NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT No.	897/Phar16/366D
UNDER	the Health Practitioners Competence Assurance Act 2003 (the HPCA Act)
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**THE DIRECTOR OF PROCEEDINGS OF THE HEALTH AND DISABILITY COMMISSIONER'S OFFICE** **Applicant**
AND	**Mr TERRENCE ZELCER** of Christchurch, Pharmacist **Practitioner**

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

ADDENDUM TO DECISION DATED 10 FEBRUARY 2017

1. There are quotation errors in the decision of the Tribunal in this matter dated 10 February 2017.

2. At paragraph 6 of the decision the Tribunal set out the Agreed Summary of Facts. There are errors in the quotation of paragraphs 15, 45, 47 and 72 of the Agreed Summary of Facts which need to be corrected.

3. Paragraph 6 subparagraph 15 should be amended to read as:

> *During the dispensing process the pharmacy technician selected a manufacturer's bottle of 50 cyclophosphamide (brand name cycloblastin) 50mg tablets in error and placed the label for the repeat prescription of 60 cyclosporine 50mg capsules of cyclophosphamide on that bottle of 50mg tablets.*

4. Paragraph 6 subparagraph 45 should be amended to read as:

> *Mr Zelcer did not take any steps to complete an incident report. He accepts that he was required to do so under SOP 38 (Dispensing Incidents) and in accordance with the standards of care expected of the pharmacy profession and that he should have done this as a means of informing the pharmacy manager (and other staff involved) of the dispensing error.*

5. Paragraph 6 subparagraph 47 should be amended to read as:

> *At approximately 2pm the pharmacy manger generated an electronic stock reorder and saw that cycloblastin (cyclophosphamide) 50mg was included in the stock re-order list. In the course of placing the order and due to the legislative change relating to this drug the pharmacy manager asked the dispensary staff, including Mr Zelcer, if cyclophosphamide 50mg had been dispensed because if so, he would need to supply a patient name and prescribing doctor if more stock was required. Mr Zelcer responded that he had observed there was no cyclophosphamide 50mg on the shelf and had therefore "zeroed" the stock. Mr Zelcer did not tell the pharmacy manager about his conversation with Mr R approximately three and a half hours earlier, or the fact that Mr R had been dispensed cyclophosphamide 50mg in error.*

6. Paragraph 6 subparagraph 72 should be amended to read as:

> *Mr Zelcer accepts that between 4 December 2013 and 6 December 2013, he did not fully follow the processes set out in the Pharmacy's SOPs which applied at the time being SOPs 38 Procedure for Dispensing Incidents and 38a Procedure for Dispensing Incidents – handling the error, nor did he meet the standards of care expected of the pharmacy profession.*

7. At paragraph 16 of the decision the Tribunal quoted from the submissions of Counsel for the Director of Proceedings. There are two errors in the quotation which need to be corrected.

8. Paragraph 16, third bullet point should be amended to read as:

- *Mr Zelcer disposed of the returned bottle of medication in the yellow returned medicines bag where it was later found with the label removed, underneath a shopping bag's worth of other returned medications. Mr Zelcer did not take any steps towards ascertaining how many tablets Mr R had taken in error, because he did not need that information, he was never going to report the incident.*

9. Paragraph 16, fifth bullet point should be amended to read as:

- *Mr Zelcer took no steps to report the incident to his manager. The pharmacy manager returned to the pharmacy within 30 minutes of the error being discovered on 4 December 2013 but Mr Zelcer said nothing. Mr Zelcer and the pharmacy manager were in the pharmacy together on 5 December 2013 but Mr Zelcer said nothing. Mr Zelcer only revealed the error when he had no other choice.*

Dated at Wellington this 19th day of June 2017

Kenneth Johnston QC
Chair
Health Practitioners Disciplinary Tribunal