AUSTRALIAN COMMISSION ON SAFETYAND QUALITY IN HEALTH CARE

Ms Mikaela Meggetto Coroner's Registrar Coroners Court of Victoria 65 Kavanagh St SOUTHBANK VIC 3006



Dear Ms Meggetto

Eliza Gill - Court ref: COR2016 004359

Thank you for your letter of 13 February 2019 concerning Coroner Audrey Jamieson's recommendation that the Australian Commission on Safety and Quality in Health Care (the Commission) assist in the development of National Poisons Information Guidelines.

Upon receiving the Coroner's recommendation, the Commission has undertaken significant research into the background and current status of Poisons Information Centres (PICs) operated by various state health agencies, including the Victorian PIC operated by Austin Health, and their efforts at networking to form a national poisons advisory system.

The Commission has now ascertained that the issue of a more formalised structure, administration and shared funding for a national poisons advisory system has been the subject of considerable deliberation over an extended period by the Australian Health Ministers' Advisory Council (AHMAC) constituted by the heads of all state, territory and federal health departments across Australia.

The development of a national approach to poisons information guidelines, as recommended by Coroner Jamieson, would be a key intended outcome of such a national system. Given this, and in order to bring Coroner Jamieson's finding and recommendation to the attention of the department heads of health agencies in jurisdictions operating PICs (Vic Health, NSW Health, Queensland Health and WA Health), I have written to each of them in similar terms and attach a copy of this correspondence for the Coroner's information. These department heads are also members of AHMAC.

As can be seen from this correspondence it is clear that AHMAC accepts the issue of a national poisons advisory system is a matter for its deliberation and determination. Whilst the Commission, like Coroner Jamieson, can see the benefits of a national approach to poisons advisory guidelines, ultimately it is a matter for AHMAC to advise their respective governments on how the issue of a national poisons advisory system, including national guidelines, is to be progressed and to underpin the system with an appropriate intergovernmental agreement.

In the interim I note the four state operated PICs continue to evolve their networking arrangements and have developed a common set of Practice Standards to guide their respective operations. The Commission was also pleased to see the responsiveness of the PICs to jointly reviewing the guidelines for the treatment for colchicine toxicity to avoid a repetition of the situation in Eliza Gill's case.

The Commission would, of course, co-operate in any further work, relevant to its statutory functions and expertise on a national poisons advisory system, that AHMAC refers to it, but is not in a position to progress issues associated with the Coroner's recommendation without a clear referral from AHMAC, as part of the ongoing broader deliberations on a national system.

Should the Commission be apprised of further developments on this matter by either AHMAC or relevant jurisdictions, it will write again to advise you. Alternatively given the Coroner's Victorian jurisdiction you may wish to make your own inquiries directly of the Secretary of the Victorian Department of Health and Human Services.

Please direct any further enquiries to:

Mr Herbert Down

A/g Director - Clinical Care Standards

(02) 9126 3583 or herbert.down@safetyandquality.gov.au

Yours sincerely

Adjunct Professor Debora Picone Ao

Chief Executive Officer

Australian Commission on Safety and Quality in Health Care

June 2019

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

D19-16988

Ms Kym Peake
Secretary
Department of Health and Human Services Victoria
50 Lonsdale Street
MELBOURNE VIC 3000



Re: Coronial recommendation for National Poisons Information Guidelines

In February this year the Australian Commission on Safety and Quality in Health Care (the Commission) received correspondence from Coroner Audrey Jamieson of the Victorian Coroner's Court following findings and recommendation she made without inquest arising from the investigation of the death of Eliza Gill from colchicine toxicity (Court Reference: COR 2016 4359). The coroner recommended, "in the interests of public safety and preventing like deaths" that the Commission "assist clinical experts in developing National Poisons Information Guidelines."

Following receipt of that recommendation, the Commission has researched the background and current status of the structures and governance of the various State operated Poisons Information Centres, and their arrangements for national co-operation and co-ordination. The Commission's inquiries have indicated efforts over the years, through the Australian Health Ministers' Advisory Council (AHMAC) deliberations, to develop a more formalised national arrangement underpinned by shared Commonwealth, state and territory funding. The Commission has also had the benefit of being provided with copies of various reports and draft papers for governments and/or interested health agencies developed over the years.

Current position

As you are aware there are four Poisons Information Centres (PICs) across Australia, located in NSW, Victoria, Queensland and Western Australia. NSW supports in turn the public and clinicians in Tasmania and ACT, Western Australia supports in turn the public and clinicians of South Australia and the Northern Territory and Queensland receives inquiries from Papua New Guinea from time to time. Table 1 below summarises the current structures and workload.

Table 1 - Structure of PICs in Australia:

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The PICs provide information, risk assessment and management advice about exposures involving medicines, drugs of abuse, products used in the house and garden, agricultural and industrial chemicals, plants, fungi, land and marine animals.

The Commission is advised that a combined total of around 220,000 calls annually, as at 2018, were taken from the general public and health professionals each year, with NSW providing a national afterhours service nationally outside of office hours (8am to 10 pm). The service can be accessed anywhere in Australia via a single telephone number (13 11 26).

It is understood that calls are answered by Specialists in Poisons Information (SPI). SPIs are usually clinical pharmacists, but may be nursing staff or science graduates, who have specific additional training in toxicology, risk assessment and the provision of poisons information. Each state provides separate training for SPIs as there is no standardised process. It is the Commission's understanding that complex cases are referred to clinical toxicologists to provide specialist advice to medical professionals. It is further understood that there is no established threshold for when cases should be referred to toxicologists, with referrals occurring in around 5% of cases. Presently NSW funds and operates the national toxicologist service roster, with around 25 toxicologists based across the country.

National Poisons Register (NPR)

Background information indicates that the four PICs utilise information contained in the National Poisons Register (NPR). The NPR was established in 1960 following a recommendation by the National Health and Medical Research Council in 1959. Its role then was to compile an ongoing listing of chemical-based products in use in Australia. The NPR was first produced in 1965 as a loose-leaf manual. The NPR moved to the Royal Prince Alfred Hospital in Sydney in 1992, with funding from all nine governments. The contributions are made on an AHMAC cost-shared basis (1/3 Commonwealth and 2/3 states and territories), and are adjusted annually for CPI.

The NPR produces an electronic database which contains information related to products (including but not limited to domestic, commercial, agricultural and industrial products) which might be involved in a toxicological exposure. Manufacturers submit their produce information via Material Safety Data Sheets (MSDSs) or other formulation documents.

The Commission understands that the NPR also contains certain prioritised treatment recommendations based on the composition and physicochemical characteristics of the relevant product. The treatment recommendations refer to management protocols contained in the proprietary database Poisindex (maintained by Micromedex) which is used as part of National Poison Data System (NPDS) in the USA.

AHMAC deliberations

It is apparent from background material provided to the Commission that the PIC arrangements, and future options for their funding, have been the subject of substantial consideration by the AHMAC.

It is understood that in 1994, AHMAC agreed to establish a single national telephone number for the PICs. The Australian Government agreed to meet the cost of establishing the phone number and the 13 11 26 number came into service on 1 March 1995. The telephony arrangements have been managed by Health Communication Network (HCN), a subsidiary of Primary Health Care Ltd, since 1995.

Callers to the number only pay a local call charge. Additional telecommunication costs are borne by the state in which the call is made. Line rental is paid for by individual states and territories to their own service provider.

The Commission has been advised that, in 2001, the AHMAC agreed to fund the development of a business case for the establishment of a National Poisons Information Service for Australia to address concerns about the long-term sustainability of poisons information services across Australia and their reliance in part on an honorary toxicologist workforce.

It appears AHMAC considered the report but did not endorse the recommendations because of two key concerns, namely the role, if any, of the Commonwealth Government in funding a national poisons information service, and the adequacy of the costings provided in the business case.

It is understood that in 2011, Queensland submitted another paper to AHMAC outlining issues with existing poisons information arrangements including the handling of charges for toxicologists, lack of control over cost drivers, adequacy of resourcing, lack of consistency in training and credentialing of staff, lack of uniform data collection, the need for better management of expensive antidotes, and the need to update the technology platform of the NPR. The Queensland paper made a number of recommendations which included:

- establishment of a centrally coordinated National Poisons Service funded on an AHMAC cost shared basis (including an Commonwealth Government contribution)
- establishment of an overarching administrative and operating framework for the service
- the National Poisons Service, once established, taking responsibility for managing expensive antidotes
- implementation of a national dataset and database, following review and evaluation by the National Poisons Service
- inclusion of the National Poisons Register in the National Poisons Service, and its future development considered in the context of emerging technologies.

I understand that AHMAC referred the paper to the (then) Health Policy Priorities Principal Committee for detailed analysis and consultation on the establishment of a national poisons information service, including an overarching administrative and operating framework, and to report its findings. NSW and Queensland were to co-lead the further work. Progress towards the development of a detailed paper supported by robust costings and data was made through 2012, with the project based in the NSW Ministry of Health. The Commission is unaware whether the draft NSW paper was ultimately finalised, submitted or considered by AHMAC.

Operational level co-ordination

As can be seen from the above background information, the four PICs have worked together to form what is referred to as the Poisons Information and Toxicology Network Australia (PITNA) and at an operational, rather than government to government level, have co-operated to evolve the PITNA. In 2014 the PITNA issued Practice Standards in an effort to place the PITNA on a more consistent and sustainable basis.

The introduction to the Practice Standards state: "These practice standards have been developed in recognition of the importance of having a high quality, integrated poisons information service in Australia. They are applicable to each individual poisons information centre (PIC), and to the evolving Poisons Information and Toxicology Network Australia (PITNA) comprised of the four individual PICS and the National Poisons Register (NPR)."

The Practice Standards indicate they represent a consensus statement, written by those working in the field and other stakeholders, of how Australian PICs should operate. The PITNA appears to aspire to develop a more formal basis through an intergovernmental MOU and the development of greater commonality of administrative and governance structures.

Coronial recommendation

The PICs appear to provide accessible, timely advice in support of public health and safety, and appear to be a well-utilised resource across Australia by both the public and clinicians. The Commission commends the efforts made at the operational level by staff of the PICs and other stakeholders to achieve a level of co-ordination and consistent standards, notwithstanding the constraint of the absence of any formal intergovernmental arrangements.

Nonetheless the coronial investigations of the death of Eliza Gill disclosed a number of inadequacies with the current arrangements for PICs, including from a clinical governance perspective, a lack of consistency in core references/databases used by the various PICs.

I understand reliance is variously had by the different PICs on:

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These issues have, of course, also surfaced in the various AHMAC considerations of the PICs and their future. From a clinical governance perspective, in 2012, the NSW draft AHMAC submission paper indicated there were considerable shortcomings in the collection and communication of data and other information. Despite significant advances in the nature and availability of information technology in the preceding decade, the paper reported that there was still no national minimum dataset or data collection tool shared across the four PICs.

With regards to databases, the NSW draft paper indicated the WA PIC used the IPCS INTOX system which has been developed through cooperation between the International Programme on Chemical Safety (IPCS) at the World Health Organization and the Canadian Centre for Occupational Health and Safety (CCOHS). The Victorian PIC used a custom-built web-based database running on a Redhat Enterprise Linux platform. The NSW PIC and Queensland PIC used an Access database.

It also reported that progress was being made towards the development of a national minimum dataset to address the current inconsistency in data capture regarding intoxicants which impacts on the ability to provide timely and nationally consistent data for public health purposes. The draft AHMAC submission acknowledged that a national poisons information network with at least a national minimum dataset (and ultimately a national database) would be able to provide up to date data on the following:

- Adverse drug reactions
- Emerging substances of abuse and toxicity profiles
- Medicine dosing errors
- Packaging and labeling issues with pharmaceuticals and consumer products
- Toxicity profiles of newly marketed drugs
- Identification of rare serious poisonings

Future directions

Ultimately the issue of progress in formalising the funding, cost sharing and administrative arrangements for a national poisons advisory system is a matter for the Commonwealth, states and territories through the auspices of AHMAC, and it appears considerable work has been undertaken in the past but apparently this has not yet resulted in any firm decisions by AHMAC.

A concluded view by AHMAC around shared funding and further evolution of the networking of the PICs, underpinned by formal intergovernmental agreement and arrangements, would support an improved national system of poisons advice and a basis for implementation of the Coroner's recommendation in relation to the death of Victorian schoolgirl, Eliza Gill.

In the Commission's response to the Victorian Coroner, the Commission proposes to outline how the issue of a more consistent national approach to all aspects of a poisons advisory system has been the subject of lengthy work under the auspices of AHMAC, and, in the Commission's view, this matter continues to properly fall to AHMAC to progress and conclude.

Of course, consistent with its statutory role, the Commission stands willing to accept any referral from AHMAC to support the development of a more consistent national approach to the standards and clinical governance of a national poisons advisory system. Such a reference would presumably be part of a broader piece of work funded and sponsored by AHMAC to progress a more formal, structured approach to the cost sharing, resourcing and networking of the PICs, along the lines contemplated in the work undertaken for AHMAC to date. It is the Commission's understanding that the ultimate aim of this work is to achieve a comprehensive national solution to these vitally important public health and safety services.

I attach a copy of the Coroner's findings for your information and assistance in considering future progress of this issue.

I am writing in similar terms to all jurisdictions operating PICs and a copy of the Commission's correspondence will also be provided to the Victorian Coroner as part of the Commission's response to Ms Jamieson.

I look forward to being updated on the further progress and determination of these issues through AHMAC in due course.

Yours sincerely

Adjunct Professor Debora Picone Ao

Chief Executive Officer

Australian Commission on Safety and Quality in Health Care

17 June 2019

Attachment - Report of Audrey Jamieson, Victorian Coroner, concerning the death of Eliza Gill (Court Reference: COR 2016 4359)

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

D19-16985

Ms Elizabeth Koff Secretary New South Wales Ministry of Health Locked Mail Bag 961 NORTH SYDNEY NSW 2059



Re: Coronial recommendation for National Poisons Information Guidelines

In February this year the Australian Commission on Safety and Quality in Health Care (the Commission) received correspondence from Coroner Audrey Jamieson of the Victorian Coroner's Court following findings and recommendation she made without inquest arising from the investigation of the death of Eliza Gill from colchicine toxicity (Court Reference: COR 2016 4359). The coroner recommended, "in the interests of public safety and preventing like deaths" that the Commission "assist clinical experts in developing National Poisons Information Guidelines."

Following receipt of that recommendation, the Commission has researched the background and current status of the structures and governance of the various State operated Poisons Information Centres, and their arrangements for national co-operation and co-ordination. The Commission's inquiries have indicated efforts over the years, through the Australian Health Ministers' Advisory Council (AHMAC) deliberations, to develop a more formalised national arrangement underpinned by shared Commonwealth, state and territory funding. The Commission has also had the benefit of being provided with copies of various reports and draft papers for governments and/or interested health agencies developed over the years.

Current position

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Chief Executive Officer

Australian Commission on Safety and Quality in Health Care

June 2019

Attachment - Report of Audrey Jamieson, Victorian Coroner, concerning the death of Eliza Gill (Court Reference: COR 2016 4359)

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

D19-16986

Mr Michael Walsh Director General Department of Health Queensland 33 Charlotte Street BRISBANE QLD 4000



Dear Mr Walsh

Re: Coronial recommendation for National Poisons Information Guidelines

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Operational level co-ordination

As can be seen from the above background information, the four PICs have worked together to form what is referred to as the Poisons Information and Toxicology Network Australia (PITNA) and at an operational, rather than government to government level, have co-operated to evolve the PITNA. In 2014 the PITNA issued Practice Standards in an effort to place the PITNA on a more consistent and sustainable basis.

The introduction to the Practice Standards state: "These practice standards have been developed in recognition of the importance of having a high quality, integrated poisons information service in Australia. They are applicable to each individual poisons information centre (PIC), and to the evolving Poisons Information and Toxicology Network Australia (PITNA) comprised of the four individual PICS and the National Poisons Register (NPR)."

The Practice Standards indicate they represent a consensus statement, written by those working in the field and other stakeholders, of how Australian PICs should operate. The PITNA appears to aspire to develop a more formal basis through an intergovernmental MOU and the development of greater commonality of administrative and governance structures.

Coronial recommendation

The PICs appear to provide accessible, timely advice in support of public health and safety, and appear to be a well-utilised resource across Australia by both the public and clinicians. The Commission commends the efforts made at the operational level by staff of the PICs and other stakeholders to achieve a level of co-ordination and consistent standards, notwithstanding the constraint of the absence of any formal intergovernmental arrangements.

Nonetheless the coronial investigations of the death of Eliza Gill disclosed a number of inadequacies with the current arrangements for PICs, including from a clinical governance perspective, a lack of consistency in core references/databases used by the various PICs.

I understand reliance is variously had by the different PICs on:

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These issues have, of course, also surfaced in the various AHMAC considerations of the PICs and their future. From a clinical governance perspective, in 2012, the NSW draft AHMAC submission paper indicated there were considerable shortcomings in the collection and communication of data and other information. Despite significant advances in the nature and availability of information technology in the preceding decade, the paper reported that there was still no national minimum dataset or data collection tool shared across the four PICs.

With regards to databases, the NSW draft paper indicated the WA PIC used the IPCS INTOX system which has been developed through cooperation between the International Programme on Chemical Safety (IPCS) at the World Health Organization and the Canadian Centre for Occupational Health and Safety (CCOHS). The Victorian PIC used a custom-built web-based database running on a Redhat Enterprise Linux platform. The NSW PIC and Queensland PIC used an Access database.

It also reported that progress was being made towards the development of a national minimum dataset to address the current inconsistency in data capture regarding intoxicants which impacts on the ability to provide timely and nationally consistent data for public health purposes. The draft AHMAC submission acknowledged that a national poisons information network with at least a national minimum dataset (and ultimately a national database) would be able to provide up to date data on the following:

- Adverse drug reactions
- Emerging substances of abuse and toxicity profiles
- Medicine dosing errors
- Packaging and labeling issues with pharmaceuticals and consumer products
- Toxicity profiles of newly marketed drugs
- Identification of rare serious poisonings

Future directions

Ultimately the issue of progress in formalising the funding, cost sharing and administrative arrangements for a national poisons advisory system is a matter for the Commonwealth, states and territories through the auspices of AHMAC, and it appears considerable work has been undertaken in the past but apparently this has not yet resulted in any firm decisions by AHMAC.

A concluded view by AHMAC around shared funding and further evolution of the networking of the PICs, underpinned by formal intergovernmental agreement and arrangements, would support an improved national system of poisons advice and a basis for implementation of the Coroner's recommendation in relation to the death of Victorian schoolgirl, Eliza Gill.

In the Commission's response to the Victorian Coroner, the Commission proposes to outline how the issue of a more consistent national approach to all aspects of a poisons advisory system has been the subject of lengthy work under the auspices of AHMAC, and, in the Commission's view, this matter continues to properly fall to AHMAC to progress and conclude.

Of course, consistent with its statutory role, the Commission stands willing to accept any referral from AHMAC to support the development of a more consistent national approach to the standards and clinical governance of a national poisons advisory system. Such a reference would presumably be part of a broader piece of work funded and sponsored by AHMAC to progress a more formal, structured approach to the cost sharing, resourcing and networking of the PICs, along the lines contemplated in the work undertaken for AHMAC to date. It is the Commission's understanding that the ultimate aim of this work is to achieve a comprehensive national solution to these vitally important public health and safety services.

I attach a copy of the Coroner's findings for your information and assistance in considering future progress of this issue.

I am writing in similar terms to all jurisdictions operating PICs and a copy of the Commission's correspondence will also be provided to the Victorian Coroner as part of the Commission's response to Ms Jamieson.

I look forward to being updated on the further progress and determination of these issues through AHMAC in due course.

Yours sincerely

Adjunct Professor Debora Picone Ao

Chief Executive Officer

Australian Commission on Safety and Quality in Health Care

June 2019

Attachment - Report of Audrey Jamieson, Victorian Coroner, concerning the death of Eliza Gill (Court Reference: COR 2016 4359)

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TRIM: D19-16990

Dr David Russell-Weisz Director General Department of Health Western Australia 189 Royal Street East Perth WA 6004

Dear Dr Russell-Weisz

Re: Coronial recommendation for National Poisons Information Guidelines

In February this year the Australian Commission on Safety and Quality in Health Care (the Commission) received correspondence from Coroner Audrey Jamieson of the Victorian Coroner's Court following findings and recommendation she made without inquest arising from the investigation of the death of Eliza Gill from colchicine toxicity (Court Reference: COR 2016 4359). The coroner recommended, "in the interests of public safety and preventing like deaths" that the Commission "assist clinical experts in developing National Poisons Information Guidelines."

Following receipt of that recommendation, the Commission has researched the background and current status of the structures and governance of the various State operated Poisons Information Centres, and their arrangements for national co-operation and co-ordination. The Commission's inquiries have indicated efforts over the years, through the Australian Health Ministers' Advisory Council (AHMAC) deliberations, to develop a more formalised national arrangement underpinned by shared Commonwealth, state and territory funding. The Commission has also had the benefit of being provided with copies of various reports and draft papers for governments and/or interested health agencies developed over the years.

Current position

As you are aware there are four Poisons Information Centres (PICs) across Australia, located in NSW, Victoria, Queensland and Western Australia. NSW supports in turn the public and clinicians in Tasmania and ACT, Western Australia supports in turn the public and clinicians of South Australia and the Northern Territory and Queensland receives inquiries from Papua New Guinea from time to time. Table 1 below summarises the current structures and workload.

Table 1 - Structure of PICs in Australia:

Poisons Information Centre	Centre details
Victorian Poisons Information Centre	 Located at the Austin Hospital - integrates with the Austin Toxicology Service.
Queensland Poisons Information Centre	Located at the Lady Cilento Children's Hospital
	May provide advice to callers from neighbouring countries
WA Poisons Information Centre	Located at Sir Charles Gairdner Hospital
	Handles calls from WA, SA and the NT
NSW Poisons Information Centre	Located at The Children's Hospital Westmead
	Handles calls from NSW, Tasmania and the ACT
	24/7 call centre service to NSW and after hours call centre
	for the whole of Australia (since 1987)

The PICs provide information, risk assessment and management advice about exposures involving medicines, drugs of abuse, products used in the house and garden, agricultural and industrial chemicals, plants, fungi, land and marine animals.

The Commission is advised that a combined total of around 220,000 calls annually, as at 2018, were taken from the general public and health professionals each year, with NSW providing a national afterhours service nationally outside of office hours (8am to 10 pm). The service can be accessed anywhere in Australia via a single telephone number (13 11 26).

It is understood that calls are answered by Specialists in Poisons Information (SPI). SPIs are usually clinical pharmacists, but may be nursing staff or science graduates, who have specific additional training in toxicology, risk assessment and the provision of poisons information. Each state provides separate training for SPIs as there is no standardised process. It is the Commission's understanding that complex cases are referred to clinical toxicologists to provide specialist advice to medical professionals. It is further understood that there is no established threshold for when cases should be referred to toxicologists, with referrals occurring in around 5% of cases. Presently NSW funds and operates the national toxicologist service roster, with around 25 toxicologists based across the country.

National Poisons Register (NPR)

Background information indicates that the four PICs utilise information contained in the National Poisons Register (NPR). The NPR was established in 1960 following a recommendation by the National Health and Medical Research Council in 1959. Its role then was to compile an ongoing listing of chemical-based products in use in Australia. The NPR was first produced in 1965 as a loose-leaf manual. The NPR moved to the Royal Prince Alfred Hospital in Sydney in 1992, with funding from all nine governments. The contributions are made on an AHMAC cost-shared basis (1/3 Commonwealth and 2/3 states and territories), and are adjusted annually for CPI.

The NPR produces an electronic database which contains information related to products (including but not limited to domestic, commercial, agricultural and industrial products) which might be involved in a toxicological exposure. Manufacturers submit their produce information via Material Safety Data Sheets (MSDSs) or other formulation documents.

The Commission understands that the NPR also contains certain prioritised treatment recommendations based on the composition and physicochemical characteristics of the relevant product. The treatment recommendations refer to management protocols contained in the proprietary database Poisindex (maintained by Micromedex) which is used as part of National Poison Data System (NPDS) in the USA.

AHMAC deliberations

It is apparent from background material provided to the Commission that the PIC arrangements, and future options for their funding, have been the subject of substantial consideration by the AHMAC.

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