GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 923/9745

Professional Conduct Committee Hearing

DECISION

Case of:	Timothy Gale (9745)
Committee:	Andrew Harvey (Panel Chair) Andrew Howard (Lay member) Catherine Hamilton Plant (Osteopath)
Legal Assessor:	Jeff Widdup
Representation for Council:	Christopher Geering (Counsel)
Representation for Osteopath:	Philip Dayle (Counsel)
Clerk to the Committee:	Sajinee Padhiar
Date of Hearing:	19 – 21 May 2026

Summary of Decision:

1. The factual allegations are admitted and proved.
2. The Registrant is guilty of unacceptable professional conduct.
3. An admonishment is imposed on his registration.

Allegation and Facts

The allegation is that Timothy Gale (the Registrant) has been guilty of unacceptable professional conduct, contrary to section 20(1)(a) of the Osteopaths Act 1993, in that:

1. On 31 January 2024, Patient A attended the Fix Me Clinic for an appointment with the Registrant (the Appointment).

2. During the Appointment, the Registrant applied dry needling treatment to Patient A, which: a. he failed to obtain Patient A's valid consent for; b. was not applied correctly and/or safely.

3.After the Appointment, when Patient A informed him of her post-treatment symptoms (the Symptoms), the Registrant:

a. knew, or ought to have known, that the Symptoms were potentially indicative of a pneumothorax; and/or
b. failed to identify the Symptoms as potentially indicative of a pneumothorax; and/or
c. did not inform Patient A that the Symptoms were potentially indicative of a pneumothorax; and/or d. failed to advise Patient A to seek immediate emergency medical treatment.

4. The Registrant's conduct at paragraphs 2a, 2b, 3b, 3c and/or 3d was inappropriate.

Preliminary issues

1. No preliminary issues were raised at the start of the hearing, save that Mr Geering invited the Committee to anonymise Patient A. The Committee agreed to do so without dissent from Mr Dayle.

Background

2. In 2024 a complaint was made to the Council by Patient A about her treatment by the Registrant on 31st January 2024.

3. Patient A is a performer in West End and national musicals. In 2019 and 2022 she had received treatment from the Registrant. In December 2023, while performing in a pantomime, she experienced another work related injury to her back. On her return to London she consulted the Registrant and first had a session of treatment with him on 25th January 2024.

4. On 31st January 2024 she returned to him for a second session in the course of which the Registrant suggested that dry needling treatment might be beneficial. Patient A agreed to this and the treatment proceeded but, shortly after the session, she experienced bad chest pain when breathing. She

contacted the Registrant who reassured her and advised her to rest. The pain worsened over the afternoon and evening. Patient A then attended Accident and Emergency. An X ray and CT scan then revealed that she had an acute pneumothorax.

5. Patient A's complaint was referred by the Investigation Committee to this Committee. In summary the Council alleged that the Registrant had not obtained informed consent before the dry needling treatment, that the treatment was not carried out safely and he did not respond appropriately when Patient A contacted him after the treatment.

The hearing

6. The charges were read.

7. The following admissions were made by the Registrant at the start of the hearing:

   Paragraph 1 was admitted
   Paragraphs 2 (a) and (b) were admitted
   Paragraph 3 (d) was admitted.
   Paragraph 4 was admitted in relation to 2 (a) 2 (b) and 3 (d).

8. Mr Dayle explained that paragraph 2 (b) was admitted on the basis that the treatment had not been conducted safely in the absence of informed consent.

9. The Committee was provided with a hearing bundle which included the witness statement of Patient A, an expert report by Mr Devan Rajendran and the witness statements of the Registrant. In addition, contemporaneous text messages, treatment and hospital records were put before the Committee. The hearing bundle also contained evidence relating to the Registrant's remediation and testimonials.

10. The Committee was also provided with a skeleton argument by Mr Geering.

11. The following paragraphs contain a summary of the evidence before the Committee, and the submissions of Counsel. They are not intended to be a complete account of the evidence and submissions.

12. Patient A gave evidence and confirmed that the contents of her witness statement were true. She corrected the date in paragraph 9 so that it referred to 31 January 2024.

13. In answer to supplementary questions from Mr Geering she said that, before the appointment on 31 January, she had back pain but not chest pain. After the treatment that day the back pain was minimal compared to her chest pain.

14. In cross examination she said that she had a good relationship with the Registrant before this treatment. She might have had needle treatment before in 2019 when her ankle was injured.

15. Patient A said that when she attended A and E her concerns were not taken seriously at first and the doctors had no knowledge of dry needling treatment. She had mentioned the possibility of pneumothorax to the doctors because she knew of someone who had had this condition. The doctors had no idea this was possible from dry needling.

16. In answer to questions from the Committee she said that before she had treatment on 25 January she suffered from back pain. After the first treatment the back pain was pretty much the same as before but after the second treatment she had shortness of breath and pain which spread around her side and to her front and became worse and worse.

17. The Registrant did not use the word "pneumothorax" after the second treatment on 31 January.

18. In answer to a further question from Mr Geering, Patient A said that she would have told the Registrant on 31 January that she had pain when she inhaled deeply.

19. The Committee was told that Mr Dayle had questions for Mr Rajendran even though his evidence had been agreed and he had been released from attending the hearing. His attendance was then arranged at short notice to him.

20. Mr Rajendran confirmed that the contents of his report were true.

21. In cross examination he accepted that the incidence of serious consequences from dry needling was low i.e. 0.1 per cent of all adverse events and pneumothorax was only one of them. The risk of pneumothorax is therefore less than 0.1 per cent.

22. He also said that the context needed to be considered. That context was of a patient complaining of chest pain and shortness of breath within 2 days of dry needling treatment.

23. In answer to a Committee question he said that the quicker the onset of symptoms after dry needling the greater the likelihood of pneumothorax.

24. The Registrant also gave evidence and confirmed that his witness statements were true.

25. He described his treatment of Patient A before 2024 and on the two sessions in January 2024. The Registrant accepted that he had a friendly relationship with her and that this had led to him providing her with less information about dry needling, including risks, than was required. He had been aware that pneumothorax was a risk and he should have spent more time with her discussing her symptoms after she had contacted him following the session.

26. In cross examination he said that he knew that pneumothorax could be life threatening. He now accepted that he ought to have known that Patient A's symptoms were potentially pneumothorax and he should have referred her to the hospital.

27. Mr Geering asked the Registrant a series of questions about his witness statements. He accepted that at times the statements contained what appeared to be quotations of things said by Patient A which she had not said. He had not prepared the witness statements himself and there were errors in the drafting.

28. He also accepted that his actions had been inappropriate.

29. There was no re-examination by Mr Dayle.

30. The Committee asked the Registrant to confirm that his position now was that he ought to have known that that the symptoms were potentially indicative of pneumothorax. He agreed that this was now his position.

31. After taking further instructions Mr Dayle told the Committee that the Registrant now admitted all the remaining factual allegations. Mr Dayle also told the Committee that a finding of unacceptable professional conduct was inevitable.

32. No further submissions were made by either Counsel at this stage.

The Committee's decision on the facts

33. The Committee accepted the advice of the Legal Assessor.

34. At all times, when considering its decision on the facts, the Committee took into account that the burden of proof is on the Council and that the standard of proof is the civil standard namely proof on a balance of probability.

35. The Committee also noted that the Council stated that there was no medical evidence to show that the dry needling treatment caused the pneumothorax and that causation of the injury was not an issue before it.

36. Paragraph 1 of the Charge was admitted and found proved.

37. Paragraph 2 (a) was admitted and found proved on the basis that the Registrant had not alerted Patient A to the risk of pneumothorax.

38. Paragraph 2 (b) was admitted and found proved on the basis that in the absence of informed consent the dry needle treatment was not applied safely.

39. Paragraph 3 (a) (b) and (c) were admitted at the close of the Registrant's case and were found proved.

40. Paragraph 3 (d) was admitted and found proved.

41. Paragraph 4 was admitted and found proved in relation to 2 (a), 2 (b) and 3 (d). At the end of the Registrant's case he admitted paragraph 4 in relation to paragraphs 3 (a) (b) and (c) and these were found proved.

42. The Committee find that these admissions were entirely appropriate and consistent with the evidence.

43. The Committee find that Patient A was an entirely credible witness. It finds that her evidence was consistent with her witness statement. Her evidence was clear and precise save that she was unclear about her treatment before 2024. The Committee noted that she was prepared to give the Registrant credit for the successful treatment she had received from him in the past. For all these reasons the Committee find that she was a witness of truth and her evidence was accepted in its entirety.

44. The Committee had some concerns about the evidence of the Registrant. His account when he first responded to the complaint did not fully address all concerns about the issue of informed consent. In addition, his witness statement failed to address directly the allegations made in the third paragraph of the Charge and his evidence, in that respect, was unclear and evasive.

45. In addition the Registrant accepted that his witness statement contained inaccuracies about things said to have been said by Patient A.

46. The Committee accepted the of evidence of Mr Rajendran.

47. Paragraph 3 (a) requires the Committee to ask whether the Registrant knew, or ought to have known, that Patient A's symptoms were potentially indicative of pneumothorax.

48. The Committee finds as a fact that pneumothorax is a recognised risk of dry needling treatment. This was not challenged by the Registrant who accepted that his failure to alert Patient A to the risk of pneumothorax meant that he had not obtained informed consent for this part of her treatment. In his evidence to the Committee he accepted that he was aware of the risk of pneumothorax in January 2024 and of its symptoms.

49. Paragraph 3 (a) is proved by the admission which was also supported by the evidence.

50. In relation to 3 (b) the Registrant did not claim that he had identified the symptoms as being potentially indicative of pneumothorax. The Committee find that this was a failing on his part because practitioners who undertake dry needling treatment should be aware not only of the risks associated with the treatment but of the symptoms if a lung is punctured. This allegation is proved by his admission which was also supported by the evidence.

51. In relation to 3 (c) the Registrant did not claim that he had used the word "pneumothorax" when discussing the symptoms with Patient A after her treatment on 31 January. He therefore did not inform her that the symptoms were potentially indicative of pneumothorax and this allegation is proved both by his admission and by the evidence.

52. The Committee finds that the Registrant's admissions to paragraph 4 in its entirety was consistent with his evidence.

Unacceptable professional conduct

53. Mr Geering submitted that the admitted facts reached the level of seriousness required to establish unacceptable professional conduct. He submitted that there were breaches of Standards A4 in relation to informed consent and A5 in relation to his failure to encourage Patient A to seek help elsewhere. Mr Geering also relied on the expert evidence of Mr Rajendran.

54. Mr Dayle reminded the Committee that paragraph 2 (b) had been admitted on the basis that the treatment had not been carried out safely in the absence of informed consent.

55. The Committee took into account the submissions of both Counsel and exercised its judgment to assess whether the actions of the Registrant amounted to unacceptable professional conduct.

56. It noted the Registrant's evidence that his familiarity with Patient A had superseded his professionalism. As a result he failed to obtain her fully informed consent to dry needling and this was a breach of A4 of the Standards.

57. In addition his failure to advise Patient A to seek medical assistance was in breach of A5 of the Standards.

58. The Committee identified other breaches of the Standards namely B1, B2, C1 and C1 (7).

59. B1 requires a registrant to have sufficient knowledge to support his work and B2 that he should act within his competence. The evidence shows that when faced with the concerns of Patient A very soon after the second session he did not recognize the possible nature of her concerns or recognize their potential. He also failed to take appropriate care of her in breach of C1 and failed to take appropriate action in breach of C 1 (7).

60. Having regard to all these factors the Committee find that the facts found proved support a finding of unacceptable professional conduct.

The sanction stage

61. Mr Geering invited the Committee to take into account the Sanctions Guidelines and the public interest of protecting patients and the public, and maintaining public trust and confidence in the profession and upholding proper standards.

62. He submitted that there were aggravating features in this case in that there had been serious consequences to Patient A and the Registrant had failed to recognise her condition.

63. He accepted that the Registrant was of good character and he had made admissions. He had reflected on his actions. He also accepted that the Registrant had developed some insight into his actions even though this was late.

64. He reminded the Committee of the need to act in a way which was proportionate and to assess each available sanction in ascending order of seriousness.

65. Mr Dayle submitted that the sanction should not be punitive in nature.

66. He submitted that the public interest should be the first consideration. The Registrant had shown insight, and reflection into his actions and accepted that his actions amounted to unacceptable professional conduct. He was also remorseful. The level of insight should be assessed as of now rather than at an earlier stage. He also drew the Committee's attention to the testimonials provided on behalf of the Registrant.

67. He submitted that there was no risk of repetition and this was an isolated incident. In his submission there was no need to go beyond an admonishment in this case.

68. The Committee had read all the evidence in the hearing bundle relevant to the issues of remediation, insight and sanction and took these into account together with the testimonials and the submissions of Counsel and the advice of the Legal Assessor. It also had regard to the Sanctions Guidelines.

69. The Committee identified the following aggravating features:

(i) Although the events occurred on one single day they involved different elements which related to a lack of informed consent and a failure to recognise that Patient A was at serious risk of harm.
(ii) The evidence also showed that the Registrant had allowed his friendship with Patient A to affect the way in which he had treated her.
(iii) The Registrant's evidence in his witness statements and communications with the Council displayed a lack of openness and transparency. The statements also contained misleading material which suggested that the Registrant was quoting what Patient A had said.
(iv) He had only accepted full responsibility for his actions in the course of this hearing.

70. The Committee identified the following mitigating factors:

(i) The Registrant is of good character and there has been no report of any repetition of his conduct since January 2024.
(ii) He made admissions to the factual allegations.

(iii) He produced a number of testimonials.
(iv) He has reflected on his failings and taken remedial action.
(v) He had shown clear remorse.
(vi) The events involved one patient on a single day.

71. The Committee finds that the Registrant’s failings were clinical in nature and they are open to remediation. It went on to ask whether those failings have been remediated and whether they are unlikely to be repeated.

72. The Committee accept that this experience has had a profound effect on the Registrant and that, as time has passed, he has learnt from his mistakes and made a genuine effort to remediate his failings. It considers that, while his insight is still developing, he has remediated and the risk of repetition is low.

73. A finding of unacceptable professional conduct is itself a significant reflection of the concerns identified in this case.

74. The Committee bore in mind that it has a duty to act proportionately and in the public interest. Proportionality involves taking the minimum necessary step to address the concerns which arise in this case but the measure must also be sufficient to address the public interest.

75. The Committee approached the issue of sanctions in ascending order and decided that it would be sufficient and in the public interest to admonish the Registrant. Its conclusion on proportionality was supported by its assessment that, in the light of the remediation and the low risk of repetition, the imposition of conditions on the Registrant’s registration would serve no useful purpose and that suspension of the Registrant's registration would be punitive and therefore disproportionate.

Under Section 31 of the Osteopaths Act 1993 there is a right of appeal against the Committee’s decision.

The Registrant will be notified of the Committee’s decision in writing in due course.

All final decisions of the Professional Conduct Committee are considered by the Professional Standards Authority for Health and Social Care (PSA). Section 29 of the NHS Reform and Healthcare Professions Act 2002 (as amended) provides that the PSA may refer a decision of the Professional Conduct Committee to the High

Court if it considers that the decision is not sufficient for the protection of the public.

Section 22(13) of the Osteopaths Act 1993 requires this Committee to publish a report that sets out the names of those osteopaths who have had Allegations found against them. The Registrant's name will be included in this report together with details of the allegations we have found proved and the sanction that we have applied today.