountability.

The 2017 CoP broadened the definition of SNAEs and strengthened clinics responsibilities. Clinics were required to investigate, document, and implement corrective actions, subject to review during inspection. New SNAE categories included events that:

- Might result in transmission of a communicable disease.
- Might result in death or a life-threatening, disabling, or incapacitating condition.
- Arise from a gamete or embryo identification error or mix-up.

2021 - Immediate Reporting and Clearer definitions

The term “Notifiable” was replaced with “Reportable,” reflecting the expectation of immediate reporting to RTAC and the Certifying Body. Clinics must now provide a summary of investigations and corrective actions. Definitions were further refined to reduce underreporting, with clearer inclusion of specific medical and surgical conditions.

ENDS

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