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Note on the revised text

Part 1 of this document was first written in 2003 and published on the Internet in 2004. The document has since gone through a series of revisions and additions. To begin with it was not possible to include certain key items of evidence that have come into my possession only since December 2010. The conclusions of the earlier document were arrived at by a long process of deduction which was necessarily limited in its impetus to an array of largely historical and circumstantial details and observations, together with certain items of extant medical evidence. These conclusions were confirmed in later editions by the inclusion of further evidence in Part 2. The part of the Analysis section under the subtitle Technocracy (Part 1, pp.41-46) – in which there is some speculative discussion of the medical and technological imperatives that I understand are likely to have informed the alleged covert research program – was greatly extended in 2012, and represents the most significant revision of the original document (excluding Part 2). In revising Part 1, I have tried to remain faithful to the earlier processes of reasoning and deduction, so as not to re-write the history and structure of this document’s development since its first edition in 2003. This does not always permit of a smooth transition, for instance where it has been necessary to include references to the recent MRI evidence in parts of the document written before that evidence emerged, and where references to time periods have been revised taking into account the current date. If this should result in confusion, the responsibility is entirely my own.

Part 2 originally took the form of a Postscript, added in 2011, in order to present a brief account of events occurring between 2004 and 2011. Through a series of incremental extensions, corresponding with developing events, this evolved into an Appendix – most significantly to present part of the key prima facie medical evidence (a selection of three images from my first Brain MRI scan) for the first time (see pp.48-50). It then took on its current form at the end of 2013 (the various sections of Part 2 do not form a strict chronological succession however). Evidence from a second MRI Head scan, conducted in March 2013, is included on pp.60-64. Crucial evidence from a Spinal MRI scan, made in July 2020, is discussed on pp.77-79. The evidence added in Part 2 essentially confirms, beyond any reasonable doubt, the conclusions previously iterated in Part 1. However, at this point in time, for reasons of its extraordinary sensitivity, this evidence remains without any explicit expert corroboration – an absence which has so far stymied the prospect of initiating any process of civil or criminal litigation over my allegations (on this point, see my Concluding Remarks on pp.115-122). The Addenda section (pp.123-158) is an addition first made during October 2021.

The identities of sensitive individual members of my extended family mentioned in this document have been redacted in the current version.
PART 1
Introduction

The purpose of this report is to consolidate the presentation of a certain body of evidence. Much of that evidence has remained concealed now for more than five decades. What follows is an exposition of institutional corruption, involving a clandestine medical operation undertaken within the NHS, with corporate backing and government sanction. The case alleges the instance of a surreptitious medical intervention involving a five-year-old child, for the purposes of medical/scientific research, and undertaken within the research facilities of the North Staffordshire Infirmary/Keele University Hospital, in 1967. In more recent times, that institution has been cited for the use in its paediatric department of surreptitious surveillance techniques, as well as the use of experimental treatment in the investigation of Sudden Infant Death Syndrome (‘SIDS’). These new historical allegations therefore signify what might be perceived as part of a pattern of institutional abuse, particularly in the area of paediatric medicine at North Staffordshire.

The following evidence is based on a personal medical and family case-history, and is dependent on, to a large extent, my own recollection and retelling of events, events dating as far back as 1967. In addition, there is a significant amount of medical evidence, and the report attempts to show how extant medical evidence relates decisively to the unfolding of contemporaneous events. I think it important to stress at this point that the formulation of any judgment or conclusion based on the evidence here disclosed has been a theoretical possibility for me only since early in the year 2001, when certain realisations and reinterpretations of key features of the evidence first came to my understanding. Since that time it has been my preoccupation to find a way of making explicit the details of this evidence, which for any right-minded individual would signify something morally indefensible, indeed shocking, to say the least. Therefore, while personally I may have held these convictions for some time, it is only now that I feel confident of being able to convey this certainty in a way that is both public and accessible.

If there have been any ‘decisive moments’ during this process, one such moment would be that at some point in early 2001 my attention was drawn to a documentary television item that referred to a tonsillectomy operation. I was reminded of my own tonsillectomy at the age of five, at the North Staffs Infirmary, Newcastle-under-Lyme, Staffordshire, where I was born and lived until I was nine years old. The content of this documentary has no evident bearing on my own case, but the program makers were concerned with the value of tonsillectomies in terms of their perceived medical necessity as routine responses to certain childhood ailments – frequently employed as proactive interventions upon essentially healthy children – and the relatively reduced popularity of this form of operation in recent decades. It led me to reconsider the relevance and the necessity of my own operation
retrospectively, and to question whether the same perceived necessity would have applied had I been a child now rather than in the 1960s. These thought processes encouraged me to reflect upon and to recollect details of my childhood past which had previously concerned me only remotely. I began to recall details of my family history and of the conduct and roles of certain family members at stages in my early years with renewed significance.

At around the time of this television documentary there were numerous other reports, in the press and on television, involving botched surgical operations and sundry ethical transgressions within the NHS, in particular the scandal at Alder Hey, involving the illegal stockpiling of the organs of deceased children for the purposes of medical research. Amongst this glut of negative publicity surrounding the NHS, as well as questions regarding the conduct of certain members of my family, both in connection with my own operation, and with respect to the untimely death of my father during the year immediately following it, I was encouraged to contemplate the fact of my tonsillectomy in a rather different light. I began to wonder about its legitimacy, for its necessity has never been satisfactorily explained to me, neither by a doctor, nor by either of my parents. There is only a barely intelligible reference to this operation in my medical records (the initials “T/A”*, written in the margin, and which appear may have been added retrospectively). There are several references to my visits to the GP during these months which mention tonsillitis and various throat illnesses, but these reports show a remarkable consistency of these symptoms both before and after the operation. There are several references specifically to tonsillitis occurring after the operation to remove them! When I recently consulted my mother about the operation, it was clear from her response that she does not now, and most likely has never understood the necessity of the operation in medical terms, and remains unable or unwilling to inform me about the issue.*

In view of this and in the context of all the other reports of what appeared at times as the sinister practices of certain employees of the NHS engaged in clandestine activities, but within the framework of routine medical practice, the question of the legitimacy of my own operation became re-emphasised, this being the only occasion before first writing this report that I have had surgery under general anaesthetic.

Due to the significant gap in historical viewpoints, this inquiry has been no simple undertaking. This gap – now 56 years – has meant that it has been extremely difficult for me to acquire substantial first-hand evidence, and the full evidence will indeed take time to emerge (crucial prima facie evidence is now revealed in Part 2 of this document, and at: http://somr.info/report). It is true that there were many aspects of my physical and psychological condition, and of my early family experiences, that did not quite add-up, that

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* My mother died in May 2014. In this revision of Part 1 of the report, although references to time periods have generally been updated to reflect the current date, for reasons of clarity I have preserved the temporal sense in which it was first written in 2003 of speaking of my mother as she was at that point, living.
begged for some further elaboration and understanding. It is as if there was some significant causal link in events of my early life which was missing. For most of my life I have been perplexed by the extent of my emotional and behavioural problems, for they seemed to be intricately connected, when viewed collectively, with a set of decidedly anomalous and incongruous *physiological* symptoms; which however, considered individually and in isolation from each other, were not serious enough to warrant significant sustained medical investigation. Unfortunately, there had been no way for me to relate these symptoms to any event of abuse or mistreatment, or of ill-health, or of injury, and therefore no way to satisfactorily engage with these problems in a therapeutic fashion.

What follows is an annotated list of items of evidence. I think it best to begin with an as plain as possible statement of the facts, to avoid falling into the trap of excessive narrative discussion and of making what is already complex unintelligible. The facts as they are (bearing in mind that they are mostly distillations of my own recollections of past events) are fairly compelling, without the need for me to goad the reader into a preferred interpretation. It is therefore in the spirit of openness and honesty that I make the following expositions. Following this list it will be helpful to summarise the key points of evidence, and especially in the light of the prospect of rather more concrete medical evidence, which in part already exists. In conclusion I shall attempt to analyse these events in their broader legal, political, and technological contexts, with the intention of precipitating a serious inquiry into the conditions which permit the engagement of health service professionals, and the use of health service resources, in research activities not principally directed towards the care of individuals, but in which the vulnerability of patients is exploited in the pursuit of medical-technical knowledge. My motivation is that of preventing any kind of repetition of such abuses of the rights of individuals and especially those who for reasons of age, or of legal disenfranchisement, find themselves in a particularly vulnerable position when exposed to the research imperatives of the medico-scientific community.
Evidence

1. On 9 April 1967, a week before my sixth birthday, I underwent a tonsillectomy operation (removal of tonsils and adenoids) at the North Staffs Infirmary, Newcastle-under-Lyme, Staffordshire. The reasons for this operation have never been clearly or satisfactorily explained to me.

2. That following this operation there were marked changes in my behaviour and in my appearance; I developed an aggressive and obsessive behavioural disorder (see items 8 & 21 below).

3. That I noticed my father’s reaction to my behaviour at this time, as he became somewhat sterner towards me and more distanced from me.

4. I had experienced a general increase in disquiet between my parents at this time. They had arguments in front of me, I suspect specifically about me, which bordered on physical fights.

5. That shortly after my seventh birthday, in May 1968, my father was taken ill with a “perforated gastric ulcer”, was taken into hospital, and died during surgery at the age of 41.

6. That I was prevented from attending my father’s funeral at the Newcastle-under-Lyme cemetery for reasons that were not explained to me at the time, nor have ever been explained. Immediately following his death, I spent a whole week at my uncle [xxxx] and aunt [xxxx]’s house, in complete isolation from my mother and sister, during which time the funeral took place. This was the first and only occasion that I ever I stayed at their house. I was not even made aware that the funeral had taken place and that I had been excluded from it. I later learned, from my mother’s admission, that it had been on the insistence of my uncle [xxxx] that I should not attend the funeral. Again she offered no explanation for this decision. [xxxx] had been my father’s best friend and brother-in-law, and paid us regular visits, even when my dad was at work.

7. Despite the fact that people rarely die from stomach ulcers, there has been to my knowledge no formal explanation of the specific cause of my father’s death. When I questioned my mother, in 2001, over the circumstances of my father’s death, she informed me that the surgeon who had performed his operation had said to her, when she consulted him following the operation, that his gastric ulcer had been “as big as a penny”. In 1968 this description referred to a pre-decimalisation British penny coin which was approximately 3cm in diameter – excessively large for a stomach ulcer. I do not know if my father’s ulcer had been diagnosed or treated prior to the GP’s visit to our
house which immediately preceded his admittance to hospital. If it had not been previously diagnosed, it seems remarkable that his ulcer should have been able to reach such a size without producing symptoms that would have led to its being detected at an earlier opportunity; and if it had been detected and diagnosed earlier, that it should have progressed to this stage without being remedied by an earlier intervention.

8. I began to experience recurring nightmares at about this time. In fact my behaviour in general at this time began to assume aspects that would be typical of any child in response to a trauma. It might be suggested that the death of my father a year or so after my operation would have been sufficiently traumatic to induce such behavioural anomalies. The important point to note here is that my behaviour was already significantly affected while my father was still alive. I am of the opinion that my father must have had concerns regarding the issue of my operation similar to the concerns that I have recently developed myself. I remember two distinct occasions when my behaviour caused my father to be quite concerned. On one occasion, during the winter of ‘67-68, I was playing with friends in the snow near the backs of our houses. Something had upset me, I don’t recall what, but in response I lay prostrate face down on a pile of snow. I remember feeling like I was playing dead, feeling defiant – savouring the coolness of the snow. I stayed there motionless for some considerable length of time, long enough to make a serious impression on my friend, who went to get my father, who arriving upon the scene realised that I was faking it. He was obviously disturbed by my behaviour, it being evidently rather odd, and shouted at me and took me back indoors.

On the other occasion, my mother was making something for my sister to wear – a pinafore dress. My sister was about fifteen. My mother had left the dress on the ironing board in the kitchen and was absent at the time. I took a pair of scissors and made numerous short cuts all along the hem of the dress in a sort of ‘cowboy’ style. Consequently the hem needed to be raised another two or three inches. My mother was very cross. I was punished for this mischief by having to stay indoors. I remember my dad couldn’t believe what I had done, it being so unlike my usual behaviour. I interpret this act as kind of provocative mischief, which was definitely uncharacteristic, and an attempt to draw attention to the fact that I had a problem, but for which I could find no other reasonable expression. My father’s reaction was not remonstrative. Instead he made a point of sitting me on a blanket in front of the fireplace, where he sat and watched me from the other side of the room for several hours. I just recall the look of seriousness on his face, and the fact that there was no interaction between us.

9. I have a particularly vivid recollection of my last meeting with my father. He had been treated at home by the family GP Dr Tellwright, prior to suffering a perforating gastric
ulcer, and had called me into their bedroom as he waited to be taken to hospital. His demeanour was unusually grave. His condition was serious but not critical. One would normally be expecting to survive a serious but nevertheless routine surgical procedure. I would not have been surprised if my father had made a friendly fatherly joke at this point, or at least to have offered some reassurance of his prompt return following his operation, but he didn’t – he was deadly serious. Considering this gravity of his mood, I have never quite been able to digest his final words to me (“Look after your mother for me, son...”), which would have made sense if delivered in a qualified, light-hearted fashion, but not, as they were, in such a deadly and pointedly serious manner, with its commanding air of fatality. I believe now that he was trying to communicate something to me which because of my young age he was not able to do directly, but only through this combination of subtle implication and gravitas. It was as if he were trying to deliberately confuse and disturb my conscience. I now understand that he was trying, in the only manner available to him, to convey to me (for my later understanding) that he knew that he would not be returning.

10. The effect of this conversation was that when my mother informed me of my father’s death I was barely shocked by it at all, but remember feeling quite numb. She told me quite calmly and in a tone of affected sympathy: “Daddy’s gone to Jesus” – the only time I can recall she ever referred to my father as “daddy”. I can remember feeling that she showed an absence of any real emotion, this being no more than an hour or two after she had received the news of his death. The whole experience was quite bizarre, and had the awful feeling of being a foregone conclusion. My father was buried at the Newcastle Cemetery, Lymewood Grove, Newcastle-under-Lyme on 31 May 1968, nine days after his death. As far as I can ascertain, the funeral was managed by Marsh & Son, Funeral Directors, Newcastle-under-Lyme, as they have some form of record of the burial in their archive. It is possible that Marsh & Son have inherited this record from an associate company, Salt & Son Ltd. I made these initial enquiries after I tried to visit my father’s grave early in 2002. I was rather surprised that the headstone which used to be on his grave was nowhere to be found in the location where I remembered the grave to be. I could not find his grave at all, although I had a quite clear recollection of its relative location in the graveyard. On later contacting the cemetery office, they sent me a map showing that the grave was indeed in the general area that I had thought, meaning that his headstone has evidently been removed. This event, in association with other evidence given below, only served to strengthen my confidence that the events of my father’s death and subsequent burial were the results of criminal concealment. As far as I am aware, from the time of the GP’s visit to my father, and his admittance to hospital, he had no contact with anyone except my mother, my sister, and myself. Nor would he have been able to make any such contact, had he wished to, due to his condition, and the fact that my family had no telephone.
11. Until recently I had a somewhat confused understanding of the sequence of events at this time of my life. I was surprised by the recent realisation that my tonsillectomy had taken place immediately before my sixth birthday, as for many years I had the idea that I had been *seven* when the operation took place. I believe that it was due to my mother’s retrospective inaccuracy that I was encouraged in this mistaken impression. The issue is of great importance in this matter because if I really had been seven at the time of the tonsillectomy, it would appear logical that the death of my father occurred *before* the operation. He in fact died only a month after my seventh birthday, more than a year following the actual date of the operation. It was not until I had the reason to sit down and contemplate this ambiguity, that I realised that my father was of course alive at the time of the operation, and the sequence of events took on a completely new significance. Whereas my previous confusion occluded the possibility of any significant connection between these two events, this new awareness began to suggest a new interpretation of events, one which included the possibility of a *causal* connection between them. Especially so, as I felt that my understanding of events had been manipulated by my mother’s deliberate inaccuracy.

12. That the school I was attending, St Mary’s R.C. Primary School, Newcastle-under-Lyme, was experimenting with the *Initial Teaching Alphabet* (‘ITA’). ITA was initially introduced to selected British schools in 1961. However, it has since been abandoned by mainstream education due to doubts over its efficacy as a teaching method.* The method attempts to introduce young children to writing and reading English by remodelling the conventional alphabet to provide unique orthographic constructions to represent each individual vowel and consonant *sound* in spoken English. It was a rather artificial attempt at managing the difficulty for children presented by the phonological irregularity characteristic of the relation between spoken and written English, in their first approaches to reading and writing. Children were then re-inducted to traditional orthography at age seven. The period of the mid-60s would

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* Supposedly, ITA assists the child in making the transition from phonological word representation to graphical word representation, i.e., by ‘simplifying’ the early acquisition of phonological irregularity, so prevalent in English. In practice, it presents the child with the task of initially learning a radically transfigured formal lexicon, which the child must then *unlearn* before s/he is able to progress to acquisition of English in its full richness and sophistication. Although there was considerable support during the 1960s among educationalists for the use of ITA, it has since been largely abandoned in the UK. It has been criticised for its overemphasis on mechanical rote-learning techniques, and a bleakly functionalist understanding of the nature of language and of linguistic acquisition in young children. ITA attempts to establish a regularised formal learning structure for language that is completely at odds with any child’s lived experience of the language outside of the classroom arena. “The main problems of using the i.t.a. include the fact that it is based on Received Pronunciation, so people with other accents find it difficult to decipher; the lack in material written, and the transition to the traditional orthography, which some children found difficult.” [Omniglot: Pitman ITA – URL: http://www.omniglot.com/writing/ita.htm – accessed 21/03/2021.] Personally, I am of the opinion that it may have impeded the development of my reading skills to the extent that I would now say that I suffer from mild aphasia.
have been a critical time for the evaluation of the ITA as a method suitable for adoption in mainstream education.

13. That the teachers at the school noticed that I was exceptionally bright.

14. That Keele University is a major educational establishment in the area, and would likely be very interested, if not directly involved in the piloting of such techniques within local educational establishments. The historical connections between Keele University and the North Staffs Infirmary are also well-established. The hospital is a major centre for medical research, particularly in the areas of paediatric neonatology and neuroscience, and the two institutions combine within the current University Hospital of North Midlands NHS Foundation Trust.

15. That I began to experience behavioural and emotional problems while still in primary school, resulting in a compulsive eating disorder as well as errant, disruptive behaviour, despite being otherwise quite enthusiastic intellectually.

16. That my mother used the impact of my father’s death as an explanation for my behavioural problems. She also used the subsequent absence of a father-figure in my life as justification to remarry and leave the area. She also related to me, on perhaps more than one occasion, an anecdotal explanation for my father’s death – that it had been hastened by his tendency to “worry” about me persistently; although my mother chose not to elaborate over the content or the reasons for my father’s persistent vexation.

17. That my mother was quite eager to leave the area, following my father’s death, and to facilitate this by pursuing a romantic attachment to a resident of East Sussex, previously unknown to us. She was introduced to my stepfather-to-be by a mutual friend, who lived in the same town as him. Two years after my father’s death she married my stepfather and we left Newcastle-under-Lyme for Bexhill-on-Sea, despite my sister’s resolve to remain in Newcastle-under-Lyme and the inevitable increase in emotional strife that this would entail for me, due to our separation. I remember expressing my desire not to move out of the area and away from my sister, but this had no effect upon my mother’s resolve to move. I now had a stepbrother and stepsister, both somewhat older than myself. My stepfather was an ex-serviceman (RAF) and maintained connections with his old colleagues. He worked as a supervisor at the local telephone exchange (GPO – the forerunner of British Telecom). My stepfather had a brother, a London civil servant, with whom we had fairly formal contact on a limited but regular basis. There was very little in common between my mother and my stepfather, except for an interest in ballroom-dancing, and I remember feeling more than a little surprised over her choice of partner. My stepfather’s demeanour was quite stiff and formal, repressed – he was not a person one could feel comfortable sharing one’s feelings with. It seemed like an
artificial choice, and indeed, the entire marriage was devoid of pleasure, love, or emotion.

18. That this move meant that I lost contact with most of my extended family, and have had no contact whatsoever with my father’s side of the family since the age of seven. My sister remained as a lodger with my mother’s sister [xxxx] in Newcastle-under-Lyme, who had taken over the tenancy of our council house when my mother left it. Sometime after we moved I became aware of a serious dispute between my sister and [xxxx], although the details of this dispute were not elaborated to me. The vague implication that I came to infer was that the source of this dispute involved [xxxx]’s reaction to some aspect of my mother’s character or conduct which had only materialised after we had left Newcastle-under-Lyme. But the content of [xxxx]’s feelings were never made explicit to me, and following this it became extremely difficult for me, in fact quite impossible, to continue any sort of contact with certain members of my extended family, including most of my mother’s siblings, some of whom, particularly [xxxx], I had previously been very close to. While I had occasional contact with my grandparents on my mother’s side, any contact with any other member of that family was routinely avoided.

19. Since this move, my relationship with my sister has been virtually non-existent. Despite us maintaining partial obligatory contact, I have always felt there to be an enormous gulf between my sister and myself, for which she has shown no sign of regret or frustration. The first occasion that my sister visited us following the move, she privately expressed sympathy for me due to some aspect of my mother’s behaviour which she had been unaware of until after we had left Newcastle-under-Lyme; but she was very vague about this and I was none the wiser as to the details of the issue, or what exactly it was my sister had become informed of (I can make an association in time between this and the dispute between my sister and my aunt [xxxx], but without knowledge of the content of that dispute, I am unable to make a substantial connection between them). Since that occasion it seemed she became resolved to this new distance between us and she has displayed a total lack of affection and a complete disinterest in my affairs or my well-being. Whenever I visited my sister after this I always had the feeling that my presence was an embarrassment for her, as though for some inexpressible reason she would rather I were not there. There has always been the feeling that there was something unspeakable or irresolvable between us since the death of my father and my mother’s and my subsequent departure.

20. In spite of the urgency of my mother’s impulse to remarry (or perhaps because of it) the marriage was a hopeless failure, maintained only by a terse mutual disrespect between family factions. My recollections of the time were that I experienced a dominant feeling
of resentment from the members of my stepfamily towards myself, resentment which seemed to stem from their attitude to my having started to attend the grammar school. In 1977, after a two-year separation while living under the same roof, my mother and stepfather were divorced and my mother and I were re-housed together. When I eventually left my mother’s home, at age seventeen, I tried to persuade her to move back to Staffordshire, to the company of her friends and family. This she eventually did, though she showed considerable reluctance, which I could not understand as she was quite isolated in Bexhill-on-Sea. More recently it has become clear to me that there has grown a deep mistrust of my mother amongst her brothers and sisters: not, as was my first impression, between herself and my aunt [xxxx] only, for reasons that I have always been at a loss to understand.

21. At the age of six or seven my experience begins to be affected by a very strong sensation of fear or dread. This would be typical of any normal person’s response (in particular a child) to an incidence of trauma. In its strongest form it precipitates nightmares of a particularly nasty, recurring kind. The content of these nightmares suggests to me a preoccupation with an hysterical fear of autocratic male authority (however, there has been no occasion of abuse or mistreatment by any male figure in my childhood to which such a fear might be attributed). In its less severe forms it may figure as a general apprehensiveness or dread of coming events, especially where these events entail some form of social obligation. This predisposition towards a specific kind of fear, alongside feelings of physical discomfort or awkwardness, engenders an aggressive and compulsive behavioural disorder. This is manifested as:

1. A tendency towards aggressive, disruptive behaviour at home and at school.
2. Recurring nightmares.
3. The beginning of a compulsive eating disorder (seeking comfort in food).
4. Persistent daily headaches and poor concentration.
5. Consistently high levels of stress associated with the sensation of enduring physical discomfort culminating in an anxiety disorder.
6. Repetitive, neurotic behaviour, mood disorders and depression.

22. All of these symptoms persist throughout my school career. As I became more habituated to the state of fear, the nightmares decrease. At the age of seven I begin to put on weight noticeably having been previously quite a ‘skinny’ child. The experience of fear becomes subsequently deferred through the development of obsessive-neurotic patterns of behaviour. As my symptoms begin to alienate me from those around me, I become increasingly sociopathic, bulimic, and self-loathing. My eating disorder developed into bulimia at some point in adolescence and persisted until my late twenties. The increase in stress together with my predisposition towards fear results in an anxiety disorder with which I have suffered ever since.
23. In my case anxiety and stress responses are complicated by a general sensation of physical discomfort (the absence of any event of trauma suggests to me that my predisposition towards fear may have a primarily physical cause), which produces an effect of restlessness, which in turn gives rise to anxiety and also compulsive, neurotic patterns of behaviour. From the age of six my experience of physical discomfort seems to feature disproportionately in my feelings, resulting in a certain ‘awkwardness’ in my disposition. I developed an early reliance on painkillers as a response chiefly to the frequency of headaches, but which has some effect on reducing sensations of discomfort. At the time I did not perceive the problem at all in this way – there is no ‘control’ or comparison through which I can compare feelings after the event of my tonsillectomy with feelings before it. Hence it has always been possible to overlook the possibility that the physical and psychological changes that I experienced were in any way associated with, or caused by, this single contributory event. It was only following 2001, after a lapse of 34 years, that I felt there were reasons why the event of my tonsillectomy could realistically be considered as just such a contributory or causal event.

24. At the age of six to seven I developed certain allergies, in particular hay fever, as well as allergies to cats and dust. These appear for the very first time in the summer of 1968, the summer immediately following the year of my operation. This is confirmed by the GP’s notes for that year. These allergies have tended to diminish as I get older.

25. At the age of ten I developed shingles (herpes zoster). Following earlier primary chickenpox infection the latent varicella zoster virus lies dormant in the dorsal root ganglia of the spinal cord. While this is normal, shingles occurs in individuals where there is an abnormal level of stress and/or immunodeficiency resulting in the dormant virus becoming reactivated in later life. The disease is extremely rare in individuals who are not either in old age or who are otherwise immune-compromised. I recall my GP’s astonishment at the time, remarking that he had never heard of a case of shingles in someone so young. In 2003, when I first researched the published NHS information regarding shingles, the NHS Prodigy website included an article entitled Shingles and Postherpetic Neuralgia, which stated that reactivation of the varicella zoster virus: “probably occurs following a decrease in cell-mediated immunity (e.g., with increasing age, HIV infection, illness).” The article stated that a diagnosis of shingles “applies to” patients over 192 months (16 years) – suggesting this as a minimum age-expectation. It quoted a probability of contracting shingles of less than 2/1000 at the threshold of age fifty – no probabilities were suggested for age-groups lower than fifty, indicating that it is not considered to be a significant risk at lower ages, i.e., where the immune system is not otherwise compromised. It remains therefore, in the absence of any prior infection resulting in immunodeficiency, truly exceptional that I should contract shingles at this
There is no preceding occurrence of infection in my medical history sufficient to explain the immunodeficiency which led to my contracting shingles.* The shingles affected the region of my upper torso bilaterally around the shoulder area, rather than the lower torso.

26. Regarding my mother’s financial position: during each of her marriages she did not work full-time but engaged in one or two mornings a week casual cleaning, and some part-time work at a nursing home. My family both before and after her remarriage have never been well-off, nor even ‘comfortable’, but living somewhere not far above the poverty level. From my birth until when I left home we always lived in rented council accommodation. Since she divorced she has consistently claimed state benefits. During the 1980s my mother was convicted of Benefit Fraud. She now receives a state pension, housing benefit, etc. My mother is indeed very careful with money (she has no expensive vices like gambling or drinking), but then, under these circumstances she would certainly need to be, if only to pay the bills. It has not ceased to surprise me, and increasingly in later years, how my mother was able to maintain the semi-luxurious lifestyle which she continues to enjoy. Since I left home she has enjoyed frequent holidays, always run a car, and generally lived a very full life. I have never once witnessed my mother in a position of financial difficulty – she has always had the financial resources to deal with whatever crisis may arise. She has even paid off debts I accrued as a student in 1988, without my knowledge, amounting to many hundreds of pounds. From my own experience of living on benefits for extended periods, I know

* Shingles and Postherpetic Neuralgia (URL: http://www.prodigy.nhs.uk – last accessed June 2004). This article, from which the above statistics are quoted, is no longer available on the NHS Prodigy website (a web-archived image of the page is available at URL: http://www.somr.info/lib/Prodigy_Guidance_Shingles.pdf – accessed 27/05/2023). The Internet Archive (URL: https://archive.org/web – accessed 15/01/2023) shows that the information on the Prodigy website was changed at some point between 17/02/2005 and 18/10/2005 to state that a diagnosis of shingles may apply to ‘Patients over 12 months’ (the latter of these two dates is the last available snapshot of any page from the Prodigy website). The available patient information was subsequently found in a much-abridged form at URL: http://cks.nice.org.uk/shingles#!scenario:1 (UK access only – accessed 16/03/2017), where it no longer quoted probabilities according to age, likewise stating that shingles may occur “Aged from 12 months onwards”. This is a simplification of the previously published information, and does not reflect the medical opinion expressed by my GP at the time of the illness. It is rather misleading as it doesn’t explain that shingles in juveniles occurs only in cases where there is exceptional immunodeficiency, as a consequence of some other prior attendant major infection.

“Recognized risk factors for HZ [herpes zoster, or shingles] occurring during childhood are a history of maternal varicella [chickenpox] during the pregnancy or a history of primary varicella in the first year of life [neither of which is applicable in my case], which are situations that can be assumed to result in blunting of VZV [varicella zoster virus]-specific immune memory during primary exposure of the child to VZV. Presumably, HZ in children reflects some interference with the normal immune mechanisms that maintain latency of VZV – for example, transient immune suppression after Epstein-Barr–virus or cytomegalovirus infection.”

that it is barely possible to run a car on this income, let alone everything else. As I have
gotten older and more financially aware this is something which strikes me as
increasingly anomalous. I now have the strong suspicion that my mother is hiding a
large sum of money, and that she has striven for many years to keep up this appearance
of poverty. My mother is no financial wizard, and I suppose (as all my assertions here
are based on personal observation and deduction) that since returning to Newcastle-
under-Lyme in the early 1980s she has sought the help of those closest to her with the
secreting and laundering of this money.

27. That the science and mathematics departments of Bexhill Grammar School used the
Nuffield syllabus and examination board for their curricula. It is significant that the East
Sussex Local Education Authority was the very last LEA in the country to make the
change to comprehensive secondary education. It was only by relocating to this
particular borough that I had the opportunity to sit an eleven-plus examination, pass it,
and thereby attend a (elite) grammar school, rather than a standard comprehensive.

28. My experiences at the grammar school are best described as being effected by an
overbearing sense of ridicule and humiliation. I had no adequate understanding of this;
my mother always explained my behaviour and temperament in terms of my reaction to
the loss of my father. For many years I also adopted this understanding as a token
explanation for the complex symptoms and anxieties I experienced. I did not mix well
with other boys and was mildly bullied. From adolescence my behaviour became
markedly compulsive and self-loathing. The extent of my emotional problems made me
unpopular, a social misfit. I was frequently bulimic, obsessively eating chocolate and
cakes and vomiting it all up. While at the grammar school, and again despite my
academic enthusiasm, I experienced persistent cognitive difficulties which made it
impossible for me to achieve the academic standards of which I should have been
capable. Despite being exceptionally bright, my progress was impeded partly by my
behaviour, by chronic difficulties with concentration, and by persistent headaches. This
will be borne out by the records of my daily attendance at the school medical office. I
took eight ‘O’ levels with good grades, but when it came to ‘A’ levels, I could not find
the commitment. I resented the workload and left before the end of the lower-sixth
form. Considering my potential, my academic and professional achievements have been
rather disappointing. I have no career to speak of and although I did manage to complete
a BA degree in my late twenties I have spent significant periods of the intervening time
doing odd driving jobs, and have not been employed since 2003.

29. I cannot emphasise strongly enough the persistence throughout my entire life from the
age of six or seven of this complex mental disorder. A friend of mine once told me that
upon first meeting me he had assumed that I was autistic, due to my obsessive self-
absorption and my failure to interact socially. While this has had a seriously debilitating effect on my professional and academic performance, upon my ability to form relationships of any kind, upon my physical and sexual health, and generally upon my emotional well-being, prior to the writing of this document it has never been diagnosed by any specialised medical resource. This is despite the fact that I have addressed the problems many times in front of general practitioners. The fact is that where mental health problems do not pose a threat to the victim’s general level of self-control, as mine have not, they are unlikely to be classed as ‘dangerous’, and so are unlikely to justify any specialist attention or expense.

30. In my early twenties I was told by a doctor that I had curvature of the spine in the thoracic spine area. In addition I also experience a distinct ‘prickling’ sensation in this area, though it is deeper – not a ‘skin’ sensation. I suffer from a certain degree of neurological impairment, including spasmotic numbness and tingling in my extremities and, on several rare occasions, I have experienced short periods of apparent paralysis. My limbs are literally ‘frozen’ and I cannot move them. This occurs particularly when attempting to rouse myself from a position of total relaxation. It usually lasts for two or three minutes. This infrequent complaint does not seem to be an indication of any gross neurological disturbance – it does not interfere with my breathing, for instance – but would seem to be an ‘opportunistic’ effect, the cause of which remains a mystery. There is no medical justification or explanation for the spinal anomaly. At least, no doctor has ever suggested one to me. As a child I suffered no malnutrition, polio, or any other bone-related disease or developmental problem. In most respects my physical development has been healthy; i.e., excepting the specific complaints outlined above – there has been no illness which could explain such a structural deformation.

31. Despite fairly early sexual activity, I experienced periodic sexual impotence and at times distinct physical difficulties with sex or with any activity demanding a high level of physical coordination. Physical exercise highlights areas of specific discomfort, in particular in the thoracic spine (between the shoulder blades) and in the neck.* On one occasion, at around the age of twenty-six, while engaged in some strenuous exercise, I had the clear sensation of something ‘snapping’ in my upper-back, to the right of my spine, very near to the location of the scoliosis. This was so pronounced that I was unable to continue with the exercise. This sensation was so completely anomalous

* An MRI scan of my cervical/thoracic spine was made on 28/07/2020 at a clinic in Novi Sad, Serbia. In one image from that scan (published on p.78 below) there is evidence of a significant anomaly to the immediate right of the spine, close to the apex of the scoliotic curve; but which has not been reported in the clinic’s radiology report. This new evidence may nevertheless now throw additional light upon the following description of the symptoms associated with this part of my anatomy.
anything before experienced; I can only describe it as the sensation of something becoming taught and then breaking with a ‘snap’. One might relate this description to the sensation of pulling a muscle or straining a ligament, but this would be to underestimate the abnormality of the sensation. Aside from the acute shock effect of the sensation, there was none of the subsequent pain that would be attendant on that kind of injury. However, during the subsequent seven years or so, I experienced severe panic attacks, upper-back and neck pains, and cardiovascular anomalies. On three or four occasions these attacks were so severe that I felt it necessary to call an ambulance, as I thought I was dying. The result of these ‘emergencies’ was that the symptoms would desist, either before the ambulance arrived, or on the way to the hospital, leaving me feeling quite foolish, but nevertheless equally convinced as to the seriousness of the matter the next time that I would experience such an attack.

32. In December 2001, I attended King’s College Hospital Accident & Emergency Department in response to the discomfort in my thoracic spine. I have experienced a persistent dull ache in my thoracic spine which has worsened significantly over recent years. In truth, this event took place some months after the point at which my suspicions were first aroused, and it is true that it was partly a motivation of mine to seek some kind of medical investigation of my symptoms in the light of these suspicions. At the time I assumed that it would be out of the question to seek such an investigation on the basis of these suspicions alone, as it was likely they would be assumed to be delusional. Hence it is true that the motive for attending the hospital was ulterior to the necessity of relieving pain and discomfort. They took two x-rays of my spine of which I have obtained copies (see image to the right). They show a marked lateral bend or scoliosis in the thoracic spine, with its midpoint just above the point where the shoulder blades meet (by the way, I was standing straight upright when these x-rays were made). Although the extent of the deformity is clearly evident, it is fairly mild when compared with many other cases of scoliosis.

“Progressive neurological deterioration is not characteristic of adolescent idiopathic scoliosis, and development of late paraplegia is extremely rare [...] Congenital deformity and scoliosis due to neuromuscular syndromes are characterized by progressive neurological deterioration with curve progression. The presence of a neurological abnormality with scoliosis will alert the care provider to look for an intraspinal abnormality as neurological disturbance is not a characteristic sequelae of idiopathic scoliosis.”*  

There is an important distinction between *congenital* scoliosis which is present at birth, and *idiopathic* scoliosis which develops later in life, often during adolescence. In most cases congenital scoliosis develops progressively along with a significant neurological deficit, leading to quite severe spinal curvature and associated pain, usually resulting in the necessity of surgery. Congenital forms of the disease indicate an *intraspinal* abnormality as the generative cause of the deformity. ‘Idiopathic’ simply means that the deformation is not caused by a progressive disease, but by some other *extraspinal* influence, knowledge of which is not fundamental to the diagnosis. It is used to distinguish the forms of scoliosis which develop at some point during childhood from those which are present at birth. In most cases the extent of the deformity is mild compared to cases of congenital scoliosis. Idiopathic scoliosis frequently appears during adolescence, and the later its onset the less chance there is for the deformity to progress before growth stops: “*Patients whose curves are of consequential magnitude prior to onset of their adolescent growth spurt are at significant risk for curve progression.*”

This suggests that the mildness of the curve in my case is an indication of its later appearance. My own example of scoliosis is certainly of the adolescent, idiopathic kind; any manifestation of earlier deformity would have been picked up by school or GP medical examinations – my scoliosis was not detected until my early twenties. The extent of the spinal curvature is not extreme enough to warrant surgery in my case, as it does not present any significant risk of neurological injury or of any consequential pain. Neither does it in itself provide an adequate explanation for the plurality of symptoms associated with this part of my anatomy. The fact of the scoliosis cannot be used to explain the progression of pain and discomfort I have in this area.

Until now the problem has been that when one presents one’s symptoms to a doctor, it is very difficult to give a complete picture. One doesn’t normally expect an holistic approach from a GP – one usually isolates a particular physical symptom and expects the appropriate treatment for that symptom, or for any disease which the symptom may indicate. In my case there is an overwhelming complexity of symptoms which it would be unreasonable to expect any GP to be able to fathom in the space of a ten-minute appointment. With the exception of shingles, none of these symptoms considered in isolation is especially remarkable, and therefore they are unlikely to indicate to a GP the suggestion of anything particularly serious or out-of-the-ordinary. The symptoms viewed routinely as discrete phenomena are easy for a GP to treat or dismiss as being non-serious or insignificant. However, when viewed historically and in sequence there is a recurring feature amongst the details of medical evidence listed above – a persistent *non sequitur* in the sequence of events – which is that of inappropriateness, or *anomaly.*

The symptoms considered collectively as a set of related phenomena are, frankly, bizarre and inexplicable, and are therefore difficult to engage with therapeutically, with the result that they have been quite disabling throughout my life. Even so, they seem to resist all conventional medical diagnosis, that is, in terms of a collective causal explanation. It is important to stress in this context that the apparent unavailability of such an explanation is a consequence of the fact that these phenomena have previously been considered only in isolation from one another, and from so many significant contemporaneous events. My presentation of this evidence relies therefore, for the first time, on this unique perspective, incorporating historical and familial factors.
Summations

My purpose in presenting this evidence in this manner has been to try to represent, in a much compressed verbal form, the processes of realisation and discovery that have preoccupied my thinking since my suspicions were first aroused, two decades ago. I have until this point tried to avoid too much interpretation of the basic facts of the case in the hope that the reader might draw whatever conclusions may be justified on the basis of the facts alone, independently of any overt persuasion or rhetoric on my part. It is true to say that these notes do not represent the totality of my thoughts or opinions on the matter, but to have attempted this would have made the issue one of impenetrable complexity and would have defied anyone’s belief. In that sense the report is experimental, in that it hopes to arrive at a consensus on largely empirical terms.

To simplify matters as much as is reasonable it may help to divide the preceding evidence into categories. As I see it the evidence falls into three categories:

1. Subjective reports of experiences of emotional and psychological trauma states. This uses the idea of trauma in its broadest sense, that is, any experience which presents a risk of undermining the values and expectations upon which one relies for maintaining one’s personal and emotional integrity and stability. In my case it appears as though I have all the classical symptoms that would indicate an exposure to some significant traumatic event or events. However, there is no known event in my past to which such a response could be attributed, that is, beyond the ‘conventional’ bereavement of the loss of my father at age seven. In addition, my symptoms are too diverse and anomalous, too temporally specific in their development, and there is a significant overlap of physiological and psychological symptoms, to effectively rule out explanation in terms of psychosexual abuse by human agency too early to be recalled.

2. Extant objective medical evidence – an accumulation of reports of mysterious ailments which, considered individually, are less significant than when considered in their entirety. In particular, one of these diseases is especially remarkable in epidemiological terms (in the absence of other contributing causes) – that of shingles at the age of ten. I have in mind those features in the report which are supported by items in my medical records. In addition to these recorded symptoms there are other observable symptoms, the importance of which I have tended to deprecate, over the years, being usually careful not to appear as a hypochondriac. These include: sleep disruption, dysphagia (problems with swallowing), problems with balance, various unexplained neurological spasms, neuralgia, neuroses, irritability, chronic fatigue syndrome, and agoraphobia. My mother has grown accustomed, over the years, to remarking that I look “pale” or unwell. This has tended to be the rule rather than the exception. I have suffered with this mild anaemia for many years.
3. Anecdotal reports of improbity amongst the remaining members of my immediate nuclear family. These reports are anecdotal insofar as I am limited to making such judgements on the basis of my understanding alone, rather than on what is objectively shown to be the case. This new understanding has taken a very long time for me to arrive at, and it is not a simple matter to explain how one knows all that one knows about one’s own family. It is precisely because I was cast as an ‘outsider’ from my family that it has taken me so long to reach this understanding, as I have not been privy to the intimate affairs of those involved. In the early 1990s my maternal grandmother passed away. Unsurprisingly, neither my mother nor my sister took the trouble to inform me about the funeral, which I missed, again, precisely because my presence there would have been too problematic and embarrassing for them. However, many things have now become demystified for me regarding my relationship with my mother, who has long displayed a compulsive, incorrigible guilt towards me; which I have always found rather repellent, and difficult to understand. My mother wore this guilt like a shield, and I was unable to penetrate or analyse it. The result has been a long-term ambivalence affecting both my relationship with my mother and my relationship with my sister, in which we have each mutually acquiesced – an ambivalence which ultimately has served only to protect their personal and financial affairs from an earlier exposure. I am not alone in these suspicions, for it has become clear to me from my more recent visits to my mother that there is a deep and widespread distrust, even hatred, amongst the members of my mother’s extended family towards herself (feelings which also extend toward my sister). These feelings first began to emerge very soon after we left Newcastle-under-Lyme for Bexhill-on-Sea – a circumstance which my mother has been consistently unable or unwilling to explain to me (re: items 17-20, pp.11-13 above).

One purpose of categorising the evidence in this way is that it helps us to understand how it has been possible for me to subsist in this condition without the matter coming to the attention of any member of the healthcare professions. It would be impossible for any doctor to isolate any single causal explanation for the diversity of my symptoms simply because, within the terms of accepted epidemiological explanation, there is no such cause to be found. In the absence of a determinedly holistic assessment and investigation of my physical condition, there is only a string of more or less disconnected complaints, and it becomes difficult to appreciate or investigate the possibility that all of these effects may be causally connected. To have contracted shingles at the age of ten is by itself quite rare, much rarer than scoliosis for instance. What is important here is that I contracted both conditions as effects associated specifically with the region of my thoracic spine. This compounds the improbability of their coincidence, especially as there is no medical explanation for their individual occurrences. When you then consider all of the additional symptoms, many of which also have a bearing on this part of my anatomy, we have a situation that is overdetermined – the sheer multiplicity of symptoms, resisting any conventional
epidemiological explanation, defies analysis in terms of statistical probability, that is, in the absence of an exceptional intervening cause.

If one accepts, as a provisional hypothesis (disregarding for the moment the apparent improbability of the suggestion, as well as its implications for medical ethics generally), that such a cause may be the consequence of some form of exceptional biological intervention, conducted illicitly and covertly in answer to the expedient demand of a highly specialised research imperative (and, as a consequence of that secrecy, without an appropriate medical trial and approval regime), it is conceivable that such an intervention might precipitate an array of medical conditions as unintended consequences, the coexistence of which it would be difficult for a GP to predicate within accepted diagnostic paradigms. Since the hypothesis is of a cause that is both unprecedented and non-natural, due to routine constraints imposed upon diagnosis it is most likely that a GP would be from the very start structurally incapable of arriving at a diagnosis that might elicit the probability of a single contributory cause for the array of anomalous conditions. Such a scenario could explain why it is I have been unable to make my case in front of any member of the healthcare professions. My psychological problems are not sufficiently beyond my control or destructive enough to compel attention from the psychiatric profession, and appear more like the hypertrophic effects of some underlying physical anomaly, which itself remains a complete anathema as far as any general practitioner might be concerned. This basic incommensurability in the routine analysis of my condition, notwithstanding its profoundly deteriorating effect upon my quality of life and experience, is significant indication as to the existence of some principle determining influence or cause which lies beyond the scope of conventional medical explanation. Effectively, the only available response from the medical profession when confronted with this serial anomaly is either one of denial, or of incomprehension. Faced with this attitude, which has often appeared to me as professional inertia, I have been compelled to gather all the available evidence – medical, historical, and anecdotal – and to give due representation to the details of that evidence, which, in the absence of any other satisfactory explanation, point to the ‘uncomfortable’ conclusion that there has been some act of physical intervention with my person, having had significant biological consequences, and which can only realistically have been my tonsillectomy.

In order to proceed with this investigation it is necessary to make the following preliminary summations based on the evidence disclosed above:

1. I had a tonsillectomy at the age of five which, on my own analysis, presaged the beginnings of a behavioural and psychological disorder – in view of the fact that this disorder was predicated as a consequence of the experience of enduring physical stress and discomfort; rather that is than on the basis of any appreciable emotional disturbance.
2. As a coincidence of my tonsillectomy I began to suffer with *hay fever*, which first appears in the summer of 1968, the year immediately following the tonsillectomy.

3. There is inconsistency in the reports of tonsillitis in my later medical records in respect of a previous tonsillectomy.

4. Following this operation I began to experience persistent daily headaches and cognitive difficulties, including attention and memory deficits. In addition I experienced recurring nightmares. I had not experienced these problems prior to my tonsillectomy.

5. That my father noticed changes in my behaviour and in my appearance; he also made an association of these changes with the coincidence of my tonsillectomy. That shortly after voicing his concerns, at times aggressively towards my mother, he was taken ill and died in hospital on the operating table.

6. That at some point since my father’s burial in the Newcastle-under-Lyme Cemetery in May 1968, his headstone has been removed, seemingly in order to deter attention from the location of his grave.

7. That my mother’s behaviour since his death has been that of a person who has something to hide, in particular, a large sum of money. This points to the subsequent involvement of my sister, who, having spent most of her adult life as a housewife, with some casual and self-employment, is now divorced, took early retirement in her mid-50s, and now owns multiple properties in the UK and Spain.

8. I contracted *shingles* at the age of ten, which is truly exceptional in the absence of any other preceding major infection which might have resulted in decreased immunity (see footnote on p.15).

9. Since this time I have suffered with long-term ‘generalised anxiety disorder’, which might share some of the characteristics of ‘bipolar disorder’ (‘manic depression’), or more accurately ‘bipolar II’ (‘hypomania’), in which the traditional ‘manic’ component of bipolar disorder is subdued. However, these have never been diagnosed by any medical specialist. In fact, I have suffered a complex mental and physical disorder, which, in the absence of any occasion of abuse or mistreatment or relevant contributory health issue, is inexplicable (in its full extent) unless it is understood as resulting from some event of medical intervention or interference with my normal biological functioning.

10. That to have implanted some article or device in my thoracic spine and/or neck region would have been entirely feasible through an incision in the back of my throat made
coincidentally with my tonsillectomy.*

11. That the possibility of such an intervention might suggest an explanation for my subsequent development of a mysterious anomaly of the spine. The multiplicity of symptoms associated with this part of my anatomy is disproportionate to the degree of spinal deformity (see items 30-32, pp.17-20).

12. This suggestion of an illicit surgical implantation implies the existence of a program of covert medical research which, in view of that secretive status, would indicate activities under the directive of certain offices of State. During the preceding two decades (most notably, and in my case consciously, since early 2001) there appears to have been a gradual efflux of knowledge of this issue from primary sources, which may have been as a consequence of its declassification, or the declassification of some other associated information (i.e., possibly around 1997); or possibly some other instance of unauthorised disclosure. This perhaps explains how I was able to arrive at my late awareness of the issue, having no previous history of making such ‘delusional’ claims; nor for that matter any prior suspicion that anything of the kind would be at all thinkable or equitable under the auspices of our medical professions.

13. That there has indeed been widespread public suspicion (rather than knowledge) of this matter (for instance, among members of my extended family), albeit largely unspoken. I believe the matter has now acquired something like the status of an ‘open secret’, but one which remains unspeakable. The implied perpetrators of these acts, which were organised in a collegial and systematic fashion, and with some degree of executive state sanction, have some assurance of immunity from accountability due to the (almost) insurmountable burden of proof that would inhibit any accusation. The reasons for this silence lie in the impenetrable aura of secrecy surrounding the issue, the lack of objective certainty or evidence with which to support such suspicions, and the inevitable vulnerability facing anyone bold enough to ‘stick their neck out’ over such an issue. It would have been quite foolish for anyone to make such an allegation without the support of a convincing body of evidence. It has been the purpose of this report to supply the beginnings of that evidence.

* See: Cervical and Thoracic Spinal Disorders: New Surgical Technique. Rick C. Sasso, M.D. (URL: http://www.spineuniverse.com/exams-tests/devices/cervical-thoracic-spinal-disorders-new-surgical – accessed 21/03/2021) for a radiographic depiction of the accessibility of the cervical spine through the mouth cavity. The final x-ray at this location shows the accessibility of the cervical spine through the patient’s mouth. There has recently been an MRI scan made of my cervical (and thoracic) spine that now reveals evidence of a distinct anomaly to the immediate right of the thoracic spine, close to the apex of the scoliotic curve. However, this apparently self-evident anomaly has not been reported in the radiology report provided by the clinic. The scan and report are discussed on pp.77-79 below.
Analysis

Technical Concerns

A dominant conclusion arising from the evidence outlined above is that the peculiar array of symptoms which has plagued me since the age of six is neither explicable in conventional medical terms, nor is it understandable in purely psychological terms. Yet there is in my case an acute interrelationship between psychological symptoms (anxiety, stress, obsessive neurosis), and a string of decidedly anomalous physiological symptoms, the coexistence of which is not satisfactorily explained in terms of mere chance or coincidence. In the preceding summations I have tried to convey the degree of frustration I have experienced when attempting to relate these issues to members of the medical profession. The persistent difficulty and resistance I have met with, which has often appeared to me as professional inertia, is that if a medical representative were to give any credence to my suspicions at all, and attempt to take responsibility for the initial disclosure of so serious an issue, it would only place him- or herself at risk of being compromised professionally, as the revelations would tend to compromise the reputation and status of the medical profession itself. It has thus proved consistently impossible to discuss these suspicions, openly and frankly, with any such medical professional. Consequently, as any approach towards a disclosure must ultimately involve a medical investigation, my own investigations have arrived at an objective brick wall.

More recently, my investigation has led me into areas of research which have provided some essential clues to the mystery of my symptoms. Apparently, on a first examination, many of these symptoms can appear superficial. Considered in isolation from each other, most of them would not even warrant the attention of a doctor, including as they do – alongside chronic pain, scoliosis, and shingles – many emotional, cognitive, and behavioural difficulties, with varying degrees of seriousness. It was enlightening therefore to notice the degree of frequency with which recent research has associated stress, anxiety, headache, cognitive deficiency, fatigue syndrome, and behavioural abnormalities, with human exposure to radiofrequency (or microwave) radiation (‘RFR’).* Research in this area has been conducted for over half a century, though much of this research has not been given widespread public exposure, especially that which is concerned with effects of exposure to low-intensity RFR. This research has involved investigation into: i) the direct thermal effect

* For an introduction to some of the research findings in this area see articles by: Balcer-Kubiczek; Belpomme; Belyaev; Cherry; Dabrowski et al.; EMF Science Review Symposium; Hyland; Lai; Moulder; Sri Nageswari; The Royal Society of Canada; Sandyk, Anninos & Tsagas; and The World Health Organisation; in the References section, pp.159-165. See also a synopsis of this research at URL: http://somr.info/rfr – accessed 27/05/2023.
of close-range radiofrequency devices (i.e., mobile telephones) upon human tissue – the principle health risk being that of the carcinogenesis of tissue due to the actions of heat-induced DNA damage in tissue cells; and: ii) effects identified as ‘non-thermal’ or ‘micro-thermal’, resulting from exposure to low-intensity radiofrequency fields, such as may occur environmentally due to the concentration of mobile telecommunications devices (i.e., mobile phones and cell towers) within communities. It has been the former type of research which has received most attention, for a combination of institutional, political, and commercial reasons. In practice most individuals are exposed to a combination of thermal and non-thermal effects due to the contribution of environmental levels of radiation, in addition to the emissions from personal communication devices. This is clearly as dependant on environmental considerations as much as it is on individual patterns of use of mobile telephony devices [Hyland, 2001; Lai, 1998].

The difficulty faced by researchers in this field is that the non-thermal biological effects from exposure to environmental levels of RFR (and electromagnetic radiation – ‘EMR’) are non-linear, and not experimentally measurable in the way that thermal effects are. In fact most data related to the safety standards of mobile devices is established from the results of experimentation on dummy heads, as it morally offensive to submit living human beings to such experimentation. Significantly, what these experiments do not reveal are the effects of low-intensity RFR upon the body’s delicate, hypersensitive regulatory mechanisms; that is, upon the balance of homeostasis. RFR has been shown to produce electrical disturbances in the brain which lead to a stress response in the central nervous system similar to the effects produced from exposure to excessive noise or bodily restraint [Lai, 1998]. Low-intensity RFR has generally been regarded as safe by telecommunications providers and many research institutions on the basis that there is no measurable heating-up effect of the kind that could be simulated by experiments on dummy (or dead) flesh. But this has resulted in a high degree of institutional blindness regarding the non-thermal effects of RFR upon actual bodily processes. Typical non-thermal effects have been identified as: “Neurological effects, such as headache, sleep disturbance, concentration disturbance, short-term memory loss..” [Cherry, 2000].

Interestingly, Dr Cherry also notes the following as effects of exposure to RFR:

“[I]ncrease in sickness for Musculoskeletal system and other organs, including: Loss of part extremities, osteomyelitis and neoplasms of bone or muscle [...] Cardiovascular system [...] mental disorders, including psychoses, psychoneurotic disorders and so-called “psychophysiological disorders”.” (my emphasis) [ibid.]

While it is not really possible within the context of this report to respect the full nuances of the debate about the implications of the (thermal, non-thermal, or micro-thermal) effects of
RFR upon biological tissue, it is helpful to find experimental evidence that supports in principle the possible recognition of a causal connection for the totality of the symptoms I have reported, symptoms which had until this point been the cause of considerable shame and humiliation to me. The previous reference actually identifies RFR as a potential cause of my spinal deformity, which we have already concluded to have been due to extra-spinal rather than intra-spinal influence (pp.18-19 above).

One can only go so far in deducing causes from symptoms on the basis of coincidental evidence before some more concrete association is required. But, in view of the absence of any other satisfactory explanation, the research quoted above at least allows for the possibility that the mystery and apparent incommensurability of my symptoms might now appear instead categorically as the kind of symptoms likely to result from the direct and chronic exposure to such an RFR device. There is a distinct affinity between the neurobiological effects of RFR reported in recent research and the kinds of symptoms I have reported – specifically, those of increased stress and cognitive disorders, as well as a whole range of complex behavioural and physiological irregularities, in particular the indication that I was abnormally immune-compromised at age ten, resulting in my contracting shingles. Research by Dabrowski et al. suggests there are immunotropic effects from human exposure to low-level microwave fields [Dabrowski et al., 2003]. In addition, research by Belpomme indicates that electromagnetic fields from radio communication devices may result in increased histamine levels and other hormonal irregularities in sensitive individuals; suggesting a possible explanation for my developing hay fever during the year following my tonsillectomy, in terms of exposure to unprecedented levels of RFR [Belpomme, 2011].

In the light of current research and taking into account all of the medical, historical, and anecdotal evidence previously detailed, the probable conclusion, pending further objective proof, that I may have been the subject of a pioneering neuropsychological experiment, involving invasive surgery, executed illicitly and covertly, in the absence of my knowledge or consent, at a vulnerable age, demands to be given serious consideration. If such proof were established (I suggest this proof is now established by the MRI evidence published in Part 2, though at this point it remains without explicit medical corroboration – see pp.48-69 & 77-79 below), this would suggest the existence of a program of covert medical and technological research involving, at the level of its practical implementation, certain employees of the North Staffs Infirmary; my father’s surgeon, Mr Lawson; my mother and (as the evidence might suggest) certain other members of my extended family; the family GP, Dr Tellwright; St Mary’s RC Primary School; and almost certainly, Keele University. Beyond these it is difficult to avoid speculation, suggesting the necessity of an in-depth inquiry, to discover exactly which institutions or corporations, governmental or non-governmental, may be implicated in the design, execution, and funding of such a proposal. It would certainly be impossible to locate responsibility within any one particular organisation.
In spite of the seeming implausibility of the suggestion, the evidence as it stands supports the conclusion that there may be a surreptitious device or implant situated in the region of my thoracic spine;* and that this device, or series of part-devices, was placed there during an operation which was ostensibly a routine tonsillectomy; this serving as an alibi for a research undertaking whose motives and directives are not at all clear, except to conclude that the research program in question was something that was never intended to reach the public domain – those organisations holding responsibility have been protected by the highest levels of secrecy for the past 56 years. I believe it was research aimed principally at advancing a technical understanding of the nature and function of intelligence (for further discussion, see the Technocracy section below, pp.41-46). This is suggested to me by the educational context of the research and its relation to ITA – an experimental teaching methodology which attempted to systemise that most elusive of educational phenomena: the acquisition of language in young children. I suspect this may have been one of the principle ‘design foci’ of the research program; although there must also have been other less transparent research incentives. I do not wish to speculate unduly on the nature of the device(s) in question, except to make the functional inference that they must include some form of communication device (otherwise, what would be the point of them?), and that this must have a power source. I conclude that such a communication device must emit some form of high-frequency analogue radio signal. I think it is safe to assume, pending further detailed corroboration, that the transmissions from this communication device are (or were) monitored in some capacity. It is not assumed however that the device would have any receiving capacity. It would have been an essential prerequisite for the device(s) to remain concealed, not to be detected coincidentally at some later date through standard x-ray procedures.

It is possible, I understand, to make an object invisible, or ‘pseudo-transparent’, to x-ray detection, by employing methods of optical diffraction on a minute scale. A functional property of x-rays is that they travel in straight lines. That is, they consist of linear sequences of sine waves of extremely small (sub-atomic) wavelength. When a solid object intercepts the x-ray beam, x-rays are prevented from reaching the photosensitive plate in proportion to the density of the object’s material structure, and what we see is a negative image of the object (i.e., the denser an object, the brighter its x-ray image). Objects of lesser density will

* To provide retrospective support for these remarks, see my discussion of the latest MRI scan made of this part of my anatomy during July 2020 – Part 2, pp.77-79 below. The latest scan reveals signs of an unidentified ‘foreign object’ to the immediate right of the thoracic spine, close to the apex of the scoliotic curve. Although its presence has not yet been disclosed by the reporting radiologist, I argue on pp.77-79 that its presence is nevertheless self-evident in the scan images. It is anticipated that this evidence may ultimately provide essential confirmation of these speculations about the nature and causes of the symptoms associated with the area of my thoracic spine – speculations originally aired in my first edition of this report written in 2003 (re: items 25 & 30-32 on pp.14-15 & 17-20 in the Evidence section above).
have a higher degree of transparency and will appear less distinct. Certain forms of polyimide resins, chemically similar in origin to ‘Teflon’ (developed by Du Pont in the 1960s), when combined with certain ‘fillers’ of a microscopic cryptocrystalline structure, may be employed to influence the x-ray beam by enhanced diffraction of the sine waves, continually bending and scattering the x-rays at the sub-atomic level. This can create an effect of pseudo-transparency to x-ray vision, as objects appear as continually changing or ‘scintillating’, and therefore impossible to ‘fix’ radiographically.* The cumulative effect of myriad x-ray diffractions at the sub-atomic level can be employed to ‘cloak’ an object from detection by, in effect, ‘bending’ the x-rays around the object and hence artificially diffusing its actual density. The effect is somewhat analogous to that of an extremely out-of-focus object in front of a camera lens – if an out-of-focus object is moved increasingly closer to the lens without adjusting focus, the object’s penumbra may become so broad and diffuse that the object effectively disappears from view (in the case of x-rays, the property of focus is irrelevant, but the broadening of the penumbra is achieved through enhanced diffraction).

By employing such techniques of enhanced diffraction, hard solid objects, conventionally detectable by x-rays, can be made to behave radiographically as if they were soft tissue, such as is only effectively revealed by an MRI scan. Any solid object, metallic or otherwise, could be coated in a layer of polyimide incorporating crystalline filler to assist in concealing it. Polyimide, or flouro-polymer resins, are noted for their chemical stability and strength, have uses in semiconductor manufacture (x-ray lithography), and are employed in the manufacture of antennae used in NASA spacecraft. Polyimide is also employed in the manufacture of surgical implants, due to its inherent bio-compatibility.†

In a recent patent application entitled: Matte Finish Polyimide Films and Methods Relating Thereto, E. I. Du Pont De Nemours & Co. describe some of the functional purposes of polyimide ‘coverlays’ as follows:

“Broadly speaking, coverlays are known as barrier films for protecting electronic materials, e.g., for protecting flexible printed circuit boards, electronic components, leadframes of

* “There are various kinds of interaction between X-rays and matter. X-rays are absorbed in dependency on the density of the material. At an interface of two materials they are slightly refracted. Due to their small wavelength, which is in the order of the inter-atomic distances, they are diffracted at a crystal lattice. By defects, they are diffusely scattered. X-rays can be used to stimulate fluorescence.”

integrated circuit packages and the like. A need exists however, for coverlays to be increasingly thin and low in cost, while not only having acceptable electrical properties (e.g., dielectric strength), but also having acceptable *structural and optical properties to provide security against unwanted visual inspection* and tampering of the electronic components protected by the coverlay.” (my emphasis).*

Although this quotation offers only a general technical description of some of the properties of polyimide films, the references to its “*structural and optical properties*” in offering “security against unwanted visual inspection” confirms in principle the possibility of employing this material for the purposes I have suggested above, i.e., to facilitate the concealment of a surgical implantation which, if its disclosure were not prevented, would reveal a medical and ethical atrocity.

On the basis of the evidence disclosed above (and especially in view of the MRI evidence now presented in *Part 2* – see pp.48-50, 60-64, & 78 below) one is led to the uncomfortable conclusion, despite its apparent improbability, that there indeed seems to be a device (consisting of a series of part-devices, including a radiofrequency device) implanted in my neck, and also possibly in my thoracic cavity.† A further conclusion must be therefore that these items were implanted in my body through an incision in the back of my throat at the time of my tonsillectomy operation in 1967 (that being the only occasion prior to any of the MRI scans discussed in *Part 2* that I have had surgery under general anaesthetic). The question of the relative sophistication as well as the durability of such a device, considering the historical time-frame of its implementation, poses itself with some urgency. It is highly likely that there has been significant material decomposition and possible breakage of this device over a period of 56 years. This may help to explain the progression of certain of the symptoms that have been reported.

It would be possible to continue in speculation on the exact nature of the device and its technological justification if only in order to better understand its purpose. Engaging in doubtful speculation however is unlikely to strengthen my case (hence I have restricted my speculative thoughts on the subject to the section below devoted to *Technocracy* – pp.41-46). Besides, having reached a stage in this argument at which the substance of the claims made above begins to appear irrefutable, I have several urgent questions which cannot be answered on the basis of speculation:

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† On 28/07/2020, an MRI scan of my cervical/thoracic spine was produced that appears to confirm the presence of a self-evident anomaly (foreign object?) to the immediate right of my thoracic spine, very close to the apex of the scoliotic curve – see the discussion of this scan on pp.77-79 below.
1) What is the nature of its connection with the central nervous system?

2) What is the exact nature of its power source?

3) What is the scope for reversibility in the implementation of the device(s)?

4) How does the answer to the third question reflect upon the probity of the original design and inception of the device(s)?

5) Exactly what information from the transmissions of the device(s) was monitored, and/or recorded, and to what extent does it continue to be? For what practical or theoretical purposes has this information been employed?

I would suggest that in the light of this report the onus is now on those public authorities and institutions holding responsibility for this undertaking to provide satisfactory answers to these questions.

Ethics

The 1960s were a decade of immense scientific enthusiasm, even bravado. I think that many individuals in the scientific community must have felt that the emancipatory power of science was the basis of future prosperity and happiness, and that the advancement of this power-in-knowledge was limitless and accelerating. This gave it a kind of supreme confidence in its mission. It somehow acquired the transcendental authority to do pretty well whatever it liked, so long as the public confrontation with morality could be suppressed. The point here is that the advancement of scientific knowledge and understanding, whether it be of external nature, or of the internal secrets of the human organism – in this particular case, the workings of the brain – is rarely, if ever, disinterested or detached from the program of the instrumental deployment of this knowledge within spheres of activity in which it is in direct competition with the rights of individuals. The research program in question it seems was a singular arrangement (although comprising what is suspected to have been a limited series of similar or identical surgical procedures), requiring an unparalleled selection of subjects, and involving a multi-million pound investment. I understand also that it must have brought together a collection of what were at the time exciting and radical new technologies and methods (that is, in addition to an implicit interest in in vivo experimentation with effects of RFR on human biochemistry) – among them, solid state physics, microelectronics (semiconductors), radio or microwave communications and engineering, artificial intelligence, and cognitive neuropsychology; as well as any consequential advancement in the understanding of specific biological mechanisms. Unfortunately for me, I was chosen as a biological host for this modern-day Promethean enterprise. Allowing for the fact that the scientific community has fortified itself with an internalised ethical immunity, on what
possible conception of Right could such a proposition achieve the collective assent of a community of technocrats? Illicit and covert neurological experiments on humans (children), resulting in permanent and irreversible physiological damage? It is a truly shocking indictment of the moral decrepitude of our civil state; something which is parallel, in microcosm, to many of the atrocious medical experiments committed under the Nazi regime.

To begin to locate responsibility for such an undertaking is a matter of considerable complexity. The implementation of such a program of research will have required the complicity of many individuals working in various capacities, all sworn to a form of secrecy upon which depends the security and continuity of their respective careers. In addition to that, such morally questionable programs of research can rely on a certain amount of in-built discretion – an implicit division of labour – so that effectively ‘the right hand does not know what the left hand is doing’. In a covert program of research such as this, it ought to be possible to apportion blame relative to the extent to which we might judge the contribution of any particular individual indicative of a greater or lesser degree of global understanding of the general dimensions of the program. However, by itself alone the allocation of individual responsibility fails to address the wider issue – that it is the prevailing structures of health service governance which make possible the hijacking of public health resources for the purposes of covert medical or scientific research. It is a matter for grave concern that specialised scientific interests, given the requisite departmental authority and research imperatives, may succeed in evading the censure of public morality by simply acting covertly, on the pretext of routine medical procedures. The case is exemplary therefore in terms of its consequences for the autonomy of individual research subjects, for it generally undermines the trust that subjects must place in those providing information regarding the exact dimensions and health implications of any proposed program of medical treatment or research.

In 1964, the World Medical Association Declaration of Helsinki ratified a document entitled Ethical Principles for Medical Research Involving Human Subjects. This was amended by the 52nd WMA General Assembly, Edinburgh, Scotland, October 2000 (quoted below).* Key features of the year 2000 Declaration are the concept of patient autonomy and the primacy of the duty of care from the healthcare professional to the subject of the research:

“In medical research on human subjects, considerations related to the well-being of the human subject should take precedence over the interests of science and society” [Sec. A#5]

Clearly, in my own case it is rather the interests of science that have subsumed all other considerations. Central also to the Declaration is the imperative of obtaining ‘informed

consent’ from prospective research subjects, or from an authorised representative, where the subject is a ‘legally incompetent’ minor:

“In any research on human beings, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail...” [Sec. B#22].

Despite having for many years held my mother in high regard, I am now of the irrepressible conviction – and this is entirely consistent with all that has been said above – that my subjection to this fraudulent operation must have been procured on the basis of her consent. But that consent could not have been called ‘informed’ by any stretch of the imagination. My mother is characteristically quite gullible and easily intimidated by those in a position of medical or juridical authority over her. Neither does she have the intellectual capacity to comprehend the likely contraindications, nor the technical details, of this particular example of neuropsychological experimentation. Nor was she made fully cognisant of the actual purposes and motivations, nor the “the anticipated benefits and potential risks of the study and the discomfort it may entail.” Without wishing to absolve my mother’s crime, it is therefore my contention that my mother was unduly coerced, both by health professionals and by certain family members (my uncle [xxxx]), ultimately persuaded by the sweetening of financial reward. But my mother’s low social class and financial status meant that she would have been likely put in the frame of mind that it would be financially irresponsible of her to withhold her consent – to do so would be to sacrifice the chance of financial security for herself and her family, including myself.

The Helsinki Declaration also lays down guidelines that would proscribe the use of such coercion in obtaining consent:*

“Medical research is subject to ethical standards that promote respect for all human beings and protect their health and rights. Some research populations are vulnerable and need special protection. The particular needs of the economically and medically disadvantaged must be recognized. Special attention is also required for those who cannot give or refuse consent for themselves, for those who may be subject to giving consent under duress, for those who will not benefit personally from the research and for those for whom the research is combined with care.” [Sec. A#8]

My vulnerability as a ‘legally incompetent’ five-year-old research subject was specifically

overlooked. My mother’s vulnerability as an economically disadvantaged plebeian was specifically targeted as the weakest point in her resistance to actually granting consent. Clearly, this research program could only subsist through the flagrant and systematic denial of each and every human right and ethical principle that should rightly have been judged to prevail under the particular circumstances. On a first examination the case suggests itself as a potential claim of civil liability against an NHS authority (specifically the North Staffs Infirmary, under the North Staffs Regional Health Authority, now the University Hospital of North Midlands NHS Foundation Trust). Given all the necessary resources it would not be difficult to prove, in line with any successful negligence claim, that the primary duty of care from the health professional to the patient has been abrogated and continues to be abrogated. However, the case does not fit easily within the framework of a routine claim of clinical negligence. To begin with, it is hardly simply negligence or derogation of duty that is implied. What is alleged here is a deliberate act of bodily invasion for purposes which are essentially fraudulent. Furthermore, it constitutes at least a conspiracy to cause grievous bodily harm. It involves practices and issues that would be completely unprecedented in the field of medical claims in general. In addition to the obvious breach of the duty of care, there have been actions involving criminal intent not only against my person, but also, as the evidence suggests, against my (thereby deceased) father.

That then is a matter for the attention of the police. The process of any combination of civil and criminal litigation must have as its aim that of achieving the greatest yield of justice on the basis of the evidence available. Being so close to the centre of the issue, I am unlikely to be able to make a thoroughly objective assessment of the case, but it would seem that this case would represent an infringement of human rights of quite gross proportions, in other words some kind of moral atrocity akin to some of the worst cases of child abuse. It is certainly one of my principle wishes that in making public this issue, not only should the perpetrators be brought to justice, but that such an act of trespass on the rights and the personal sovereignty of anyone, especially those of a child, should never again be perpetrated, or be subject to co-operative concealment, on UK soil. In view of this I would suggest it would be desirable for a complete review of the principle of ‘legal competence’ from which capacity children are currently excluded.

It is hard to imagine a repetition of this kind of atrocity in the present day. The danger here is that the scale of the impropriety becomes softened with the passage of time and the potential benefits in terms of the advancement of medical and scientific knowledge provide retrospective justification for the means employed. Fortunately, the conduct of most scientific and medical research needs to comply with standards of openness that permits the enforcement of stricter ethical constraints. During the latter decades of the twentieth century there has been a widespread reaffirmation of respect for the pre-eminence of all forms of human and individual rights, which during earlier decades had tended to become
marginalised under the onslaught of a brutalising and totalising technocratic machine. But there is nothing in principle, save for a commitment to the persistent expansion, recognition, and implementation of individual rights, that can guarantee to prevent such a repetition.

On the analysis of the events to which I have referred, we are able to form a clearer understanding in retrospect of the ethical and political climate of the 1960s, in which scientific knowledge and advancement appears to be very closely allied to the interests of the nation state. The phenomenon of the ‘space race’ provides an excellent example of this coalition of interests. The program of the salvage and protection of human rights (exemplified by the establishment of the European Convention on Human Rights, and by the ratification of numerous international protocols to protect individuals from the vagaries of corporate and institutional power) was, during the epoch of the 1960s, very much in its early stages. At this time it seems it was entirely plausible to make this kind of ethical trade-off, subsuming any notion of individual sovereignty to the higher aspirations of national enterprise and technological prowess, especially when the secrecy of such an act of moral debasement could be confidently maintained. It is consistent that, subject to the findings of an independent inquiry, ultimate responsibility for such a research program should be located within executive levels of the machinery of State, independently of which the fabric of secrecy could not be maintained. At the horizon of this issue is then a crisis in the ethical distribution of justice, in the maintenance of the sovereignty of the rights of the individual subject, and in the capacity of the state constitution to conceptualise and inculcate those rights within an ethical code of law, one that is not under constant threat of being relativised according to circumstance. It has been a perennial problem within UK law how to incorporate well-established principles of international law in respect of human rights into a system in which the judiciary must apply jurisprudence to the common law in order to interpret otherwise incomplete legislation.* The result of this is a series of ad hoc judgments serving by default community interests, and by which generalised principles of individual rights are marginalised and effectively eclipsed. Nowhere is this more apparent than in the exercise of health service legislation, and the comments in January 2001 of the then Health Secretary Alan Milburn on the subject of the scandal at Alder Hey are apposite, if rather optimistic:

“The days have gone when the NHS could act as a secret society […] It cannot operate behind closed doors. It cannot keep patients in the dark. It has to actively earn the trust of patients. […] And if things go wrong it needs to explain why, it needs to be quicker to say sorry. In short, the NHS has to be open and honest in dealing with the people it serves. It is the right of the individual, not the right of institutions, that counts.”†

If this is so then such an effect will have been greatly facilitated by the incorporation of the European Convention into UK law by the **Human Rights Act, 1998**, which came into force on 2 October, 2000. Since then it has been illegal for any public body such as the NHS to act in a way that is incompatible with the rights of the individual as they are laid down in the Convention. Prior to the Human Rights Act, victims of infringements of Convention Rights would have had to apply to the court in Strasbourg to have their case heard. The Act now provides for such cases to be brought in the UK courts; however, there remains a problem over the miscibility of a fairly concise *written* code with an institution as loosely-bound as English Common Law. When it comes to presenting test cases of the HRA within English courts we still end up in the constitutionally critical and rather recursive position of having the Judiciary legislate on its own Executive because the latter is inherently corrupt and is the master of the Legislature, not properly its servant. The fact that Convention rights have become domesticised still does not provide us with the guarantee that the existing institutions of law will be able to prosecute infringements effectively, let alone prevent their commission or concealment. There is the problem with the ‘ecological validity’ of this inherited legal remedy – that it would depend on the capacity of the State to vicariously judge itself as acting (in this case) *criminality* within the terms of its own common law. The NHS is after all a public institution, served by a ministerial department. The principle motivation of this report has been to try to prevent the repetition of such acts of corporate and institutional malfeasance, that is, to remove the conditions of their structural possibility. It is not sufficient in my view to provide more efficient means to prosecute the perpetrators of such crimes, or the means for them to make quicker apologies. To begin with, in order to achieve such an assurance, we must examine what are the principle aporias in NHS governance that permit the conduct of unethical medical or scientific research on human subjects, as it were, behind closed doors. It is important that any corrective measures taken must be pre-emptive in scope – the current adversarial system of litigation is ill-equipped to provide anything other than compensatory relief for the victims of research malpractices, after the fact, and offers little guarantee of protection against their repetition.

**Consent**

At the forefront of this issue is the problem of consent. One of the principle difficulties faced by the parents in the Alder Hey case was the difficulty of making a legal case on the issue of consent, simply because the law on consent is unclear. The fact that one has given one’s consent provides no indication as to the quality of that consent, upon what information that consent is based, or upon the institutional affiliations of the informant, or upon the duration or the depth of the consent. The mere fact of consent provides no clues as to the reasons or the understanding of the consenter implied in his or her consent. Taking the scenario of my mother’s provision of consent as an example, supposing that my mother had raised any
question as to the ultimate safety of the proposed implantation (which it seems inevitable that she must have, however vaguely), it is likely that she would have been confidently reassured on that point, so as not to provoke the slightest grounds for her to refuse her consent. This would have been to disregard the fact that the informant could not have been fully cognisant (since the proposal was previously untested, and medically uncertified) of all the potential side-effects and contraindications – for instance, that it might result, as in fact it did, in persistent daily headaches, as well as an array of other unforeseen and debilitating consequences.

Why is it then that a parent, on the basis of some putative idea of ‘informed consent’, can subject her offspring to potentially lethal or otherwise damaging practices, simply because, in the process of her becoming ‘informed’ the health professional responsible for eliciting consent has done little more than misinform, seduce, and possibly intimidate, on the basis that that professional has, to all intents and purposes, a limited appreciation of the full medical implications of the proposed plan of action, and is likely himself acting under pressure from some presumed higher authority, or financial inducement?

“Scientists are human beings, and are subject to the same foibles as any member of other sections of society. They are just as capable of cheating, lying, sharp practice, self-deception and the full spectrum of crimes and misdemeanours as anyone else. So why should we believe anything that they tell us?”* 

This may be a cynical view, but it is unfortunately the case that the provision of consent is treated on most occasions as little more than a legal hurdle which must be passed with the least inconvenience, and, in this particular case of covert practice, with as little risk of disclosure as possible. The fact that a child is deemed ‘legally incompetent’ should not imply that the adult responsible for that child’s care has a right to make decisions that impose upon the child’s physical autonomy. The problem with the designation of ‘legal incompetence’ is that with the best intentions it allows the ethical code of beneficence to override the code of autonomy.† We tend to rely upon the efficacy of adult beneficence, as a guarantee of the exercise of due care, and to disregard the validity of a child’s volition, or the truth value of her statements. This has the effect of disempowering the subject and exposing her to a wider spectrum of risk, so that beneficence is easily supplanted by malfeasance, as is so often the case in human affairs.

**The NHS Litigation Authority**, in its willingness (at least in 2003) to provide information on the implementation of the HRA within health service litigation, has suggested the

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* The Ethical Conduct of Scientific Research, 1998, by Rod King.

following:

“[T]he current legal position which permits children to be treated against their will if their parents consent, even where they are mentally competent to make their own decisions, might be challenged under Article 14 in conjunction with Article 8. Such a challenge might be argued on the basis that it is discriminatory to make a distinction between mentally competent adults (who cannot be treated against their will, other than under mental health legislation) and mentally competent children when respecting their private life.” * 

When we use the idea of rights as applied to a child we employ a different concept of right than when we speak of the right to freedom of choice, expression, or will. The rights of children are usually formulated in terms of a child’s vulnerability to exploitation or abuse; that is, they are conditionally passive rights which emphasise the need to protect a child from aberrant adult behaviour. As parents we are invariably in the position of having to decide whether, in any given circumstance, we should apply the principle of protection or the principle of autonomy in respect of our children’s behaviour; however, the perception of risk is often blind to the actual presence (or absence) of real or potential threat. Parents may habitually take the safer option, but this implicit over-protectionism deceives us of the reality that the vulnerability of children is a condition of the accumulation of ideas and commonsense notions that adults have for and about children. It is a legacy of a rather Victorian idea of childhood as a special state of innocence or ‘unworldliness’, which has a negative corollary in the idea of children as social liabilities – better seen and not heard. Few people would consciously defend such an attitude these days, but this does not alter the fact that many of the social structures which exist for the management and care of children are constructed upon archaic notions of what constitutes the very idea ‘childhood’, and of what determines the responsibilities of adults to and for children. The idea of children as ‘legal incompetents’ is a legal anachronism, coextensive with the Victorian idea of children as behavioural liabilities, incapable of making equitable decisions or of holding or voicing valid opinions. In the strict legal context children are stripped of their identity and of their right to dissent. The only certain conclusion is the disempowerment of children and their inhibition from making the kind of informed choices and intuitive judgements that are essential to the processes of maturation. It is to repeat the common adult fallacy which interprets a lack of the skills required to communicate understanding, mistakenly, as a lack of understanding itself. Consider, for example, the questionable safeguard of ‘protecting’ children from attendance at the funerals of their deceased parents. After all, is it possible, or desirable, to inoculate a child from the experience of bereavement?

Despite the existence of numerous conventions and protocols, which express well-

intentioned and laudable principles in respect of the rights of children across the globe (I have in mind, in particular the UN Convention on the Rights of the Child, Nov. 1989), the lived experience of countless millions of children fails to live up to these high expectations. According to the Convention it is invariably the duty of the state to ensure the enforcement of these principles. But how do we know whether or not, and in respect of each individual circumstance, these duties are being respectfully met? How much time and money does the state spend in attending to these particular duties in situ, or is it more often the case that institutions bearing a duty of care to children are inadequately prepared for the execution of this duty, are poorly regulated and audited, so that we simply do not have the information with which to provide an accurate response to these questions? We have already seen that the law has a fundamental problem in resolving the requirements of protection of children with the principle of autonomy, so while it may in theory be obliged to respond to infringements of the rights of children with judicial rigour, due to the implicit disempowerment of children under UK law, the chances are that the great majority of cases of human rights and other physical abuse of children are simply neither recognised nor accounted for. An adversarial legal process is unfairly biased against the prosecution of cases relying to a large extent on the evidence of individual testimony, especially where that evidence is discreditable for reasons of immaturity, inhibiting the prospects of successful prosecution either at trial or pre-trial. The success of prosecutions against perpetrators of child abuse is, I fear, under current judicial arrangements, never more than the tip of the iceberg, for the reason that children, by and large, are not equipped with the means to notify of incidents of abuse, or even to know exactly when their rights have been violated.

To return to the issue of medical research in particular, this is an area which spans a diversity of institutional profiles and regulatory mechanisms, but it is not an area which presents a high volume of risk of abuse when compared with other institutions (in particular those of Care and Education). It is hard to judge if we might ever be in a position of being able to legislate effectively against the truly corrupt instances of clandestine abuse such as that I myself have suffered. But at least we can try to build into the state apparatus mechanisms which offer us some greater confidence in the ability of the state to self-regulate over such issues. The extension of ethical review committees into all areas of health service practice might be a step towards resolving the appalling regulatory mess that currently prevails. The imposition of independent audit commissions as well as supervised commissioning for research is a priority. Particular attention should be paid to the methods of sourcing of potential research subjects to avoid the targeting of vulnerable minorities. For instance, in my own case, how important to the implementation of the research was the selection of a Catholic school as a research venue? Catholic minorities (in the predominantly Protestant UK) are financially underprivileged, have larger families, and are more likely for these reasons to succumb to pecuniary persuasion.
Technocracy

In terms of our everyday expectations, it is hard to imagine how a program of research such as this might have been conceived at all, let alone actually implemented. Taking into account the enormity of the ethical transgression which it implies, we will need to look beyond the simple disinterested pursuit of scientific knowledge for a credible motivation. One problem for the lay public in facing up to the probable reality of this disclosure is that an acknowledgement of its truth first requires an understanding of the urgency of the necessity behind the proposal; i.e., as a scientific and technological imperative. In the absence of that understanding, the tendency will be for lay opinion to revert to denial, in natural defence against the extraordinary horror incited by the prospect of the truth of the disclosure.

Some speculative discussion of the meaning of the research in terms of its implications for the advancement of science and technology viewed within the historical trajectory of the mid-1960s is required therefore in order to understand how this research proposal was expected to fulfil the promise of access to knowledge that could not have been acquired by any other possible (i.e., ethical) means; and in the absence of which recondite data considered indispensable to the further progress of certain technologies during this period was understood to be simply beyond the reach of contemporary scientific discovery.

The scientific understanding of the executive functions of the brain, in terms of either: a) the localisation of functions within specific parts of the brain, and the interrelationship of those functional parts; or in terms of: b) the neurophysical and neurochemical operations at the cellular-synaptic level, had previously been limited, in terms of a), to neuropsychological studies of brain-damaged patients (deductions of localised cerebral function arrived at by matching impairments in motor or executive functions to specific localised injuries); or, in terms of b), to the post-mortem dissection of dead brain tissue. Both these forms of investigation were rather limited in scope. Neuropsychological investigations might have been successful in isolating which areas of the brain were necessary to certain discrete cerebral or motor functions, but were able to establish little definitive information about the precise order and sequence of cerebral processes and their dependencies. Likewise, microscopic examination of dead brain tissue led only to hypotheses about the activity of neurones and neurotransmitters in a living brain.

The post-war period was characterised, in technological terms, by a drive towards the codifying of information electronically, i.e., digitally. Alan Turing’s successes in breaking the Enigma Code at the end of WWII had suggested to information scientists that much of the processes involved in the collation, sorting, and adjudication of information might be handled more efficiently, and in ways that might guarantee freedom from human error, if they could be ‘outsourced’ to machines. Turing had precipitated this trend in his
experimental concept of intelligent machines. Turing’s belief was that mental operations could be broken down into a series of finite logical steps, and that therefore it was theoretically possible to build a computational machine which could imitate these operations in their entirety. Again, technological development in this area faced two major limitations. Firstly, early computers had to be enormous in size due to the multiplicity of non-solid-state electronic components (valves) requiring individual connections; and storage media were limited to paper punch-cards and magnetic tape – limitations that perceptibly would be gradually reduced along with a slow advancement and refinement in materials and electronics. Secondly, what level of sophistication of intelligent operations was it reasonable to expect from machines? While these two factors were clearly interconnected, an answer to the second problem was more difficult to perceive by projecting forward advancements in electronics, as it involved putting the question: What is the nature of intelligence?

Turing’s idea was that a distinction between conventional machines, i.e., those limited to a fixed number of discrete states, or phases, and theoretically possible ‘intelligent machines’, should be made on the basis of the prospective ability of the latter to imitate any conventional machine, at least in virtual terms, by the incorporation into its mechanism of a potentially unlimited number of new routines, by methods of successive digital encoding. The digital computer, as a basic theoretical concept, is thus understood as a universal machine. The defining characteristic of digital computers is therefore their capacity to ‘learn’ new routines, or programmes, and the only limitations on this potential are the practical ones of available digital storage and processing power. In its distinctive learning capacity, the digital computer is conceived to be analogous to the brain of a child (as exemplified by a child’s special ability to rapidly absorb new languages, for example).

In his 1950 paper: Computing Machinery and Intelligence*, which is accepted as a seminal treatise in the emergence of the discipline of Artificial Intelligence, Turing sets a formative agenda for the process by which digital computers might succeed in imitating the functions of an adult brain:

“Instead of trying to produce a programme to simulate the adult mind, why not rather try to produce one which simulates the child’s? If this were then subjected to an appropriate course of education one would obtain the adult brain […] Our hope is that there is so little mechanism in the child brain that something like it can be easily programmed. The amount of work in the education we can assume, as a first approximation, to be much the same as for the human child.” [Turing, 1950, p.456]

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And further:

“We may hope that machines will eventually compete with men in all purely intellectual fields […] It can also be maintained that it is best to provide the machine with the best sense organs that money can buy, and then teach it to understand and speak English. This process could follow the normal teaching of a child.” [Ibid., p.460]

As an expression perhaps of the sublimated aspirations of scientific advancement, the 1950s and 1960s saw an expansion of the genre of Science Fiction, which populated an imaginary universe with aliens, humanoids, androids, and robots, with varying degrees of sophistication. Naturally, the fictional products of the literary imagination generally outstrip what is achievable in terms of everyday scientific reality; but the former tend to set dimensions of conceivable expectation with reference to the latter. Certainly, from this period onwards academic discourse in the areas of Experimental Psychology and the Philosophy of Mind began to orient itself to the discipline of Artificial Intelligence, eventually leading to the development of Cognitive Science as an academic discipline. It would have been difficult for anyone, even the most down-to-earth scientist, to conceive a model for the future which did not involve forms of robotic technology, employing a cybernetic model of intelligence based on human intelligence. The desire then for the establishment of such a cybernetic model gained support both from futuristic projections of technological advancement, but also from the present day need to define more accurately the scope and direction for primitive computational ‘intelligent machines’. If those machines should begin by making basic approximations of human intellectual processes, the future development of those machines required a more sophisticated understanding of the workings of the human brain, with particular emphasis on the developing child’s brain; more sophisticated that is than those which had so far been deducible within the fields of Neuropsychology, Experimental Psychology, Behavioural Psychology, or from the study of dead brain tissue.

Artificial Intelligence is not a discovery, nor is it a fact. It is a model – an attempt at a copy, or a reduction, of human intelligence in so far as the latter is understood as a logical mechanism. This leaves much about human intuitive and associative thought processes untouched and unexplained. Nevertheless, an understanding of such a logical mechanism pertaining to the operational neural networks of the brain, as it might be appropriate to imbue machines with the power of something-akin-to-a-thought-process, was lacking in the mid-1960s. Hence the appearance of a technocratic imperative to overcome this hurdle in the advancement of scientific knowledge, perhaps once and for all time. The problem with such a research demand was that the neurological processes under examination, that is, live in vivo cerebral functions at molecular scales, are not accessible to normal scientific observation and measurement without some means of invasive probing of an active human
brain in a conscious living subject. The project therefore faced an immediate ethical hurdle – not only would the methods required be unprecedented and previously untested, but the application of those methods, in order to unlock the secret of a person’s intimate cerebral processes, would, in any conceivable practical context, be highly morally objectionable.

Such was the degree of imperative attached to this research project that, in the face of anticipated public disapprobation, it demanded that the subjects of the research be kept entirely unaware of the methods by which they were being examined, or it would never pass public ethical acceptance. In addition, and as a consequence of this necessary secrecy, the information required needed to be collected remotely (and therefore continuously), and which therefore necessitated the illicit bodily implantation of a series of devices to record and transmit this information discretely. We may infer further that this requirement necessitated the arrangement of a surgical opportunity, on the convenient pretext of a routine tonsillectomy (in any case, a medical procedure frequently employed proactively upon essentially healthy children), whereby these devices could be implanted permanently, and irreversibly, and in such a way that guaranteed that they might not later be discovered coincidentally by routine medical examination.

It is more difficult to speculate on the exact form or content of the information thereby transmitted, without some more intimate knowledge of the research programme. But I think it fair to assume that, as a minimum, some form of representation of brain activity from differing functional areas of the brain (cortical, parietal, occipital, limbic, etc.) was required to be measured (with particular attention to the brain stem – medulla – as the ‘basic input-output system’ for the brain), so that the correspondences between these areas during various executive tasks could be appreciated sequentially, probably in the form of a series of matrices. It might then be possible to construct a categorical model of brain functions in terms of the interrelations of executive functions, sensory functions, short-term and long-term memory, storage, retrieval, search, association, etc., by combining existing neuropsychological knowledge regarding the localisation of cerebral functions with new data signalling the interactions and dependencies between those functional parts. As an example of the conceptual parallels existing between contemporary neuropsychology and cybernetics, the former employs such concepts as “the Central Executive” and “Working Memory” when referring to the topology of cerebral functions – compare these two in particular with the Information Technology categories: Central Processing Unit (CPU) and Rapid Access Memory (RAM).

There is little more that I can confidently assert from the evidence available to me – the full extent of the connectivity of the devices is not so readily accessible from the images presented in Part 2 of this report (see: pp.48-50, 60-64, & 78 below), that is, without more specialised training in neuroanatomy, and further dedicated scan procedures; in particular
MRI scans of my complete thoracic cavity.* It remains to say that this research programme was clearly atypical in its design and scope – there was no apparent requirement, for instance, for the kind of representative sampling of research subjects that is characteristic of medical research in general. Perhaps any normal functioning brain would have satisfied requirements, but it seems I was selected in part for my above-average intelligence. It is unlikely that I would have been the sole research subject, but there would certainly have been few others. It was also atypical in the sense that it was not research directed principally at improvements in medical treatment and care, but seems to have gained its chief impetus from scientific and technological imperatives outside the field of medicine.† Clearly, this research programme was intended to supply information that would be seminal and irreplaceable, and might not require to be repeated in quite the same form. Most importantly, it could conceivably be kept tightly secret.

Of course, the industry that has benefitted perhaps more than any other from advancements in information technology is that of the weapons and defence industry. For this reason I think it is reasonable to speculate further that a key impetus for this research programme will have been provided by the UK Ministry of Defence. The burgeoning technocracy of the post-war period has been engaged in a relentless pursuit of progress whereby the ends, however imperfectly conceived, can always be made to justify the means. The global stalemate in nuclear threat which was such a defining characteristic of the sixties, seventies, and eighties, has given way to an imperious domination in asymmetrical conventional warfare, assisted principally by advancements in electronic communications and information technology. In the key area of military supremacy, Western technocracies acquired by expediency the mandate to supervene over all human considerations – for the ‘greater good’ of homeland security – and this mandate impels a kind of sheep-like obedience to the imperatives of technological advancement. In order to fulfil the dream of technological prowess, certain moral and human sacrifices must be made. The question which must be asked is: How did the progress of scientific and technological advancement become so prepossessed with the idea of its own nobility, such that it is now capable of forgiving itself the grossest of ethical atrocities?

Speaking as a victim of this kind of atrocity, I am acutely aware that my complicity was not

* At the time of first writing this (in 2003), there were no existing MRI scans of my thoracic cavity. Since 2015, there have emerged three such scans of my thoracic/cervical spine – these are discussed in detail in Part 2 of this report, pp.72-80 below.

† While it seems reasonable to conclude that the dominant impetus for the research arose from within the cognitive sciences, vis-à-vis the pursuit of Artificial Intelligence, it is not unreasonable to speculate, since the research clearly provided an unprecedented and unique opportunity for the study of in vivo neurological processes, that the knowledge acquired may have facilitated a range of consequential advancements across a diversity of medical fields.
a prerequisite. Quite the opposite, for it depended on my absolute ignorance, to be maintained at all costs. My identity in this matter is of little consequence – it could have been anyone, though pitifully it had to be a child, and one of high intellectual capacity, and of sufficiently young age to be at a formative stage of linguistic development – a factor which in turn effectively inhibited the processes of understanding that might have enabled me to conceptualise what it was that had actually happened to me at the age of five. The imperative of non-disclosure necessitated a policy of non-intervention and disregard towards an array of biological contraindications which had the ultimate effects of isolating me from the pleasures of social engagement, as well as from the fruits of personal or professional achievement. While my mother, and subsequently my sister, became habituated to a regime of rigid silence and dissimulation over the issue, I was left to struggle on alone, effectively incapacitated by my symptoms.

Leaving my personal difficulties aside, my father has suffered an even more tragic fate – to be murdered at the hands of his doctor and surgeon. My mother clearly had priority in the arrangement and consent for my fraudulent tonsillectomy operation. When my father’s suspicions were alerted by the disturbing changes in my behaviour and in my appearance following the tonsillectomy, he challenged her over the propriety of that arrangement. She alerted her affiliates and as a result he was expediently killed in order to silence him. I am aware of the absence at this point in time of any prima facie evidence to confirm this specific allegation; however, the medical evidence published in Part 2, albeit as yet uncorroborated, will ultimately confirm my allegations with respect to the illegal nature of my tonsillectomy operation, thus reinforcing the allegation of foul play in my father’s death, and further mandating its full and proper investigation.
PART 2
(2004-2020)
Part 1 of this document was first published on the Internet in June 2004, following my submission of the evidence to both the Metropolitan and Staffordshire Police forces in late 2003. I had received a reply in 2003 from the Staffordshire Police that, due to the lack of any prima facie evidence in my report, there were insufficient grounds upon which to pursue an investigation. I later learned from my sister herself however that police officers from New Scotland Yard had visited her (in 2003 or 2004) with some questions regarding my allegations. I have no information regarding the outcome of that investigation.

There was a degree of frustration with this lack of interest or response from the police, and my investigations subsided. The seriousness of the allegations was too great a responsibility for an individual to pursue alone, as it was unlikely that I would be taken seriously, particularly in view of the absence during this period of any item of prima facie evidence with which to support the allegations. In addition, to have persisted openly would have exposed me to the possibility of attempts on my life being initiated by those with most to lose from a public disclosure of the matter. However, I did present my concerns to several GPs, which inevitably led to concerns that I was suffering from some form of delusional illness. Subsequent meetings with psychiatrists were ultimately inconclusive however, and I have not been diagnosed unequivocally with any recognised psychiatric disorder.

MRI Evidence

In July 2007, I placed myself under the supervision of the South Thames Assessment & Recovery (‘START’) Team of the South London & Maudsley NHS Trust (‘SLaM’), who are a mental health outreach service assisting homeless people, principally because of social problems I was experiencing, including homelessness and the alienation from my family, but also with a view towards enlisting professional help in testing the authenticity of the allegations I had previously made. I remained under their supervision, largely through my own insistence, until I agreed to be discharged in June 2010, after finally settling into accommodation. During this three-year period I did not receive any formal psychiatric diagnosis from a psychiatrist at the START Team.

During my supervision there I was referred for a Brain MRI scan at St Thomas’ Hospital, London, which was made on 2 October 2008. In April 2009, I received a consultation with the neurologist Dr Thomasin Andrews at Guy’s Hospital over the scan, during which she reported nothing anomalous to be revealed in the scan. However, after obtaining my own copy of the scan in December 2010, and after lengthy examination and reflection on the scan contents, I arrived at the conclusion that several images in the scan reveal what appear to be self-evident anomalies. On the internet page: http://somr.info/report there are published a selection of three vertical (coronal) sections from Series 7 of the scan. Series 7 of the scan
comprises 26 such vertical sections, beginning from the front of my skull and progressing rearwards. Sequential slices are approximately 6mm apart. The selection is a 3-image sequence – 7.13, 7.14, and 7.15 – starting approximately at a midpoint between front and rear, including the spinal column, and is displayed below in enlarged details with 3x magnification (for access to the full images, or if reading this document in printed form, see the online versions at the web address quoted above). There are possibly further anomalies revealed in other images from the MRI scan that I have not identified.*

A close look at the sequence reveals what appears to be a foreign object to the left of the spinal column just below the base of the skull (right & left are reversed in the images, as in a mirror image). The object appears in cross-section as a small circular object with a cylindrical or torpedo-shaped projection, of at least 12-15mm depth. In the enlargement of section 7.14 below, one gets a distinct impression of the internal ‘C’ structure of this object, which perhaps indicates some clue as to its functional composition:

* For reference purposes, and for purposes of verification, the contents of the original full MRI scan CD (plus that of the 2nd scan referred to below on pp.60-64) is available as a compressed ZIP download, at URL: http://somr.info/report/rep9.php – accessed 27/05/2023.
In the enlargement of section 7.13 below, approximately 6mm forward of 7.14, there also appear to be two linkages associated with this object, and which proceed upwards towards the base of the skull:

![Brain MRI coronal section 7.13 (detail)](image)

The enlargement of section 7.15 below, approximately 12mm to the rear of 7.13, is the furthest-rear image in which the object is visible. It appears somewhat narrower and less circular than in the previous two images, suggesting it approaches its limit at this point:

![Brain MRI coronal section 7.15 (detail)](image)
There was a six-month delay between the date of the scan procedure in October 2008 and my consultation with Dr Andrews in April 2009, due to the fact that the scan results were not sent back to the referring physician at the South London & Maudsley NHS Trust until nearly three months after the date of the scan procedure. It was not possible to make arrangements for a consultation until these were produced, in December 2008. Since obtaining my own copy of the scan in December 2010, I have tried to obtain medical corroboration of this evidence, both through the NHS and privately. However, the extremely controversial nature of what is revealed in the scan has meant that these attempts have so far proved unsuccessful, as no doctor has been prepared to take on the initial responsibility for its disclosure.

Following the scan procedure, Dr Crews at the SLaM Trust informed me that he was having considerable trouble locating the scan results, but eventually the Radiology Dept. at St Thomas’ Hospital sent a report of the MRI findings to the SLaM Trust on or around the 23 December 2008, i.e., eleven weeks following the date of the scan itself. I have seen the notes made by the SLaM Trust which relate to this report, which transcribe the findings as:

“Ventricles normal.
There are a few small periventricular and subcortical sulci consistent with minor small vessel ischaemia.
There are tortuosities of the left vertebral artery leading to slight mass effect on the dorsal aspect of the medulla.
No evidence of trauma, brain injury or space occupying lesion.
Conclusion: Minor small vessel ischaemia. No significant intracranial abnormality identified.”

There is nothing in these findings which alerts to any cause for concern, in view of my age, and nothing that identifies the significant anomaly I have pointed out in the images above. Both the Radiology Dept., and later Dr Andrews at Guy’s Neurology Dept., deliberately avoided any mention of this self-evident anomaly. An explanation for this reticence I suggest must be sought in the fact that the anomaly is not one that is predicable or identifiable in terms of conventional neurological diagnosis, originating as I suggest it does from a clandestine medical invasion. As this object has clearly not arrived in my neck by accident, but by an illicit and covert design, for Dr Andrews to have openly disclosed it to me would inevitably have exposed her to extreme personal vulnerability – of the kind that I have personally been exposed to since making a request for a copy of the scan from St Thomas’ Hospital in December 2010 (for further elaboration on this point, see below pp.81-97). My understanding is that any individual doctor might find him- or herself similarly unable to discuss or disclose it, not wishing to be compromised professionally, and with a view to his or her own personal safety. What possible words might they volunteer to describe this phenomenon?
In an attempt to locate a copy of the original report made by the Radiology Dept. at St Thomas’ Hospital, I made a subject access request under the Data Protection Act to St Thomas’ Information Governance Dept. on 29 June 2012. I eventually received copies of my Guy’s & St Thomas’ NHS Trust (‘GSTT’) medical records from the IG Dept. on 2 October 2012. However, these did not include a copy of the MRI findings report. I then made an arrangement to view my records in person at the hospital on 13 November 2012. I also filed a complaint with the Information Commissioner’s Office (‘ICO’) to address the failures in the IG Dept.’s response. On viewing the online copy of my MRI scan at the hospital, in the relevant “Reports” section, the only written information was “no reports found”. I insisted to the manager that there must have been a findings report, as one had been sent to the SLaM Trust on 23 December 2008. She said she would make enquiries with the Radiology Dept. I later received a call from the manager to say she had found the report, and I should return to the hospital to collect it.

I now have a copy of the missing MRI findings report (verified by Dr Scott Hawkins on 6 October 2008; first typed by “RJ1RANV” on 2 October 2008). The content is essentially the same as that transcribed into the SLaM notes; i.e., concluding with: “No significant intracranial abnormality identified”. In an update to my complaint to the ICO I asked that they consider the following issues:

- Why was there a delay of eleven weeks between the writing of the MRI findings report, and its being forwarded to the referring physician at the SLaM Trust?
- Why was the findings report not attached to the online copy of my MRI scan?
- Why did it take four-and-a-half months from the date of my subject access request, three separate visits to the IG Dept., and numerous telephone calls, for the IG Dept. to fulfil my request for a copy of the MRI findings report?

My own conclusion must be that, as the item revealed in the scan images above is significantly anomalous and highly controversial, the physician who wrote the report deliberately omitted to disclose the anomaly in order to occlude any further attention to it. I further conclude that the MRI findings report was then intentionally sequestered from my online record, in an attempt to obscure the identity of the reporting physician.

The ICO advised me, on 14 March 2013, that it did not fall within the remit of the Data Protection Act 1998 to address either the issue of the eleven week delay in the initial forwarding of the MRI findings report, nor my wider suspicions regarding the reasons for the failure to attach that report to the online scan record. However, the ICO requested that GSTT explain the ‘filing system’ under which the MRI findings report was stored, and the reason it was not attached to the online copy of the MRI scan. They advised me that in order to address my concerns falling outside the remit of the Data Protection Act, and if I was
subsequently dissatisfied with GSTT’s response to the ICO’s enquiry, that I should complain separately to GSTT itself.

The response from GSTT to the ICO’s enquiry, which was sent to me on 12 April 2013, included the following explanation:

“When a patient has a radiology exam at the Trust the images are taken and stored in the image application Picture Archiving and Communication System (PACS). The image is then reported on by a radiologist and that report is written in another application called Computerised Radiology Information System (CRIS). If the digital stamp that is created by PACS for the image is not the same as for the report, then the report cannot be attached to the image in PACS. Therefore, when the Information Governance staff were looking for the report as an attachment to the image in PACS, it was not found and an assumption was made that one did not exist”

This explanation does not however explain under what circumstances the ‘digital stamps’ respectively created under ‘PACS’ and under ‘CRIS’ would permit a report ever to be successfully attached to the online record, which we must expect to be the standard requirement. If the respective digital stamps are required to be identical, or to have some additional digital association, then why were they not so in the case of my scan images and report?

In view of my dissatisfaction with GSTT’s response to the ICO, I submitted a letter of complaint to GSTT’s Complaints Office on 19 March 2013, requesting explanations for the eleven-week delay in the initial forwarding of the MRI findings to the referring physician; the failure to attach the findings report to the online copy of my scan; and a full explanation of the reasons why neither St Thomas’ Radiology Dept., nor Dr Andrews in Guy’s Neurology Dept., had seen fit to alert either the referring physician or myself to the evident anomaly revealed by the MRI scan.*

I received an initial acknowledgement of my complaint dated 20 March 2013, expressing the Complaints Dept.’s aim to respond “within 35 working days” (the published complaints guidelines specify “25 working days” as the routine response time). I then received a second letter, dated 16 April 2013, advising me that “due to the seriousness of the issues raised” in my complaint, that their investigation cannot be completed within 35 days, but to expect their response “within the next 4 weeks”. Their response was therefore anticipated by 14 May 2013. Following enquiries towards the end of May, I was informed that the response to my complaint had been written on 16 May 2013, but that the response could not be issued as

it awaited approval by the Trust’s Chief Executive, Sir Ron Kerr. I finally received their response in the first week of June, dated 3 June 2013.

With regard to the absence of the MRI findings report from the online copy of the scan, the response merely repeats the explanation given earlier (quoted on the previous page) to the Information Commissioner’s Office and so, for the reasons stated above, remains unsatisfactory.

With regard to my complaint over the reticence, or the cover-up, by St Thomas’ Radiology and Guy’s Neurology Depts., over the evidence of the anomalies revealed by my scan, page 2 of the response describes the original process of the reporting of the scan findings, and restates a version of the original conclusion; i.e., “No significant intracranial abnormality and some small vessel ischemia.” (it omits the word “identified”, after “abnormality”, in the original). It states: “[Y]our MRI has been reviewed again by the Neuro-radiologists on 8th May 2013. They say that they agree with the original neuro-radiology report of Dr Hawkins”. The response however includes no documentary statement of this ‘review’, and no indication of the identity of the physician(s) affirming this second opinion. It remains therefore entirely unconvincing. As a reminder of my earlier assertion, it was in an attempt to obscure the identity of original reporting radiologist that the MRI findings report had been sequestered from the online copy of the scan.

The response goes on to state:

“The specific structures about which you have expressed concern and which you have highlighted on your website are as follows:- the sagittal sinus (a vein running across the brain between the two hemispheres), and the left vertebral artery (seen with some surrounding soft tissue). […] I have been advised both are normal structures and are seen on all MRI Brain.”

At the time of making this complaint, the images presented above (pp.49-50) included some speculation about image 7.26 (of the extreme rear of my skull), in addition to images 7.13-7.15, which I had thought may have also been anomalous. I am now satisfied that image 7.26 is an image of the sagittal sinus and is normal, so I have now removed this reference. The remaining images, being the 3-image sequence 7.13-7.15, are those it is suggested in the above quotation are explained in terms of the “left vertebral artery” – an explanation which is quite unsatisfactory as the revealed structure of the object referred to in these images is not at all adequately explained in terms of arterial material and “surrounding soft tissue”. This explanation does not adequately account for the variation in density (indicating a variation in material composition) suggested by the internal ‘C’ structure of the object seen in image 7.14 (p.49); neither does it explain the two mysterious linkages proceeding upwards from the object seen in image 7.13 (p.50).
In this refusal to address the evident anomaly revealed in images 7.13-7.15, GSTT’s response to my complaint merely recapitulates the serial cover-up of this evidence begun by St Thomas’ Radiology Dept. in October 2008. The response is therefore bogus and ultimately untenable. It appears as a tactical response, made in awareness of the anomaly revealed in the images above, but whose purpose is to defer an honest and open response to the substance of the complaint in defence against the threat of immediate legal action. This can only be explained with recognition to the hugely controversial nature of what is revealed by the evidence presented here, and its implications of organised criminal activity within certain sections of the Government and the health service, and which therefore places an extraordinary level of responsibility upon the individual or organisation affirming its initial disclosure.

The original MRI findings report made by Dr Scott Hawkins had concluded with the statement: “No significant intracranial abnormality identified” (p.51 above – my emphasis). Interpreted literally and precisely this statement does not actually exclude the possibility of an unidentifiable abnormality. The statement could be interpreted as non-committal and ambiguous – as an avoidance of the issue – with respect to an apparent abnormality for which there was no available diagnostic interpretation.

The reticence of both Dr Hawkins and Dr Andrews in jointly declining to make any reference to the actual anomaly revealed by the scan, I suggest is explicable in the following terms:

1. As the object revealed by the scan was an illicit implantation without any medical precedent, there was no existing medical definition or diagnostic category with which to describe it.

2. The presence of such an unidentifiable object in my neck area could only indicate the suggestion of clandestine (illegal) activities by medical professionals at some point in my earlier medical history, and therefore to disclose knowledge of it would be to break some implicit code of secrecy. It therefore presented the doctors at Guy’s & St Thomas’ with the prospect of an unmanageable controversy which, had they opted for disclosure, would have only compromised them professionally and exposed them to extreme personal vulnerability.

My complaint to GSTT was submitted before I had access to a copy of a second MRI Head scan. The three images I have referred to from the 2nd scan reveal the presence of further structures, clearly non-biological in origin, and situated behind the back of my throat, close to the brain-stem (see below, pp.60-64). They provide de facto confirmation, in principle, of the presence of illicit neurosurgical implants in my neck area, and reinforce the conclusion
that the explanation given in GSTT’s response to my complaint, in respect of images 7.13-7.15 (pp.49-50), is a dishonest and cynical tactic in diversion from the truth.

On 28 June 2013 I sent a report of the cover-up by GSTT to the Metropolitan Police, including copies of both MRI scans. After four weeks, having received no acknowledgement of this from the police, I wrote again to GSTT’s Complaints Dept., on 23 July 2013, expressing my dissatisfaction with their response to my complaint.*

I eventually received their response on 16 September 2013. This response however falls short of the “full investigation” of my further concerns promised in their letter of acknowledgement issued on 24 July 2013. In fact it rather escapes addressing those concerns by raising a procedural difficulty over access to the evidence of the 2nd MRI scan. They state that as this scan was conducted at another hospital, GSTT do not have access to this material, and therefore are unable to comment on it. The following sentence of their response states that they retain their original position that there was nothing abnormal to report in the first MRI scan, and that that is the end of the matter, so far as they are concerned.

Firstly, although I had included a copy of the 2nd MRI scan with my letter to them, I did not expect GSTT to offer any opinion or comment on that specific evidence. My reason for including it was to qualify the reference in my letter to the three images shown below (pp.60-64) from that scan being published on my website, so that GSTT should be in no doubt as to their authenticity. The reference in the letter is only a coincidental one – as those images do in fact provide further confirmation of the principle of the existence of illicit surgical implants in my neck area, and cast additional doubt on the credibility, as well as the honesty, of GSTT’s initial response to my complaint.

Secondly, GSTT’s difficulty with my reference to evidence originating from another hospital, should not have prevented them from addressing the serious points raised in my letter; for instance: a) their spurious explanation for the object referred to in images 7.13-7.15 from their own scan in terms of the “left vertebral artery”, in view of the revealed structure of that object; and: b) their failure to identify the “Neuro-radiologists” who on 8 May 2013, their response claimed, had reconfirmed the opinion of the original MRI findings report from October 2008.

My only expectation of GSTT is quite a reasonable one: that they should report thoroughly, openly, and unambiguously upon the evidence produced within their own departments. The progress of my complaint shows however that GSTT is completely recalcitrant in its refusal

to do just that. It seems therefore that Guy’s & St Thomas’ NHS Trust are prepared to persist in this cover-up, including the Chief Executive himself, even in the face of overwhelming evidence, simply because the consequences of admitting it would be too devastating for them.

GSTT’s final statement is to declare the ‘local resolution’ stage of the complaints procedure complete, advising if I remain unsatisfied to pursue my complaint with the Parliamentary & Health Service Ombudsman (‘PHSO’). I referred the complaint to the PHSO on 23 September 2013.*

I received an initial decision on my complaint to the PHSO dated 18 November 2013. Under normal circumstances the PHSO operates a 12-month limitation period on the acceptance of complaints, which they chose to exercise in this case, declining to conduct an investigation as the complaint was first made to GSTT more than two years after I came into possession of a copy of the MRI scan (i.e., in December 2010). The assumption apparent from the PHSO’s decision letter was that, in view of the fact that at the time of requesting a copy of the scan I already had suspicions the scan may have revealed evidence of anomalies that had not been reported by St Thomas’ Radiology or Guy’s Neurology Depts., merely obtaining possession of a copy of the scan gave me sufficient grounds for lodging a complaint to GSTT, and that it was unreasonable for me to delay making that complaint until March 2013.

It is clear from their decision letter that the PHSO had acknowledged that my full understanding of the causes of the complaint was not established until I received the full response to my subject access request from St Thomas’ Information Governance Dept. in November 2012, as it was only at that point that I had access to the original MRI findings report from St Thomas’ Radiology Dept. Nevertheless, the PHSO chose to overlook this essential criterion, emphasising preferentially the fact that I had at that point been in possession of the scan material for nearly two years, and had made some attempts to seek expert corroboration of the evidence during 2011-12. They chose to ignore the fact that all of these efforts on my part (including two approaches to Dr Andrews at Guy’s Neurology Dept.) had failed to obtain any expert corroboration of the evidence. The suggestion of the PHSO is therefore that I ought to have made an unsubstantiated and incoherent complaint to GSTT on the basis of my notional suspicions alone, which is quite unrealistic and plainly absurd.

The PHSO offers the option to request a review of its decisions, which I therefore sought to do in a letter dated 25 November 2013. I judged that the reason for the apparently unrealistic

* My complaint to the PHSO, their initial decision, and the subsequent correspondence referred to below are published at URL: http://somr.info/report/rep6.php#phso – accessed 27/05/2023.
and unfair decision by the PHSO was that their decision had been made upon insufficient information, and felt confident if I gave a more detailed explanation of the causes inhibiting my ability to make a coherent complaint before March 2013, then in fairness the PHSO ought to have been persuaded there were sufficient extenuating circumstances justifying an extension of the time limit. In my letter requesting a review of their decision, I tried to explain the extremity of the circumstances I faced, including attempts on my life, following my request for a copy of the MRI scan material from St Thomas’ Information Governance Dept. – circumstances that developed in exact correspondence with that request and with the various approaches I made to departments of GSTT in pursuit of my enquiries over the evidence.

In my understanding, the time period during which it is feasible to lodge a complaint begins at the point at which knowledge of the causes of the complaint is established for the complainant. Therefore, it ought to have been difficult for the PHSO to uphold their decision considering that there was no explicit expert corroboration of the evidence prior to the making of the complaint in March 2013, and therefore no legal basis upon which to pursue a complaint, only a rather vain hope that GSTT might voluntarily admit to its own cover-up. Even allowing for this error of judgement on the part of the PHSO, most regulatory bodies are prepared to extend their standard time limits on the acceptance of complaints where there are either: a) extenuating circumstances which may have inhibited the bringing of a complaint within the time limit; or: b) clear reasons in the public interest which make it advisable or imperative for the regulator to do so.

In my letter requesting a review I had given ample reasons which ought to have satisfied an extension of the time limit in terms of (a) above. To describe these as succinctly as possible: the extraordinary context of my claims against GSTT – that it had engaged in a five-year-long interdepartmental cover-up of medical evidence that pointed to an historical medical atrocity of unprecedented and horrific proportions (albeit occurring outside of GSTT, but within the NHS, in 1967) – meant that there was enormous institutional pressure operating against the disclosure of the evidence. In this context, the response from the various departments of GSTT I approached with enquiries over the evidence was to interpret my suspicions as ‘delusional’, resulting in a series of referrals to Community Mental Health Services, initiated by GSTT and facilitated through the administrative route of my GP surgery. Alongside this, and beginning in exact coincidence with my application for a copy of the Brain MRI scan evidence in December 2010, I experienced a series of attempts on my life through the indirect method of poisoning (for further elaboration, see pp.84-87 below). My efforts to present evidence of these attempts to St Thomas’ A&E Dept., and to the police, were likewise treated as ‘delusional’, resulting in further referrals to the Community Mental Health Team, and the evidence went unexamined. Henceforth, in effect, I had no access to health services or to protection from the police against an ongoing series of attempts on my
life; circumstances that have persisted (with some periods of relative respite) from December 2010 until the present, and which clearly resulted as direct and indirect consequences of my attempts to expose evidence of an historical NHS atrocity.

In the PHSO’s final decision upon my review request dated 31 December 2013, there is no indication that the Review Team has given any serious consideration to the reasons set out in my letter of 25 November 2013, and they have maintained intractably their original decision not to investigate the complaint. The decision is devoid of any sensitivity over the extraordinary context of my claims against GSTT, and is blind to the possibility within that context of an implicit threat to my safety, or that this might inhibit my ability to pursue those claims. The review decision repeats the absurd suggestion that it was “reasonable” to expect me to have made the complaint to GSTT within a year of my access to the MRI scan evidence, in the absence of any expert corroboration of the anomalies revealed in it.

In my request for a review I had concentrated on the reasons indicated above, that there were extenuating circumstances that seriously inhibited my ability to make a complaint before March 2013. I had not argued the reasons for the PHSO to extend its time limit in the public interest; although it is arguable that such reasons ought to have been apparent to the PHSO from its own analysis of the evidence already in its possession.

In spite of the existence of medical evidence proving irrevocably that a medical atrocity was committed against a five-year-old child by surgeons working within the NHS in 1967, there is a ‘regime of silence’ operating against the disclosure of that evidence, effective across all major institutions in the UK, and which has so far prevented its open public discussion. As my complaint against the institution concerned (GSTT) over its cover-up of that evidence has reached its final stage without satisfactory resolution, and as there remained no explicit expert corroboration of the evidence with which to pursue further litigation in court, the only remaining option for an independent investigation of the alleged cover-up is one conducted by the office of PHSO, as the principle regulatory body for complaints against the health service. As the PHSO is now in possession of the evidence in question, the onus falls upon the PHSO to examine the evidence to establish legal knowledge of it for the first time; otherwise there can be no investigation in the public interest of GSTT’s role in covering-up that evidence. Should the PHSO insist upon exercising its time limit on the complaint, this would unreasonably impede the conduct of a necessary investigation.

If it is the case that certain departments of the NHS are responsible for the conduct of a medical atrocity that had – in 2013 – remained hidden for forty-six years, it is imperative that the issue achieve open public discussion, in order for the public to have the confidence of a guarantee against any future repetition of such atrocities. If it is also the case that other NHS departments have subsequently concealed evidence of that atrocity, if only for reasons of
administrative convenience, that is a criminal matter that also demands an investigation in the public interest. In these circumstances it ought to have been clear to the PHSO that there were overriding reasons in the public interest why it should waive its standard time limit on the acceptance of a complaint. Only on the assumption that the complaint was either frivolous or delusional could it have avoided that conclusion.

2\textsuperscript{nd} MRI Head Scan (2013)

In January 2013 I asked my GP if I might be referred for a second opinion on the Brain MRI scan previously conducted at St Thomas’ Hospital, and possibly further scan investigations. I was referred to the National Hospital for Neurology and Neurosurgery (‘NHNN’), at UCLH NHS Trust in London. A further MRI scan was conducted there on 6 March 2013. Although I have yet to receive any consultation over these scan results, I obtained a copy of the scan from the Medical Records Dept. of the hospital in May 2013. A selection of details of three images from this scan is displayed below:

1. MRI Head sagittal section (detail) - 20.0mm to the right of the central axis

The image detail above is one of a series of 128 vertical (sagittal) sections of my head. The sections show a sideways view, progressing from right to left of the skull. Sequential slices are 1.6mm apart. The image above is the 52nd image in the sequence, and is a section of the skull offset 20.0mm to the right from the central axis. The superimposed arrows point to two rigid square, box-like structures, approximately 1cm square (see adjacent sections below for
additional clarification); although the rearmost of these objects is less clearly defined across the three images selected here. These items are positioned behind the back of my throat, close to the brain-stem; i.e., in a position immediately below the *foramen magnum* – the large aperture at the base of the skull. The objects are clearly not of biological origin, appearing to be of a rigid rectilinear construction.

The second image below is 1.6mm to the left of the first image (i.e., 18.4mm right of the central axis). The forwardmost of the two objects is shown with slightly better clarity:*

*These images are also published online at URL: http://somr.info/report/rep0.php – accessed 27/05/2023.*
Prior to my GP making the referral to NHNN, I had contacted the hospital independently by letter in October 2012, enclosing a copy of the earlier MRI scan from St Thomas’, and requesting a second opinion on that scan. No private consultation had followed from that enquiry, but my concerns were addressed to my GP in January 2013 resulting in the NHS referral. I had also reported some symptoms of faintness, and pressure in my left occipital region, unconnected to my specific concerns over the images from the first scan, which added weight to the referral.

During my consultation with Dr Heaney, Consultant Neurologist at NHNN, on 8 February 2013, I presented him with copy of the earlier scan and asked him to explain the aspects of the images 7.13-7.15 (see pp.49-50 above) which were giving concern. However, Dr Heaney was noticeably reluctant to discuss the items I referred to in any meaningful detail and appeared nervous and impatient at my request. He was unable or unwilling to identify the specific items I pointed out from the scan. So I did not get the second opinion I had been seeking. His recommendation for a second scan was made ostensibly to assess if there had been any deterioration in the mild ischaemia previously reported in 2008 by Dr Hawkins at St Thomas’ Radiology Dept. sufficient to explain the recent symptoms of occipital pressure.
I received a copy of Dr Heaney’s letter to my GP dated 18 March 2013, in which he interprets NHNN’s radiological report on the second scan simply thus:

“I am reassured that there has not been significant deterioration in the radiological appearances, and that there is no acute lesion to account for his symptoms.”

This statement is highly specific in that it relates only to a comparison of any potential difference (deterioration) between the first and second scans, and to the absence of any acute lesion which might explain the symptoms of occipital pressure. It makes no commitment to any statement about the absence of anomalies in general (compare, for instance, with the final sentence of Dr Hawkins’ report on the first MRI scan, which had concluded with the statement: “No significant intracranial abnormality identified” – see p.51 above) or to any statement intended to allay the concerns that had evidently led me to seek a second opinion over the findings of the earlier scan. The radiological report quoted in his letter consists also of a list of specific exclusions – it makes no inclusive statement about the absence of anomalies in general.*

I received the copy of the 2nd MRI scan from UCLH Medical Records Dept. two months after this letter from Dr Heaney. After studying the scan I became aware of the apparent anomalies as depicted in the images above. At this time I was awaiting a response to my complaint against Guy’s & St Thomas’, so I did not immediately raise an issue with NHNN over their failure to report anomalies from the 2nd scan. However, at the time of referring the complaint against GSTT to the Health Service Ombudsman, I sent an email to Jill Rayfield, Dr Heaney’s secretary, on 26 September 2013, attaching copies of the three images above and asking for Dr Heaney’s corroboration of the fact of the self-evident anomalies revealed in those images.

In his letter of reply dated 3 October 2013 Dr Heaney refutes the existence of two box-like structures of non-biological origin in the scan images, suggesting that the two superimposed arrows point only to: “the posterior aspect of the foramen magnum and the lateral mass of C1” (i.e., the large aperture at the base of the skull, and the first cervical vertebra), and declaring these as “entirely normal”. This statement however can only be interpreted as the deliberate refusal to acknowledge the reality of the anomalies indicated by the two arrows, as it is plainly self-evident that the rigid rectilinear character of the two items could not occur biologically, and their presence in my neck can only have resulted from a surgical implantation, however sinister and distasteful such a conclusion might be to an ethically-minded medical professional. While I accept that Dr Heaney would not have had the

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* The correspondence with NHNN following the 2nd MRI scan, together with my subsequent complaint, is published at URL: http://somr.info/report/rep0.php – accessed 27/05/2023.
knowledge or information required to accurately identify the objects in question, resulting as I allege they do from an unprecedented surgical implantation, without official medical approval or publicity, it is inconceivable that he could honestly have not noticed these items simply because they do not conform to any existing diagnostic paradigm. In response therefore to the appearance of a further cover-up of medical evidence at NHNN, I submitted a complaint to UCLH Governance Dept. on 11 November 2013.

UCLH’s response to this complaint was received on 17 December 2013, and included a covering letter from the Trust’s Chief Executive Sir Robert Naylor, dated 16 December 2013, together with a report on the complaint investigation from Prof. John Duncan, Divisional Clinical Director of the Queen Square Hospitals, dated 12 December 2013. Prof. Duncan’s investigation report does nothing at all to address the concerns raised in my complaint. He states that he has himself reviewed the MRI scan made at NHNN on 6 March 2013, and has also sought the opinion of Dr Katherine Miszkiel, Senior Consultant Neuroradiologist at NHNN. He quotes Dr Miszkiel’s report to say that the “anatomy of your neck is normal”, with “no signs of any foreign body or device whatsoever”. He refutes my observations of the self-evident anomaly indicated in the three images reproduced above (pp.60-62) with the statement: “[W]e see no box like structure behind the back of your throat”.

The rectilinear structure of the anomaly revealed in these images is perfectly self-evident, and confirms the non-biological origin of the anomaly beyond reasonable dispute – it does not require any specialist training in neuroanatomy to be able to perceive it. For instance, in the enlarged detail of the third section shown on p.62 above (shown below with elevated tones), one can quite clearly perceive the internal rectilinear ‘G’ structure of the forwardmost of the two objects, confirming beyond doubt its artificial construction:
The statements of Prof. Duncan and Dr Miszkiel can only be interpreted therefore as blatant mistruths. Prof. Duncan has not addressed the details of my complaint that refer to the institutional context of the implied covert research program responsible for these illicit surgical implantations (i.e., that it occurred controversially within an NHS Hospital), and which may provide an explanation for why Dr Heaney found himself compelled to conceal his awareness of them; he merely denies having seen the anomaly, thereby avoiding any further discussion. One might paraphrase Prof. Duncan’s denial as: “We do not ‘see’ the box-like structure, because it is not one that is predicable within accepted diagnostic paradigms” – in effect the equivalent of his saying “no comment” to a question of highly sensitive medical and legal importance. His investigation (and Dr Miszkiel’s report to which it refers) has clearly been subject to the same systemic constraints that inhibited the initial reports on the scan. It is simply the case that no single NHS department, and no individual NHS clinician, dares (for reasons of their own personal security) to take on the responsibility for unilaterally disclosing the evidence. To do so would be to reveal a medical atrocity of extraordinary and horrific proportions, one which is likely to challenge anyone’s faith in ethical medicine, and risk bringing the reputation of the entire medical profession into disrepute.

I saw little point in asking UCLH to look again at my complaint, the initial complaint investigation having so stubbornly avoided addressing the issues it raised. The only hope for a satisfactory resolution lies within the route of an independent investigation. Therefore I referred this complaint, as with the previous complaint against Guy’s & St Thomas’ NHS Trust, to the Parliamentary & Health Service Ombudsman on 18 December 2013. The PHSO responded on 9 January 2014 with a decision to take up the investigation of my complaint against UCLH NHS Trust.*

Eight weeks following the PHSO’s decision to investigate the complaint, on 5 March 2014, I sent them an email seeking an update on the progress of their investigation. I asked that they provide evidence of their independent medical evaluation of the MRI scan and, if that expert opinion confirmed the presence of items of non-biological origin as highlighted in the images referenced above, to also confirm that they had referred the suspicion of a cover-up of evidence by the Trust to the police. I received a reply from Tracy Hancock, Allocation Manager at the PHSO, on 6 March 2014, to say that the case had not yet been referred to an investigator and that only at the investigation stage would they be able to respond to my request for information. Eight days after this I received the first communication from the investigator Paul Farrell, including an introductory letter and copy of the PHSO’s draft investigation report.

* My letter of complaint to UCLH, UCLH’s response, and the subsequent referral to and subsequent correspondence with the PHSO are published at URL: http://somr.info/report/repo.php – accessed 27/05/2023.
Rather surprisingly, the decision of the draft investigation report was not to uphold my complaint against the Trust. The report is rather brief and the decision hinges upon the evidence of the PHSO’s medical advisor, quoted only indirectly in the report, who apparently had concurred with the opinions given by the three specialists at NHNN that the images: “do not show evidence of artificial structures in your neck”. The report included no copy or verbatim statement of the medical advisor’s findings from his examination of the scan however, nor any details relating to the advisor’s specialism, qualifications, or identity. The report is ambiguous as to the extent of the medical advisor’s examination – whether it had involved an examination of the original MRI scan itself, or only of the three modified image-details I had attached to my email to the PHSO of 13 January 2014. There appeared therefore to be little substance to the advice quoted in the report and, in view of the fact that the investigation had been completed within six working days of its being allocated to an investigator, I suspected it had been conducted with the aim of peremptorily dismissing the complaint. I sent a letter addressing my comments on the draft investigation report to Paul Farrell on 25 March 2014.

In those comments I reiterated my understanding of the systemic constraints inhibiting disclosure of the evidence, and which seemingly had influenced the reports of the three specialists at NHNN. In light of the PHSO’s draft investigation report, I suggested that the same constraints now appeared to be affecting the attitude of the PHSO towards its own investigation, i.e., including the advice of its medical advisor; since, on any frank and honest perception of the MRI images (with or without specialist training in neuroanatomy) the evidence of items of non-biological origin in my neck is plainly irrefutable. I had also pointed out the existence of a catalogue of evidence – in the form of an earlier edition of this report (already in the PHSO’s possession) – supporting the allegation that I had been the victim of a medical crime in my early childhood, and which had been the occasion of the illicit surgical implants.

The final investigation report of the PHSO followed ten days after my letter, on 4 April 2014. The report does not change the decision of the draft report not to uphold the complaint. The only essential difference between the two reports is that in para.3 Mr Farrell has added some information regarding the specialism and qualifications of the medical advisor in response to my comments. This does not fully answer my request on this point as we are still without any explicit verbatim statement of the advisor’s examination findings – the report still only quotes him indirectly. Mr Farrell’s accompanying letter to the report states that: “[W]e only looked at the MRI scan images you sent to us”, suggesting that the advisor has considered only the modified image-details sent to the PHSO by email attachment on 13 January 2014, and has not examined the original MRI scan itself (which was however already in the PHSO’s possession). Such a cursory inspection of the derived image-details hardly constitutes an objective medical examination of the evidence in question.
After speaking to Mr Farrell on the telephone on the 9 April 2014, he informed me that the medical advisor in question was a regular (‘internal’) advisor employed by the PHSO, and had conducted his examination of the MRI images on one of his routine visits to the PHSO offices during a discussion with Mr Farrell at his desk. His opinion had been given *informally* that is, by word of mouth – there is no documentary or signed declaration of his advice for which he might later be held accountable. Neither do we have any idea of his identity; we are only told that he is an “*orthopaedic & trauma surgeon*” whom Mr Farrell is satisfied (for the purposes of his peremptory investigation) “*has suitable experience to examine and understand MRI images*”. In response to my question that the advisor might be simultaneously employed by the NHS, Mr Farrell informed me that he is employed by the NHS and therefore “*not entirely independent of the NHS*”, but that this did not affect his contractual duty in giving medical advice ‘independently’ to the PHSO.

The PHSO’s investigation has been conducted with deliberate disregard for the arguments made throughout my complaint of the self-evident nature of the MRI scan evidence, and that the refusal to disclose this evidence amongst the various medical professionals involved can only be explained therefore in terms of systemic and institutional constraints operating against its disclosure across the broad institution of the NHS. These arguments and the reasoning behind them have simply been ignored, in preference for the informal verbal opinion of a medical advisor whose specialism (orthopaedic & trauma surgery) is not even relevant to an expert opinion on the evidence concerned. Even if it could be claimed that the quoted advisor has *quasi*-independence from the NHS (despite being principally employed by that organisation), how likely is it that he would have the professional confidence to overturn the opinions of three specialists in the area of neuroradiology, which is not his own specialism?

In spite of the claims of the PHSO to be ‘independent of the NHS’, it clearly felt compelled to conduct an intentionally crude and blinkered investigation for the sake of its own administrative convenience, at the same time refusing to conduct a thorough, formal, and independent evaluation of the medical evidence in question. Its actions in response to this complaint therefore reveal the PHSO’s structural inability to offer any effective regulation in the context of the most serious ethical transgressions conducted within the NHS. The *intractability* with which the PHSO maintained the findings of its draft investigation report through to its final report, in ignorance of evidence and arguments raised against the draft findings, compares with that of its sustained decision not to investigate my earlier complaint against GSTT NHS Trust (see pp.57-60 above).

During April 2014, I submitted a Freedom of Information Request to the PHSO in which I requested details of the specialisms of the PHSO’s contracted medical advisors, as well as details of the contracts required between the advisors and the PHSO. The response to the
FOI request revealed that the PHSO employs 42 such ‘internal’ medical advisors, none of whom are specialised in neurology or neuroradiology. It also maintains contracts with 102 ‘associate’ advisors, including one neurologist and three neurosurgeons. The contractual agreements maintained between associate (and ‘external’) advisors and the PHSO specify that it is an obligation for the advisor to provide signed copies of their advice reports within 15 days of receiving the case file. There is no such specific contract however which applies to the PHSO’s internal advisors – they must sign the standard PHSO employment contract signed by all PHSO employees, which includes no specific clause relating to internal advisors’ reports. During our telephone conversations Mr Farrell had informed me that there was no medical report submitted by the advisor in question, and that the only written record of his advice is a note written by Mr Farrell himself.*

In the light of the information received from the FOI Dept. I sent a request for a review of its investigation decision to the PHSO’s Review Team on 30 June 2014. The response dated 17 July 2014 from Nicola Bubb, reviewer at the PHSO, states that my request for a review does not meet the PHSO’s review criteria for the reasons that I have not identified any factual errors in their decision letter, submitted any new information, or explained which evidence they have overlooked.† However, in order to satisfy the review criteria, it is not necessary for me to point out evidence that has been overlooked in the PHSO’s investigation, only that the PHSO has overlooked or misunderstood my complaint (see the postscript on p.2 of Mr Farrell’s decision letter of 4 April 2014, which details the review criteria)‡.

In my review request it was necessary for me to reiterate the two substantial features of my complaint, well represented in all of my complaint correspondence, and which had not been acknowledged, discussed, or refuted in the PHSO’s investigation report. These had emphasised: a) the self-evident nature of the anomalies revealed by the MRI scan; and: b) the systemic constraints operating against disclosure of the evidence across the broad NHS institution, and which were likely therefore to be affecting the quoted advice of the PHSO’s own medical advisor (himself an NHS employee). As Mr Farrell had rigidly ignored any discussion of these two factors in his investigation report, the PHSO cannot honestly claim that it has not overlooked these major elements of my complaint.

Ms Bubb’s response to my remarks on pp.4-6 of my review request, with regard to the poor

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* For access to copies of the PHSO’s investigation reports, and additional correspondence, see URL: http://somr.info/report/rep0.php#phso. The PHSO’s response to my FOI request is available as the ZIP archive PHSO_FOI_response.zip from cloud source URL: https://shorturl.at/gmnEO (links accessed 27/05/2023).

† Copies of my letter requesting a review, and the response from Nicola Bubb are available at URL: http://somr.info/report/rep0.php#phso-review – accessed 27/05/2023.

quality and immaterial nature of the medical advice quoted in the investigation report, is to defend the validity of that advice on the basis that the notes made by Mr Farrell from his discussion with the medical advisor had been “approved” by the advisor himself. Ms Bubb states that the PHSO is not required to obtain a medical report or to use an external (or associate) advisor. However, she has not answered the allegation implicit in my review request that the choice of an internal advisor in this case was made specifically to exclude the obligation to provide a material report. A formally objective investigation ought to have chosen an advisor with a specialism that matched those of the three specialists from NHNN under investigation (i.e., in neuroradiology), and the only available advisors with such a specialism are associate or external advisors, who are contractually obliged to provide such a material report. The choice of an internal advisor therefore has avoided the submission of a medical report from an advisor with an appropriate specialism, so as to enable the PHSO’s investigation to proceed on the basis of immaterial advice against which no legal challenge could be made.

During a telephone conversation with Mr Farrell he informed me that the decision to use an internal advisor was made between himself and Maria Leader (the “lead clinician” referred to in para.4 of Ms Bubb’s letter). I am informed that Ms Leader has a nursing qualification; Mr Farrell, I understand, has no medical qualification. The claim that the advisor had approved Mr Farrell’s notes from their discussion does not save the quoted advice from the charge of hearsay made on p.6 of my review request, for the reason that the advisor has not himself written the advice and cannot therefore be held legally accountable for any indirect quoted instance of that advice.

Furthermore, and in addition to these objections, the PHSO’s response to my review request does not address the fact made clear on p.5 of my review request that the PHSO has not actually conducted an independent medical evaluation of the original MRI scan material – the quoted advice was given following a cursory examination only of the three modified image-details I had attached to my email to the PHSO of 13 January 2014. It is not acceptable that an independent medical evaluation of the scan should be conducted by the advisor looking at the derived image-details (only) that have been copied from the original scan material and modified by the patient.

The remaining option to challenge the PHSO’s decision is that of a Judicial Review. However, my experience has shown that no lawyer is currently prepared to represent me in the case.
Complaint to the General Medical Council

In February 2012, a year previous to my complaint to Guy’s & St Thomas’ NHS Trust (pp.53-57 above), I had submitted a complaint to the General Medical Council which had included copies of an earlier version of this report and of the Brian MRI scan conducted at St Thomas’ Radiology Dept. In retrospect it was probably ill-advised of me to have complained to the GMC in the first instance, before submitting any complaint directly to GSTT, who had failed to disclose the evidence revealed in the MRI scan. However, in view of the serious criminal nature of the historical allegations over events in 1967, which were not the original responsibility of GSTT, at the time it seemed proportionate to do so. I had no expert corroboration of the evidence, and therefore I doubted that I would get a satisfactory response from a complaint to GSTT, as it seemed unlikely that GSTT would voluntarily admit to its own cover-up. I expected that the GMC would have the resources to independently assess the evidential value of the MRI scan; and, in view of the additional evidence contained in this report, would therefore have been obliged to treat my allegations with some seriousness.

This complaint was made before I had access to the documents provided in response to my subject access request to GSTT in November 2012 (see p.52 above), and was therefore ill-informed with regard to the details of the alleged cover-up, in particular the identity of the original reporting radiologist at St Thomas’. However, it did highlight the failure of Dr Andrews at Guy’s Neurology Dept. to disclose her awareness of the significant anomaly revealed in the scan, as well as pointing out the general difficulty in obtaining expert corroboration of that evidence. The GMC’s initial response was to declare the complaint ‘out of time’ as the events of 1967-68 referred to in my complaint and report occurred more than five years previously. There followed a series of three more letter-exchanges in which I drew attention again to the recent cover-up of the MRI evidence (indicating wilful negligence on Dr Andrews’ part) as being clearly within the GMC’s five-year limitation period, and stressing the *prima facie* value of that evidence.

Throughout this exchange the GMC held to the position, as stated in their second letter of 20 March 2012, that: “The Assistant Registrar has read all the information that you have provided and has seen no evidence of the implementation of a cranial device hence the decision to not progress with your complaint.” At no point in this exchange (prior to their final response) did the GMC specifically mention the MRI evidence itself or state that they had evaluated that evidence and found it to be normal. It was not until their response to my fourth letter, in which I raised the question that it might be the case that the GMC is unwilling to accept the MRI evidence without further written corroboration from a neurological expert, that they explicitly state the reason for their refusal to acknowledge the
evidence; i.e., due to the circumstance that: “We are not able to medically evaluate your scans”; despite having stated (paradoxically) in the preceding paragraph: “The Assistant Registrar has considered all of the evidence that you have provided, including the visual MRI evidence”.*

As the MRI component of the evidence (with respect to images 7.13-7.15 from the scan (pp.49-50 above) included in my submission to the GMC) was clearly crucial to the substance of my complaint, why did it take an eight-letter exchange for the GMC to state explicitly that they are unable to evaluate it? It would have been reasonable for them to qualify the statement in their initial letter of 2 March 2012: “From the information that you have provided, we cannot identify any issues that would enable us to conduct an investigation”, with an explanation to that effect, rather than persist in an eight-letter exchange on the basis of an ambiguity, especially as I had in my first letter pointed out the difficulties inherent in obtaining any such expert corroboration of the evidence. It does not seem unreasonable to expect that the General Medical Council should be in a position to evaluate first-hand medical evidence that is presented to it. However, it is clear that the GMC were simply averse to discussing or even acknowledging the element of the MRI evidence until they were finally pressed upon the subject.

Spinal MRI Scans (2015-2020)

As related in Part 1 above, I have experienced complex and quite inexplicable physical problems in the region of my thoracic spine for many years (re: pp.17-19 & 29-31 above). More recently, in June 2015, I developed a set of aggressive symptoms in the region between my thoracic spine and left shoulder blade, although at the time it was difficult to say exactly what brought these symptoms on – there was no obvious physical injury to the area or incidence of conventional muscle-straining or the like. The symptoms began with an ache between the spine and left shoulder blade together with the feeling of a sharp ‘lacerating’ sensation; at other times a burning or stinging one, which would accompany certain kinds of movement in this area. Added to this there was a patch of skin about 7-8cm in diameter in which the flesh below the skin was quite numb to pressure. It felt at times as if there was something hot under the skin – the sensation one has when a sizeable area of tissue is trying to recover from a traumatic injury. Associated with this were certain neurological problems, including a transient and intermittent loss of feeling in the skin in other parts of my body such as my lower left arm, left side of my head and neck, and left upper-thigh, together with some disturbance of cardiac rhythm. The symptoms local to the spine still persist in a less acute form and are increasingly troublesome, and worryingly complex. Moreover, despite the existence now of three MRI scans of my spine made in response to my reports of these symptoms, the symptoms have been left largely unexamined and undiagnosed and therefore untreated by medical services.

In trying to present the nature of these symptoms initially to my GP, it was necessary for me to situate the problem within the context of my claims about the existence of illicit surgical implants in my neck area, which had been revealed (although not yet medically acknowledged) in my two earlier brain MRI scans (re: the two sections occupying pages 48-69 above). However, it remains unclear whether these new symptoms may or may not have developed as either direct or indirect consequences of the experimental surgery I have alleged was the true purpose of my tonsillectomy operation aged five.

During July 2015, I met with two different GPs at Blackfriars Medical Practice at a series of appointments arranged in response to the new symptoms. My discussions with both doctors became inhibited when I tried to present the new symptoms in the context of my existing reports of the presence of illicit implants in my neck area. To my mind, the initial stages of an assessment of the new symptoms could not proceed objectively while disregarding the factor of the suspected illicit implants. It could not be excluded the possibility of their having some bearing upon the emergence of the new symptoms; especially because the full extent of the implants and their biological implications had not yet been established through medical examination. While both GPs were inevitably reluctant to engage in open discussion of the
suspected implants and their possible bearing upon the new symptoms, each succeeded in avoiding any confrontation with that difficult subject by making two early referrals with the potential for further medical imaging investigation: an osteopathic referral to the BMI Hospital, Blackheath; and a neurological referral to the Royal London Hospital (Barts and the London NHS Foundation Trust).

Following a consultation with a spinal surgeon at the BMI, an MRI scan was performed of my thoracic spine on 23 July 2015. The scan was scheduled as “MRI Spine thoracic”, and during the procedure I reported to the radiologist that there were specific concerns with the area of my left scapula. Following the scan the radiologist gave me a copy of the scan on disc. There is no verbal report on the scan included in the scan material and during my subsequent consultation with the same surgeon no anomalies (and no explanation for my symptoms) were reported to have been revealed by the scan. I received no radiological report on the scan either during or after my second consultation at the hospital.

The second scan was the result of the second GP’s referral to the Neurology Dept. at the Royal London Hospital (‘RLH’) and was made on 11 September 2015. The scan was preceded by an initial consultation with a neurologist at the hospital on 18 August 2015 during which she made the scan request online, stating explicitly that she had specified a scan of my left shoulder in the request. The scan was scheduled as: “MRI Whole Spine, MRI Shoulder Lt”, as reflected in the appointment letter from RLH’s MRI Dept. of 21 August 2015. The scan actually performed however includes no dedicated scan of the left shoulder and is limited in scope to the width of the spinal column itself (i.e., to the “Whole Spine” element detailed in the appointment letter). There is no available explanation for why the scan had avoided the area of the left shoulder, as requested by the first neurologist and promised in the appointment letter. That specific part of the request must therefore have been deliberately excluded as the result of a positive intervention by someone in a senior position, either at the Neurology Dept. or elsewhere within RLH, following the letter to me from the MRI Dept. of 21 August. There had however been no further discussion between anyone at RLH and myself between the date of my first appointment and the date of the scan procedure.

It is significant also that in the verbal report included in the scan material the reason for the referral is stated as “right shoulder numbness with burning shooting pain” (my emphasis); however the scan included no dedicated attention to the right shoulder either. This was an utter perversion of the reports I had made of my symptoms during my initial consultation with the neurologist. These had concerned only the area between the spine and the left scapula, and had been the reason for that doctor to specify a scan of the left shoulder in addition to the whole spine in her initial request. There is no possible ambiguity involved in the instruction “left shoulder”; therefore I think it quite inconceivable that this
misrepresentation of my symptoms could have arisen as an innocent mistake. In the radiological report included with the second scan the only problems reported relate to mild age-related degenerative changes in the cervical discs, reported as: “narrowing of the left C6 and right C7 neural foramina”, in addition to “some minor lumbar facet degeneration”.*

There has been no satisfactory explanation from the hospital for the omission of the scan of the left shoulder. The symptoms affecting this area still persist and are worryingly complex, but have clearly been refused appropriate investigation or treatment by the Royal London Hospital (see additional comments on p.79 below).

The refusal of further physical assessment/treatment in the UK

The symptoms described on p.72 above that emerged suddenly in June 2015 have been chronically recurring in a relapsing and remitting cycle since that time, becoming frequently unstable, with pain and inflammation to the area. Following the MRI scans conducted in 2015, and the refusal by the Royal London Hospital Neurology Dept. to thoroughly examine the area between my thoracic spine and left scapula, I began to formulate more concrete suspicions about what might have caused the sudden emergence of the symptoms in June 2015. I had good reason to suspect that I may have received two bouts of damaging microwave radiation from a mobile device carried in my backpack on two occasions during June 2015 (and never used otherwise by myself), and that the device had been modified with the specific intention of causing me an internal injury (i.e., as part of the series of sophisticated attempts on my life that are discussed in more detail in the section: Attempts on My Life, on pp.81-97 below). These suspicions are quite difficult to substantiate or explain in this context, chiefly because I no longer possess the mobile device in question. However, if this should later transpire to be the probable cause of these symptoms, then it is likely that they are the effects of an area of internal, probably irreversible, tissue damage: i.e., necrosis.

During 2016, as the symptoms were not subsiding and the problem itself was clearly resistant to healing, I made attempts to present my suspicions over the possible cause of the injury to my GP. I also gave her a comprehensive account of evidence pointing to the fact that clinicians at the Neurology Dept. of RLH had deliberately avoided examining the problem, following an exceptional intervention by someone in authority at the Neurology Dept. arbitrarily to prevent a dedicated scan of the left scapula, even though that part of the assessment had already been requested by the first neurologist I saw there, and scheduled by the MRI Dept. in its appointment letter to me. The evidence strongly suggested wilful

* Each of the two spinal MRI scans is available to download as a complete ZIP archive at URL: http://somr.info/report/rep9.php#spine. The radiological report quoted here is accessible within the scan material itself. A copy of the MRI Dept.’s appointment letter to me of 21/08/2015 may be accessed at URL: http://somr.info/lib/Barts_MRI_appt_21.8.15.pdf (links accessed 27/05/2023).
negligence by clinicians at RLH, and indeed could be interpreted as an intentional cover-up by the hospital of evidence proving the existence of attempts on my life. The evidence, including correspondence direct from RLH to my GP, gave ample reason for my GP to suspect that the problem had not been thoroughly examined by RLH, and to seek whatever further investigation might be available under the NHS. Such a response however would involve at least an implicit challenge from my GP to the latest decision by the lead clinician at RLH Neurology Dept., which was not to sanction a scan of the left shoulder (even though he could not himself provide a reason why that part of the scan had been latterly excluded). That alone would be a lot to expect from my GP; the added suggestion of a possible cover-up at RLH implied that any challenge from my GP would risk a possible disclosure of that cover-up. Hence, my expectations of any positive action being taken by my GP on my behalf over the issue became greatly diminished.

In these discussions with my GP, it was not possible to explain the suspected cause of the exceptional injury to my back in any way other than as one of a series of attempts on my life. This element in itself acted to solidify my GP’s position in terms of responding not to a physical health problem, but of reacting to a perceived mental health one – an interpretation that she has since relied upon exclusively. It has indeed been the stock response from all local medical establishments in recent years to treat my reports of attempts on my life as the effects of a ‘delusional psychosis’; and in referring those reports exclusively for the attention of mental health services, to have successfully deferred any serious medical or legal attention to the actual physical evidence proving the fact of a series of attempts on my life.

What ultimately drives this response from front-line clinicians is not so much the suggestion of a willing ‘conspiracy’ to suppress attention to the evidence operating across the broad NHS, but rather it is the vulnerability felt by any individual clinician to the prospect of exposing their own professional liability by being seen to ‘advocate’ for the claims of a patient who has long maintained serious allegations of a criminal nature against several high-profile NHS bodies. In this arena of heightened sensitivity, the more palatable option for any front-line clinician is to assume the default prophylactic response, and to pass the buck of responsibility to another clinician. After all, one of the principle motivations behind the reported attempts on my life has to be understood as the need (including that amongst NHS executives) to continue in suppressing from public attention the reality of those alleged medical crimes.

My GP’s response to my reports of the continuing symptoms, that they must first be assessed by a mental health professional (in view of my speculations over the causes of those symptoms) was both tendentious and unhelpful; and, in addition to disregarding evidence pointing to RLH’s wilful negligence in its assessment of the problem in 2015, also disregarded two other important factors:
1. That mental health professionals are neither obliged nor trained to assess material such as MRI scans in assessing a patient’s beliefs or reports about his physical health. Therefore, if there is MRI evidence that may corroborate a patient’s claims about his physical health (in my case I had made disputed claims about four existing MRI scans), then that evidence may not be fairly or objectively assessed merely by subjecting those beliefs and reports to a psychiatric ‘triage’.

2. In my case there had been a series of spurious referrals made to mental health services by clinicians in several departments of Guy’s & St Thomas’ NHS Trust (‘GSTT’), and in my previous GP practice (Waterloo Health Centre), between 2011 and 2013, in response to allegations I had made of a cover-up by departments of GSTT of the evidence of my first Brain MRI scan (made at St Thomas’ Hospital Radiology Dept. in October 2008). These had resulted in a series of (still unresolved) complaints made against GSTT (see pp.48-60 above); against the South London & Maudsley NHS Trust (‘SLaM’); and against Waterloo Health Centre, between 2013 and 2015.

My GP was quite aware of the strength and substance of those complaints, and of the fact that they would by their very nature seriously inhibit my ability to engage in any further assessment by clinicians at SLaM (an engagement nevertheless entailed by her referral, as SLaM is the NHS Trust administering the local Community Mental Health Team). My GP’s insistence upon such a referral therefore merely served the appearance of an appropriate first-line response to my reports of symptoms following my suspicions of an attempt on my life, and was made in the knowledge that I could not with self-respect engage with the referral in any meaningful way. It was simply the least controversial response available to my GP, deeply sensitive to the issue of her own professional liability in the matter. Furthermore, the accumulation of spurious referrals to mental health services appearing indelibly within my medical records tended to function as a self-perpetuating myth, predisposing any future clinician redundantly to repeat the same referral process. This tendency was therefore quite counterproductive to my need to achieve any physical attention to the chronic medical problem in my back.
C-Spine MRI (July 2020)

The symptoms described on p.72 above that emerged suddenly in June 2015 have been chronically recurring since that time. Whatever persists as the cause of the symptoms remains for periods of time relatively stable, at other times becoming markedly unstable. In July 2020, while abroad, having at that point experienced intermittent relapses of the symptoms over five years, I experienced a marked flare-up of the symptoms resulting for the first time in inflammation and irritation to the surface of the skin in the area, as well as a local rash developing there. This new development was quite alarming, particularly as it was accompanied by exaggerated internal symptoms, and so I sought a private medical examination at a local clinic in Serbia, where I happened to be travelling at the time.

A C-Spine MRI scan was performed on 28 July 2020 at the Zdravlje Plus Clinic, Novi Sad. The following day I received a copy of the scan together with a radiology report from the clinic’s reception.* Prior to the scan procedure I had described the history of the symptoms affecting the area in detail to the radiologist. However, there was no subsequent consultation with the radiologist to discuss the results of the examination.

While the radiological report provided by the clinic seems quite thorough in its analysis of the scan in conventional diagnostic terms, it includes no mention of my reasons for seeking the scan, and makes no reference to my reports of the specific symptoms affecting the area – hence the report provides no satisfactory medical explanation for those symptoms. Nor is there any mention of any unexplained anomaly revealed by the scan. As with the report made by the radiologist at RLH with respect to the scan made in September 2015, the only issues revealed within the report are age-related degenerative changes affecting the vertebrae and discs; with the addition, in the case of the Serbian report, of a reference to my mild scoliosis.

On viewing the copy of the scan, I noticed what appears to be a self-evident anomaly in the first frame of the fourth series of the scan (18 images in total) with the title: “eT1W_TSE”. In that image (“Frame 0”) there is revealed an object with an odd ‘tubular’ appearance to the immediate right of the spine (‘left’ in the image), but which also appears to extend across the front of the spinal column; i.e., in a vertical position just below the apex of the adjacent spinal scoliosis (see item identified by the arrow in the image below):

* The C-Spine MRI scan is available to download as a complete ZIP archive at URL:
I have no expertise in reading the scan images, but it seems that the item I have pointed out in the above image is a *self-evident* anomaly revealed by the scan (which means that we do not need an expert to point out its existence to us). In spite of the thoroughness of the report provided by the clinic in Novi Sad in reporting upon issues internal to the spinal column in conventional diagnostic terms, it has nevertheless failed to acknowledge this self-evident anomaly adjacent to the right of the spine – the anomaly has been entirely overlooked in the clinic’s report. This particular anomaly appears to be situated on the front-right side of the spine, and is speculated to have originated as a further aspect of the illicit implants that derive from my tonsillectomy operation in 1967. As such it does not suggest itself as a sufficient explanation for the symptoms that emerged to the left of the spine in 2015, and which I have alleged on p.74 above to have resulted from an exceptional injury to that area. Those symptoms therefore still require further examination and assessment, and I have not by myself been able to locate any aspect in the recent scan images that might indicate the presence of such an injury.

This reticence of the Serbian report towards the anomaly that is actually present in the latest scan seems fairly characteristic of the responses so far received from clinicians faced with
the existence of what appears to be a series of illicit implants – as I have pointed out to exist within each of the earlier brain MRI scans discussed on pp.48-50 & 60-64 above. I suggest it was merely a different aspect of this tendency towards reticence and oversight that drove clinicians at the Neurology Dept. of the Royal London Hospital to refuse to conduct a thorough examination of the areas adjacent to the thoracic spine; i.e., in order to pre-empt a situation in which those clinicians would be similarly compelled to cover-up evidence they anticipated may be revealed in the scan results that they were nevertheless obliged to produce. My confidence in this suggestion is based upon the fact that during my initial consultation at RLH (at which a scan of the left shoulder was actually formally arranged), I had given the neurologist a copy of an earlier edition of this report, which included the sections referring to the two earlier brain MRI scans; and in which I had also speculated over the possible existence of further illicit implants in my thoracic cavity (re: pages 29-31 & 45, in Part 1 above). It is established in his correspondence with my GP that the lead clinician at the Neurology Dept. was familiar with the content of my report. Hence, the exacerbation during July 2020 of the symptoms affecting the area of my thoracic spine with what continues to be fairly unremitting pain and inflammation reflects the progression and worsening of the problem following the decision by the Neurology Dept. at RLH, subsequent to my initial appointment, to exclude a thorough examination of any wider part of my thoracic cavity.

**My continuing frustration with UK front-line health services**

Following the scan made in July 2020, in early September 2020 I made a further approach to Blackfriars Medical Practice in an attempt to seek further medical examination of the symptoms still affecting the area to the left of my spine. I emailed my GP a copy of the image above, describing the recent exacerbation of the symptoms, together with images of the rash affecting the skin in the area, hoping she would agree to make some kind of referral for a second opinion on the latest scan, or some other appropriate examination. Her response was a blunt restatement of the position adopted by the practice four years earlier – to insist that any speculation I had about the causes of my symptoms that went beyond those reported in the existing radiological report must first be subject to a psychiatric triage.

Due to the coronavirus situation, I received only a telephone appointment with my GP. During the call, I suggested to her that the reporting radiologist might have wished to avoid reporting on the exceptional self-evident anomaly in the scan in order to avoid a *tsunami* of controversy – i.e., with a view to limiting his professional liability in the matter – and that his resulting report might be less than a thorough and objective assessment, especially since he had limited his remarks to issues internal to the spinal column.
My GP’s response to a form of that argument was that it: “*may be in the realm of delusion, which needs a review by a psychiatrist*”. But my GP is aware, as he has been since 2016, that any suggestion of a referral to mental health services was an obligatory red-line for me that I could not with self-respect abandon. There had been a series of communications between my previous GP practice and departments of GSTT and of SLaM, in association with referrals made to the Community Mental Health Team (itself a subsidiary department of SLaM) between 2011-2013, that had included several deliberate falsehoods depicting aspects of my alleged behaviour, and which were explicitly defamatory and injurious to my character. These lies, involving false allegations of violent and aggressive behaviour on my part, were designed to silence my complaint against GSTT over its cover-up of the evidence of my Brain MRI scan (see pp.48-60 above) by a failed, fraudulent attempt to invoke my detention under the Mental Health Act. They were in part the responsibility of a clinician at SLaM – a Consultant Liaison Psychiatrist – who has never met or spoken to me, but who had been shown one of my letters of complaint against GSTT. My complaint to SLaM from October 2015 over this communication remains unresolved, since after taking more than a year to formally respond to the complaint, the Trust then refused to respond to a subject access request under the Data Protection Act (made in February 2017) for subject data held by the Trust in relation to the complaint. The Consultant is now no longer employed at the Trust.

Hence, although I am aware that this policy towards my case is one imposed at the management level of the practice, my GP’s insistence upon the imperative of a referral that will automatically involve psychiatric assessment by clinicians from SLaM continues to act as an effective block upon my access through front-line health service to the kind of physical investigation that must itself be considered as imperative to the proper assessment of the physical problem that continues to affect my upper thorax. Blackfriars Medical Practice is in possession of my letters of complaint against SLaM and against Waterloo Health Centre over their libellous communications referred to above, and therefore it is a matter of spectacular insensitivity that my GP should now insist upon my being initially triaged by psychiatrists working within SLaM (or by any NHS psychiatrist for that matter) before I might hope to achieve any respectful physical assessment of the suspected injury to my back. Since a psychiatrist would be disinclined to consider any MRI scan evidence in his or her assessment, and would not therefore be in a position to definitively exclude the possibility of a physical anomaly revealed by the scan, should it not then have been more appropriate for my GP to refer me instead for a second radiological opinion on the latest scan, with its self-evident signs of an exceptional anomaly? I had asked for such a referral in my telephone call to her on 9 September 2020 – a request my GP simply dismissed, insisting upon the bugbear of her referral to SLaM instead. Could it be that my GP simply does not have an executive power of choice, in this instance, of doing what is clearly in the best interests of my health?
Attempts on My Life

Between 2001 and 2006, I had ceased all contact with my family as a consequence of my emerging suspicions, and my subsequent allegations against them. Following 2006, in view of the fact that (prior to the emergence of the MRI evidence) neither the police nor the medical profession had sufficient reason to take my allegations seriously, I regained some contact with my mother and sister and simulated that I had revised my suspicions, openly accepting that they had in fact been delusional, and feigned a withdrawal of my allegations. This coincided with my self-referral to the START Team (see p.48 above). It was at this point that I became aware that New Scotland Yard had initiated (at least) an earlier investigation, and had visited my sister to question her (in 2003 or 2004), although I had no information from the police about the outcome of that inquiry. I visited my mother and sister periodically between 2007 and 2010, on superficially amicable terms, but I was unsatisfied that their behaviour was generally consistent with true innocence over the whole affair, particularly with respect to their shared financial position, though I did not voice this dissatisfaction until late in 2010.

In November 2010, I sent a provocative email to my sister, anonymously, to appear as if it had come from a third party, declaring knowledge of her criminal guilt (money laundering), and a vague threat of some impending consequences. This coincided with a series of phone calls to my mother in which I intimated that I was beginning to revisit my earlier suspicions. These phone calls were quite acrimonious, but culminated during the first week of December with my mother saying that she wanted to send me a cheque for Christmas, and that for security reasons she wanted me to telephone her as soon as I received the cheque in the post. It was normal for my mother to give me cash for Christmas and birthdays, but this was usually done in person when I visited her. While suggesting these arrangements, my mother’s tone was at times highly stressed, emotional and panicky, which was inexplicable and unjustified within the context of the conversations.

I received the post from my mother, containing a cheque and a Christmas card, upon returning to my flat around midday on the 10 December 2010. I telephoned her immediately, as she had asked me to. The call was quite short and to-the-point. Shortly after the call there was a ring on the external intercom to my flat (i.e., from the main entrance to the block). I am usually careful about answering the door, and as I was not expecting anyone I did not respond. Within a few minutes there was a ring on my internal flat door, which was repeated persistently. I did not respond to these either, as it was clear that the visitor(s) had gained entry to the building by subterfuge, having received no response from my intercom. At this time I made no conscious connection between my mother’s letter and the visit. There were no further visits to my flat until 1am the following morning, when exactly the same sequence...
As earlier was repeated. Again, I refrained from answering the door. From my window I managed to see two men from above and behind (my flat was on the fourth floor) as they left the building. As far as I could tell they were early middle-aged (30s-40s), well-built, both wearing black woollen hats and sports jackets. They walked to a car, a blue BMW, parked in an adjacent side street, and drove off. I had never seen these men before, and I had no friends at this time likely to try to visit me unexpectedly at 1am in the morning – these events were completely exceptional.

It was not until the following day – Sunday 12 December 2010 – that I came to understand, in retrospect, the reason for the exceptional visit to my flat at 1am the previous morning, and made the connection between it and my mother’s letter, the earlier visit following my phone call to my mother (with her inappropriate panic), and the sequence of preceding communications between us. Anyone who knew intimately my daily routine at this time, and my lack of any social connection whatsoever, could not fail to make the same association also – i.e., the unavoidable conclusion that my sister (together with her partner-in-crime [xxxx], who are de facto organised criminals) and my mother had conspired to engineer these visits to my flat by two thugs in an attempt to harm (most likely to murder) me; as they now had the clear impression that I had returned to pursuing my allegations against them, and had a reasonable fear of some impending consequences.

I made a report to the police on the night of 12 December 2010, and was visited by two uniformed police officers. They spoke to me for a considerable time (40 minutes to an hour) during which some of the details related above were discussed, though afterwards I was unsure if the officers had got a clear enough picture of the sequence of events leading up to the two visits. I told them of the initial anonymous email warning sent to my sister, and the subsequent telephone calls to my mother, and also of a further email sent to my sister that same day; i.e., after the second visit to my flat at 1am, but this time sent explicitly from my own email address, which was familiar to my sister. One of the officers offered me the possibility of making a statement, saying that this would result in the police visiting my family. I was conscious of the lack of any explicit evidence to support my allegation, pending further police investigation of possible CCTV evidence for instance, and was prepared for a quick denial from my family, and their assertion that I was, of course, delusional; so I deferred the option of making a statement at that point. The officer seemed content that I should decline to make a statement. The officers discussed with me my mental health history, and the fact that I had been under the supervision of the START Team, and the likely suspicion that I might well be delusional. I suggested that they contact the START Team directly in order to eliminate that suspicion. We discussed at some length the content of my major allegation (i.e., the fraudulent nature of my tonsillectomy operation in 1967), of the earlier submission of evidence to the police in 2003, and of the initial investigation begun by New Scotland Yard. When the officers left I had the impression that some sort of
coherent investigation would follow over the coming days. I expected that they would make some form of referral to New Scotland Yard regarding the outcome of that office’s earlier enquiries; and that they would contact my social worker for clarification over my mental health. I wanted to allow time for the police to make these background enquiries, before submitting a statement, as the enquiries should have detracted the police from their assumption that my allegations were delusional, thus reinforcing their potential as fact. It would anyway have been premature for the police to visit my family before such enquiries could be made.

Over the next few days I received an email from my sister to say that if I continued to send further emails containing the sort of vague threats of the previous ones, they would report me to the police. I responded to this with an email saying that I hoped she would report me, but that of course she was too paranoid to do so, and that that was the reason she and my mother had conspired to send two thugs to harm me. In spite of my reply to her email, and further aggressive telephone calls and text messages I made to her and my mother over the next few days, she did not report me to the police however. My sister certainly had grounds to report me to the police considering the threatening nature of my repeated communications with her and my mother, and I thought it a significant indication of her culpability that she failed to report me.

I waited for a period of about two weeks after the police visit to my flat for the police to contact me. However, they did not contact me, and so I went to Kennington Police Station (on 28 December 2010), this time with the intention of making a formal statement, as had been discussed during their visit. At the station I saw the same two officers who had visited my home. They refused to let me make a statement however, giving no explanation, and even declared that they had never offered to take a statement in the first place. I was astonished at this turnaround by the police, and took the officers’ numbers telling them I would be making a formal complaint about them (see the section below, pp.98-105, for an account of the progress of that complaint). It was clear that the police were now refusing to attach any seriousness to my allegations regarding events on the 10th and 11th December, and had opted instead for their preferred explanation that these allegations were the results of delusional thinking. It was also clear that the officers had made no enquiries regarding the results of the earlier New Scotland Yard investigation; nor had they made any referral to the START Team to clarify the situation regarding my mental health.

To try to counteract their assumptions, I gave them a copy of a letter from Jane Hughes, my social worker at the START Team, confirming that I was not likely to suffer from any delusional symptoms. I also gave them two copies of email exchanges between my sister and myself, and made a brief written statement upon one of these pointing out that my sister had not reported my email and telephone threats to the police, in spite of her threats to do so, and
in spite of my persisting with those communications. I saw that this evidence provided a sufficient test of the possible strength of my allegations, and also suggested that my sister might have abnormal reasons for not reporting me to the police. Had the police attended appropriately to this evidence, it should have given grounds for them to revise their earlier assumptions. However, the officers were highly reluctant to accept any of these documents from me, and I had to insist that they did. The police clearly had their own reasons for adopting their preferred interpretation that my allegations were delusional, and were wilfully blind towards any evidence I offered to them to the contrary, or indeed towards following up on earlier internal police intelligence. In refusing to accept a statement from me regarding my allegations against my family, the police obstructed the collection of relevant evidence. Their misconduct over the issue of the statement suggests that it was their intention from the beginning to prevent this.

During the two-week period leading up to New Year 2010/11, I started to experience other attempts on my life, in the form of attempts at poisoning, in various food products I purchased, cigarettes, and bottled water. I understand that the source of these attempts on my life is other than that of my family, and that it emanates indirectly from the broader institutional and/or corporate bodies potentially implicated in the allegations I have made – there appears to have been a sophisticated, organised, and clandestine attempt to assassinate me unconnected with any contemporaneous threat posed by members of my family. The fact that certain products I purchased from various local stores appeared (astonishingly) to contain poison suggests several things:

1. That there was a degree of preparedness and determination behind attempts to assassinate me which can only be understood as a form of organised imperative, exercised with ultimate power and influence, and with unlimited resources.

2. There was a degree of foreknowledge of the shops that I frequented, and of the kinds of products that I usually purchased, as well as of my immediate movements, in terms of exactly when I would be at a particular store.

3. There was such a degree of penetration of local businesses by organised criminals contracted with this undertaking, that such criminality could be induced and mandated within the management and employees of the stores at short notice.

4. That the reasons behind the planned assassination obviated the use of any ‘conventional’ method of killing, such as by shooting – in other words, it would be problematic if I should die by violent means, rather than by means which could be interpreted publicly as ‘self-inflicted’, ‘accidental’, or as ‘natural causes’.

Until I lost possession of my flat in January 2019, I had retained numerous items in my possession that were suspected to contain various kinds of poison, collected between December 2010 and February 2014; including a bottle of water, which I strongly suspected
to contain a solution of radioactive polonium-210. I had consumed literally a few drops of the water, being habituated at this time to taste-testing everything I consumed, and was able to distinguish, after researching the toxic effects experienced as a result of that exposure, that it was likely to have been poisoned with a radioactive substance – polonium-210 has recently been employed in other assassinations.* Importantly, this kind of threat to my life emerged for the first time in direct coincidence with my request to St Thomas’ Hospital Information Governance Dept. for a copy of my Brain MRI scan in December 2010 – beginning exactly during the period between my making the request and receiving the scan copy. The fulfilment of the request would imply that I would shortly acquire for the first time the key prima facie evidence sufficient to confirm my major allegations.

During December 2010 I visited St Thomas’ Hospital Accident & Emergency Dept. on three separate occasions with symptoms of mild poisoning, the last of these being on 31 December, following my minimal consumption of the poisoned water. I had managed to avoid consuming any fatal dose of poison, being generally alert at this time to the likelihood of this kind of threat, carefully taste-testing everything I consumed in the smallest possible amounts. When I did encounter the presence of toxicity, the effects were therefore mild, and I was able to self-medicate against them by consuming large amounts of water and vitamin C. Consequently, during these visits to the hospital, the symptoms were not immediately apparent to an external observer, and these visits were largely attempts on my part to obtain

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* I am aware that polonium-210 is a highly radioactive source of low-penetration alpha radiation, which is dangerous if inhaled or ingested. Alpha radiation will not penetrate most materials, e.g., skin or paper; and as polonium-210 emits no significant gamma radiation, this makes it easily transportable. The effects experienced after tasting a few drops of the water (a-d were experienced immediately or shortly after) were:

a) An immediate ‘hit’ or ‘buzz’ from the oral presence.
b) A feeling of being hot and flushed, with severe vasodilation.
c) Acute liver pain.
d) Several isolated tiny dark-red spots appearing very quickly on my skin in the wrist area, then disappearing over a period of several days.
e) Developing general sickness over the subsequent 12 hour period, which became negligible after a further 24 hours.

Obviously, I did not receive a fatal dose, and was able to eliminate the toxicity by eating lots of fresh foods, water, vitamins, kelp (iodine), and fish oils, soon after the general sickness developed. I did go to A&E shortly after consumption, with acute liver pain, but before the general sickness developed, so the symptoms weren’t very apparent; and again, as related below, the doctor refused to take my claims of being poisoned seriously, and refused to make any tests, having been alerted by my online summary health record of my previous supervision by mental health services, following my self-referral in 2007 (see p.48 above). I had not at that point formed the suspicion of radiotoxicity, and only reached this conclusion after subsequently researching the subject. Before these events, I had already decided to leave the country, to avoid this series of attempts on my life, and my visit to the hospital came a few hours before I boarded a plane, so there was no subsequent follow-up visit to the hospital or my GP. The general sickness had already developed by this time, but fortunately it was not so severe to prevent my travelling. I recovered shortly after while abroad by my own efforts [see: Guilmette, R., Why ²¹⁰Po?, Health Physics News, Vol. XXXV number2, Feb. 2007 (URL: http://somr.info/lib/polonium_210_story.pdf – accessed 27/05/2023).]
some biochemical evidence, through blood or urine tests, of these attempts on my life. On each visit to St Thomas’ however the doctor assigned to me made reference to the online summary of my SLaM mental health record, on which was recorded my period of supervision by the START Team (see p.48 above), and which alerted them to the suggestion that my complaints of poisoning were delusional. Consequently, they felt no obligation to take these complaints seriously, refused to make any blood or urine tests, and referred me instead to mental health services.

In view of the fact that my reports of attempts on my life were being persistently spurned both by the police and subsequently by health services, and despite being in possession of evidence that would have proved attempts of poisoning, it became clear from these experiences that any recourse to the police or to medical services was useless for me, against what was becoming an insistent threat to my life. Ironically, only by succumbing to a fatal or near-fatal dose of poison would I have had any chance of impressing upon the police or health services the reality of these attempts. Therefore, I saw the necessity to urgently vacate my flat, which I did on 1 January 2011.

When I returned to my flat six weeks later I discovered that my locks had been tampered with, as though they had been expertly picked but leaving them stiff and slightly damaged. It also appeared that certain consumable items I had left in the flat may have been poisoned, as after taste-testing a selection of these I experienced symptoms of an immediate disturbing increase in heart rate which, had I continued to consume the product in normal amounts, I suspect would have resulted in heart failure. Since my experiences before New Year 2010/11, every product I ate or drank had to be tested in gradually increasing amounts, starting with the merest taste (alternatively, with certain products, I would make initial tests on the skin on the inside of my wrist). On numerous occasions since December 2010 the symptom experienced from the oral presence of a tiny amount of various products was just such a disturbing increase in heart rate, to which I would respond by washing my mouth urgently, and consuming large doses of vitamin C to counteract the toxicity. While this has been highly inconvenient, only by rigorously taste- or skin-testing everything I consumed did I manage to succeed in anticipating every attempt at poisoning. However, it has not been possible entirely to avoid repeated exposures to non-fatal doses of toxicity.

I attempted to report the illegal entry to my flat to the police, by telephone, and also by visiting Kennington Police Station. However, my report was spurned once more. After that time and through until the autumn of 2012 I was unable to make regular use of my flat, in view of the anticipated risk to my life there, and had to maintain constant motility and secrecy over my whereabouts, avoiding using any regular channels of communication, to prevent my movements being tracked. Effectively, for a period of 20 months, I was forced to remain in hiding.
Later, towards the end of 2013, there was a further resurgence of these attempts, meaning that again I had to take great care over my movements, avoiding shopping in the same shop more than once, and always travelling to unfamiliar locations to shop, and of course continuing to taste- or skin-test everything I ate or drank, before consuming it normally. This was my only recourse to any form of protection, since it was clear that any attempt I might make of presenting evidence of poisoning to the police would be sneered at, and would at best result in a further referral to mental health services.

After three years of experiencing these kinds of attempts on my life, I was becoming quite adept at anticipating and averting attempts to poison me, and the attempts on my life had largely (but not completely) abated between the autumn of 2012 and the end of 2013. However, there began in January 2014 what I understand to be a resurgence of attempts by members of my family, firstly to establish my whereabouts, with a view to then arranging their own (second) attempt on my life. However, I am uncertain exactly which events had precipitated this renewed concern on their part.

I had had no further contact with my mother or sister since the events in December 2010, when I had communicated to my sister by email my awareness that they had orchestrated an attempt on my life. In that email I had included comments intended to confuse my sister over my actual address. Following this my sister would have been uncertain whether or not I remained at the address they knew as mine. On 10 January 2014 I received an unexpected email from my sister containing no content other than an unrecognisable hyperlink. The email was sent to a distribution list containing eight email addresses with mine as the last, none of the others which I recognised. I did not follow the link, but instead forwarded the email to the Staffordshire Police, as I thought it highly suspicious.

This scenario was repeated on the 29 January, and again on the 11 February, each time with emails containing unrecognisable hyperlinks (different from the first, and from each other) and each sent to a varied handful of addresses. Again I did not follow the links, sensing that my sister was trying to lure me into clicking on a link which would then enable her, or her associates, to track my location. On the 13 February, I received an email from a different, remote family member, alerting me to the fact that my mother had become dangerously ill, suggesting that I should contact my sister; which was odd since my sister clearly had my email address, and had sent an email to me only two days before, containing no information whatsoever. I did not reply to the email of 13 February.

On the supposition that my sister might somehow have obtained some assurance of my address (despite my refusal to subscribe to the tracking links), with a view to orchestrating a further attempt on my life, there were limited options available to her and her partner-in-crime. In view of the fact that I would be unlikely to answer the door to any assailants they
might send to call on me (I assumed by this time my sister was wise to this policy of mine with respect to unexpected callers), aside from staking-out my flat for extended periods of time by contractors who would not be familiar with my appearance, the only conceivable means of access to my residence were my external letterbox and the small gap underneath the door of my flat. I was, needless to say, already alert to the possibility that someone might try to deliver a toxic substance by either of these two routes.

On 14 February 2014, the day after the email from the remote family member, I was at home when I noticed distinct feelings of numbness on the left side of my head, with some faintness. The symptoms were not at that time very persistent, but I noticed them intermittently throughout the day. It was not enough to convince me that someone had put poison under my door, but the next morning I took the precaution of cleaning the floor inside the front door with a damp cloth and a vacuum, while wearing protective gloves.

I did not experience further symptoms until the afternoon of Monday 17, when, about 30 minutes after returning to my flat, I began to feel very sick and faint, with more numbness on the left side of my head. I cleaned the floor inside the door again with a vacuum, but did not use a cloth. After a while I started to feel more ill with pain in the left side of my head and an increasing heart rate. My heart rate was accelerating and seemed uncontrollable, and I became worried of an incipient heart attack. I prepared to call 999, but hesitated in view of my previous experiences with emergency services. At the same time I took 2g of soluble vitamin C (a very large dose) which quickly moderated the heart rate and it eventually subsided. The sickness and faintness persisted however, along with numbness on the left side of my head, so I determined I had no choice but to leave the flat, which I did the same day.

Following this event, I was ill for a period of several weeks with ongoing neurological and cerebral-vascular problems involving the left side of my head, leading me to suspect that the substance I had been exposed to at my flat may have included some form of neurotoxin. I strongly suspect that some extremely toxic substance (i.e., potentially fatal if inhaled in tiny amounts) was placed under my front door on more than one occasion between 13 and 17 February 2014, and that the effect of attempting to vacuum the substance was to make it airborne (i.e., by it being partly expelled through the fan of the vacuum cleaner). I had no adequate defence against such an attack, and for the remaining duration of my tenancy (which ended in January 2019) I could not determine to what extent my flat remained contaminated, and so I was unable to safely occupy the flat after 17 February 2014.

I left the UK on 17 February due to the implicit threat to my life should I have remained there, and spent the next thirteen months as a de facto refugee from that country and from the European mainland (see pp.106-107 below for a description of my application for political asylum in Turkey). It was therefore infeasible for me to make any report of the events in
February to the Lambeth Police. I did however report them to the Major Investigations Dept. of the Staffordshire Police by letter sent as an email attachment on 26 February 2014, attaching the two additional suspicious emails from my sister. I have received no response to this report from the Staffordshire Police, and there is neither any indication that the Staffordshire Police have referred the report back to the police in Lambeth.

It became necessary for me to return to the UK in March 2015, principally for financial reasons (see p.107 below). When I visited the flat for the first time to collect my mail on 7 March 2015, I spoke to my neighbour who reported to me that that same morning he had heard someone unlocking the door to my flat, and noises coming from inside the flat like the opening of cupboards and movement of furniture. He had assumed that it was me, until I informed him that I had only just that moment returned to the flat for the first time in over a year. He also pointed out that the keyhole covers from the two mortice locks on my front door had been removed, which I also acknowledged. There was no one to my knowledge who had copies of the keys to the flat who may have entered there legitimately.

That same afternoon I reported the suspected illegal entry to my flat to the police in person at Walworth Police Station, at the same time attempting to alert the police to the presence of a serious toxic hazard at the flat, as a result of previous attempts on my life there, and which was preventing me from occupying the flat. Neither of these reports however was greeted with any serious attention. After several further phone calls to the police on the ‘101’ number over the following days, eventually it was agreed that an officer would visit me at my address on 13 March 2015.

I met with PC Burgess 184LX of the Lambeth Police outside my address at 2pm that day.* Despite my neighbour having agreed in advance to be present at the arranged time of the officer’s visit, he was not however at home when the officer and I rang on his doorbell. This was unfortunate because the significance of this occasion was that it was the first time there had been any available witness evidence to support the series of reports of attempts on my life, and associated illegal entries to my flat, that I had tried to make to the police since December 2010.

From the recording of our discussion, it is apparent that PC Burgess was not briefed appropriately regarding the nature of my report made at Walworth Police Station with respect to the context of an attempt to poison me at the flat, and the fact that the apparent illegal entry had not resulted in anything being obviously removed from the flat. Hence, in the absence of evidence of a property crime, or of an open and explicit threat of violence, the officer saw no reason to pursue an enquiry, or to make any crime report. In the absence of

* There is an audio recording available of my conversation with PC Burgess on 13/03/2015.
my neighbour’s testimony, the content of our conversation was essentially me trying to impress upon PC Burgess, with some apparent frustration, the reality of the toxic hazard at the flat – which in itself was evidence of an attempted murder – and to elicit some meaningful response from the police, without which I could neither safely occupy the flat, nor safely remove my belongings from the flat.

Generally since December 2010, the Lambeth Police have refused to treat my reports of attempts on my life (and the material evidence offered to them) with the seriousness and sensitivity they required. The nature of those allegations, and of the specific non-visible evidence in support of them, demanded the attention of officers with criminal investigation skills (CID), as well as forensic/toxicologist teams. However, as already mentioned above, the Lambeth Police were anyway predisposed to treat my allegations as ‘delusional’, which tended to preclude the police from investing these kinds of resources in response. The result of Lambeth Police’s exclusive reliance on ‘beat coppers’ in the assessment and collection of evidence was its blindness and insensitivity to any evidence other than that which pointed to an obvious crime against property, or to the sort of intended violent crime where the perpetrator incriminates her/himself by issuing an open written or verbal threat to the victim.

In the recording, PC Burgess is generally dismissive of the potential evidence of an attempt to deliver poison under the front door of my flat, because there was no obvious visible sign of it. As the officer’s remit, as she understood it, ended at the recording of the obvious visible signs of a crime, she was unreceptive to my information about the existence of a highly toxic substance at the flat, which could not be seen, and which was particularly concentrated in my vacuum cleaner. PC Burgess was also reluctant to accept a copy of the evidence of my statement of the events of February 2014 made in my letter to the Staffordshire Police of 26 February 2014, and the tracking emails sent by my sister at that time. Her remarks in the recording suggest that she felt this would have overcomplicated her task of making a report upon what we had discussed, and what she had seen (or not seen) at my flat that day.

Despite informing PC Burgess that my report of the attempts on my life in February 2014 was made only to the Major Investigations Dept. of the Staffordshire Police, as I was not in Lambeth, and had no way of making an effective report to the Lambeth Police, it is apparent from the recording that she did not see the relevance of making any referral to the Staffordshire Police for their evaluation of my report, or with regard to intelligence about a possible investigation of members of my family by that force. This lack of a ‘joined-up’ approach on behalf of the Lambeth Police, and the unwillingness to link-up the then current report with my series of previous reports (other than as further indication of ‘delusional thinking’ on my part), or to attach any credibility to those reports, meant that the evidence of poisoning, which undoubtedly existed at my flat, would continue to go uninvestigated; and
therefore would continue to prevent my occupation of the flat indefinitely. Having already been minimally exposed to that toxicity, and feeling lucky to have survived that exposure, I did not feel that I could safely dispose of the evidence that I knew to exist in my vacuum cleaner for instance, and to do so would have been to destroy the evidence of an attempt on my life. In view of the suggested illegal entry to my flat, I had also to consider the possibility that my belongings, or fixed facilities within the flat, might have been ‘booby-trapped’ in my absence. Hence, in the absence of any resolve by the Lambeth Police to take seriously my reports of the existence of a serious toxic hazard at the flat, I remained unable to safely occupy the flat, or to remove my belongings from there. There was however no further response from the Lambeth Police to the reports made to them in March 2015.

As I remained unable to occupy my flat following my return to the UK in March 2015, between May 2015 and January 2016 I stayed instead at the flat of an old friend in another part of London. During much of that period I experienced a relative absence of organised attempts on my life (a respite facilitated only in part by the fact that my sister, for one, had no inkling of my whereabouts, absent as I was from my home address). There had however been frequent periods of relaxation of those efforts before between 2011 and 2014, only for them to be re-engaged at a later opportunity, apparently with the intention of taking me strategically by surprise.

In July 2015, I came into possession of items from my medical records from 2013 – specifically, two letters of referral of myself to mental health services, in response respectively to my two complaints made in 2013 regarding the cover-ups of MRI evidence at Guy’s & St Thomas’ and UCLH NHS Trusts (see pp.53-60 & 65-69 above). This encouraged me to make two further complaints: the first against The South London & Maudsley NHS Trust (‘SLaM’) in October 2015; the second against UCLH NHS Trust in November that year. These two complaints followed shortly after my several attendances at the Royal London Hospital, with regard to the problem that developed in June 2015 in the region of my thoracic spine/left shoulder blade (there is no connection however between RLH and the complaints to SLaM and UCLH). In relation to the problem in my left shoulder, I have alleged that doctors at the Neurology Dept. of RLH deliberately misrepresented my reports of the symptoms and were wilfully negligent towards the assessment of the problem (see pp.73-74 & 79, in the section: Spinal MRI Scans (2015-2020), pp.72-80 above).

The end of the year 2015 therefore was marked by a general resurgence of my interactions with medical institutions, partly in relation to my earlier (and still unresolved) complaints against GSTT and UCLH over their respective cover-ups of evidence; together with two new complaints against UCLH and SLaM. Added to these was the prospect of a new potential serious complaint against the Neurology Dept. at RLH. This is the context – the new
complaint against UCLH was referred to the PHSO on 28 December 2015 – in which I experienced a further resurgence of attempts on my life towards the end of January 2016.

There was an increased determination behind these new attempts, in view of the kinds of substances employed, and the tactics employed to deliver them. The substances again appear to have included radiotoxic substances (symptoms of exposure to which are unmistakable, even in the mildest doses), and they were delivered to me by persons with whom I had some sort of passing incidental acquaintance, by their replacing items already in my possession with identical items containing poison; although it is very difficult for me to substantiate these claims, since I am not inclined to attempt to retain the evidence. However, in my judgement it is an indication that those contracted with this undertaking were employing methods of last resort (in view of the nature of the substances involved, which are difficult to safely handle even by the poisoner), and therefore were absolutely determined to succeed, no matter what. It is also suggestive of a degree of synchronicity between the processes of my complaints against several medical institutions and the cyclical nature of these attempts on my life; bearing in mind that my first experiences of attempts to poison me began in December 2010, in exact coincidence with my application for a copy of my Brain MRI scan from St Thomas’ Hospital Information Governance Dept. (GSTT NHS Trust). Bearing in mind also that during the period following my return to the UK in March 2015, when there was a noticeable lack of activity on my behalf regarding the unresolved 2013 complaints against GSTT and UCLH, until late 2015 (when I renewed attempts at litigation against UCLH) there was a corresponding period of reduced intensity in clandestine attempts to poison me.

In view of the increasing desperation behind these more recent attempts, I felt I had no choice but to leave the UK once more, which I did on the 8 February 2016, becoming once more a de facto refugee from my home country. I spent the next five months outside the UK and mostly outside mainland Europe (where the attempts on my life are generally most persistent and organised), returning to the UK in July 2016 (see below pp.107-109, for an account of my movements during this period). My commitment, for a large portion of the period December 2010 to July 2016 (during which time I received very little income) to constant mobility and secrecy over my whereabouts, as a way of tactically avoiding attempts on my life, meant that I needed to spend a significant portion of my limited savings on travel and additional accommodation. As I had by July 2016 been able to safely occupy my flat in London only for roughly 17 months (September 2012 to February 2014) of the intervening 67 months, I was by that time running very low on cash. Therefore, in July 2016 I felt that I had no choice but to try to make my case more vocally at home.

Between July and October 2016, I submitted copious information and evidence to various national news organisations with regard to my historical allegations against the NHS and the
British government; the recent cover-ups by several London hospital trusts of medical evidence that would otherwise have supported those allegations; as well as evidence which pointed to the inactions of the police with respect to reports of those cover-ups, and with respect to evidence of attempts on my life; together with evidence of the refusal to appropriately assess or treat my current health problems, in particular by the Royal London Hospital. There has however been no recognition or acknowledgement whatsoever from any of these news organisations in response to my reports. Despite all of these efforts therefore, I remain without any protection from the law against the still-persistent organised attempts on my life.

As I had meagre financial resources, I was unable to maintain indefinitely the mobility and tactical avoidance necessary for me to survive the attempts upon my life. One consequence of this was that, as I could no longer afford my usual habit of changing accommodation on a nightly or two-nightly basis, I tended to remain in certain hostels in London for extended periods of several days or longer. During the first two weeks of October 2016, while booked consecutively into two separate hostels, and with the perpetrators apparently taking advantage of the length of my stays, my luggage was broken into on two separate occasions and attempts were made to poison food and toiletry items I kept there. There were signs on each occasion that the lock on my case had been tampered with, meaning that I was able to anticipate each invasion before succumbing to a fatal toxic exposure. Subsequently, after testing certain toiletry items on my skin and experiencing toxic reactions, on each occasion I was able to avoid any further exposure by discarding all of the consumable contents of my luggage. The novel ‘directness’ of these kinds of attempts to invade my property meant that it was becoming increasingly problematic for me to leave my luggage unattended for any length of time at all.

Both of these attempts were reported to the Metropolitan Police, either on the ‘101’ number, or by visiting Holborn Police Station. Characteristically, the police refused to pay any serious attention to these reports, unless I could present them with some form of medical evidence of poisoning. However, as my exposures on each occasion were relatively mild, and as there were no obvious visible signs of poisoning at the time of visiting the police station, it was most unlikely that I would succeed in getting a doctor to take my reports seriously either (especially in view of my earlier experiences at St Thomas’ Hospital A&E Dept. in December 2010 – see pp.85-86 above). In the circumstances, the most likely result of any approach to health services would be that of being further referred to mental health services – a result that would be quite counterproductive, as the effect would only be to reinforce the likelihood of the same form of response on any subsequent occasion, due to the reduplication of such referrals existing in my medical records. Ironically then, the only circumstances in which the police might have taken my reports seriously is if I had succumbed to a fatal or near-fatal dose of poisoning.
I have related above that, as all attempts since December 2010 to poison me by indirect methods had failed consistently, the perpetrators were now employing methods of last resort, involving an increased ‘directness’ in their approach. It is important to point out that, in order to be able to guarantee access to my luggage (i.e., for instance, by being booked into the same dormitory as myself), and to have some indication of how long was my intended stay in a particular hostel, the perpetrators must have depended on the complicity of the respective hostel management in order to plan and execute the attempts. They must also have employed additional persons to watch my movements, so that if I was to return unexpectedly to the hostel at the critical moment, then they could be adequately forewarned of that possibility. In view of the combined odds working against me therefore, and in view of the unavailability of any protection from the Metropolitan Police against the continuance of these organised attempts, on the 17 October 2016 I was forced once again to flee the UK, and the European mainland (see pp.109-114 below for an account of my efforts at seeking asylum in Morocco in November 2016; and again in October 2017).

My first attempt at seeking asylum through UNHCR in Morocco was short-lived (see pp.109-110 below), and I returned to the UK on 2 December 2016. The following few months, until April 2017, were spent in much the same manner as before my departure in October 2016; i.e., by moving from hostel to hostel and from town to town on as frequent a basis as I could afford. I developed a strategy of inhibiting attempts to break into my luggage by ‘sealing’ the fastenings on my suitcase with “Magic Tape” (writable sellotape), which I would then ‘sign’ with indelible marker pen. This method proved to be more secure than any lock (I was unconcerned about theft), as any invasion of the suitcase would have necessitated destroying the unique inscription on the seal, leaving it obvious to me that someone had broken in. The problem persisted however that it was unsafe for me to leave the suitcase unattended and unsealed for any length of time at all – for instance time spent in the kitchen cooking a meal.

In April 2017, I found a place to stay with a friend who had become terminally ill, so that in exchange for sanctuary, I acted as his carer for several months. The location was one that I had not frequented previously and while I was there I refrained from most internet use, or from regularly using a mobile or smartphone, so that my presence might remain as private as possible. It could not have been a permanent solution however, as I was largely inhibited from any communication, such as that that would be necessary to advance my medical claims. After five months in this position, I resolved to depart the UK once more to pursue again the application for political asylum with UNHCR that had been aborted at the end of 2016, departing the UK once more for North Africa on 27 September 2017.

The quite remarkable events occurring in association with my asylum application in Morocco during October 2017 are related in the section titled Applications for Political
Asylum (see pp.110-114 below for an account of my approaches to UNHCR in Cairo, and again in Rabat, Morocco). In those pages I have referred to the fact that the common pattern of attempts on my life by methods of indirect poisoning (involving the supply of toxic products masked as standard ones, by routine purchases made at shops and market stalls) had now extended to Morocco, within a predominantly Muslim population, amongst which I had previously enjoyed relative sanctuary from such organised attempts on my life. This indicated to me that during the year of my absence from Morocco significant steps had been taken by European ‘mafia’ to extend its distributive reach (and economic influence) into this domain, seemingly in anticipation of my return there to pursue again my previously aborted asylum application. At the same time (I suspect these two developments were not unconnected) there were strong indications of corrupt behaviour by staff at UNHCR Rabat, who had tried to conceal the fact of my asylum application from detection by external agencies, by falsifying the details of my identity on the asylum registration. The upshot of this was that, had the attempts on my life there succeeded, the event of my death in Morocco need not have attracted any unwanted controversy.

For these reasons, and because UNHCR Rabat were resistant to my requests that they should process my application without further delay (in view of the pressing medical issues involved), as I now had effectively no more protection in Morocco than I had anywhere in Europe, when UNHCR notified me by email on 23 November 2017 of a three-month delay prior to my interview for refugee status determination, I decided to leave Morocco the following day and return to the UK, travelling overland.

After returning to the UK, things continued much as before – with the need to constantly change my location to stay ahead of attempts to poison my belongings. This was usually manageable, except for instance on New Year’s Eve when it was necessary to book my accommodation a week in advance. On 23 December 2017 I made an online booking for New Year’s Eve at a hostel in Hackney. Consequently, my attackers had a reasonable amount of time to plan a significant attempt on my life. This involved the use of sedation after I arrived at the hostel, leaving me unconscious for several hours having left my luggage unguarded. Several items in my backpack appeared to have been tampered with, and therefore I suspected may have been poisoned. I addition, I believe that the battery in my mobile phone may have been exchanged for a modified battery (for what purpose remains unclear). I noticed that the battery showed signs of slight damage. As both the phone and battery were quite new, this indicated to me that the battery had been swapped. Fortunately, when I awoke I realised immediately what had occurred (being anyway alert to this kind of possibility out of sheer necessity), and again was able to avoid any fatal toxic exposure by discarding the consumable contents of my backpack, and abandoning any further use of that particular phone.
These events were reported to the police at Stoke Newington Police Station, where I had a meeting with Detective Sergeant Bent (no satire intended) on 8 February 2018. In spite of the fact that in the sequence of events which followed the making of the booking online, up until and including my reception at the hostel, there were circumstantial factors which might have indicated to the police that the hostel management were complicit in the attempt on my life I was trying to report, and in spite of my offering material evidence to DS Bent which would have confirmed the reality of an attempt to poison me and to tamper with my phone, DS Bent dismissed all my reports out of hand, declaring: “I think it’s all in your head”; and stated that he was unwilling to invest police resources in examining the evidence.

One might raise the question: If they were able to sedate me in the hostel, then why didn’t they just finish the job? My answer to that would be that the plan in place was clearly that I should succumb to the effects of the various poisoned items after having left the hostel (since it was a one-night booking), so as not to invite any suspicion upon the hostel management, whom I have good reason to believe were implicated in the attempt. This underscores the idea that in general the method in all the attempts on my life was to cause me to suffer poisoning in as indirect a way as possible. My death might then be interpreted either as ‘self-inflicted’, ‘accidental’, or as the result of ‘natural causes’ (since not all poisons are readily detectable after death); thereby without attracting any unwanted controversy.

Following the events in Hackney at New Year and until the present time, there has been little respite in the persistence of attempts on my life, although there have been some noticeable shifts in strategy on behalf of those responsible. Generally, the perpetrators were able to take advantage of my financial insecurity and dearth of funds during this period, which seriously inhibited my ability to travel abroad to seek sanctuary in countries beyond the borders of Europe. So while I was compelled to remain within the UK for much of the year 2017, it was necessary for me to ‘double-down’ on my efforts to stay one step ahead of any attempts to track my location for the purposes of interfering with my luggage – the strategy that has, since 2016, tended to be the last resort of those determined to end my life in order to forestall my efforts to bring to public light evidence of an historical NHS crime against humanity. While I retain in my possession several items which will eventually confirm the reality of attempts on my life during this period (including items from the incident in Hackney at New Year), it is very difficult in this context to represent details of these examples with any credible detail – the substances employed are generally quite sophisticated, and vary according to the current strategy of the perpetrators. The nature of their chemistry is therefore frequently obscure and hard for me to positively identify, meaning that I can only speculate on the nature of the substances employed; until such time that is as they may be submitted for toxicological analysis.
I appreciate that in recounting these events, which in their very nature and persistence over time are truly exceptional, that the narration begs an enormous suspension of disbelief from the reader, not least in terms of explaining how I have actually survived all of these attempts, if they were as determined as I have presented them to be. The key here is in the indirectness of the attempts (implying a loss of control by the perpetrators over the end result) – a characteristic determined by the chief concern on behalf of those responsible for avoiding unwanted controversy. The other key factor enabling my survival has been my constant vigilance and attention to detail (not to mention a great deal of luck), which has so far meant that I have always been able to anticipate when it was likely an attempt had been made, even if this meant being exposed to a non-fatal dose of toxicity.

The final point to make is that, to maintain such a series of attempts on my life over a period of what is now more than 12 years (with some periods of relative relaxation) – requiring access to toxins not readily available in the public domain (including, indeed, nerve agents and radio-toxins), plus the logistical provision of such substances within standard manufactured products – must have demanded a level of civil influence and control (exemplified in particular by the continual suppression of police interest or action) such as is only befitting those in the position of state actors. This returns me to the point made earlier – that the organised criminals serially contracted with this urgent undertaking acted under the protection of those with ultimate power and influence, supported by unlimited financial resources.
Complaints against the Police

Upon my enquiring, in August 2011 (on at least four separate occasions), as to the progress of any investigation, or of any information recorded in consequence of the police visit to me in December 2010, or of my reporting the subsequent illegal entry to my flat in February 2011 (pp.82-86 above), I was told by desk staff at Brixton and Kennington Police Stations that there was nothing on the police computer relating to either of the reports I had made. It was even suggested by a desk officer at Brixton Police Station that access to these reports may have been ‘restricted’, for whatever reason. It seemed to me therefore, either that the police were treating any report I had cause to make to them with an approach of ‘blanket ignorance’, by disregarding relevant evidence, and also in declining to make routine logs of the reports; or that perhaps the records had indeed been restricted from routine police access, as had been suggested by the desk officer. In either case, it was clear that the reports I had made to police in December 2010 and February 2011 were being suppressed, if not ignored completely, and in order to pursue an enquiry over the reasons for this suppression, as well as the misconduct of the two officers over the issue of my statement in December 2010, I submitted a complaint to the Metropolitan Police Directorate of Professional Standards (‘DPS’), in September 2011.

The outcome of this complaint, and of the subsequent appeal to the Independent Police Complaints Commission (‘IPCC’), was generally a ‘whitewash’, as neither of these procedures attended satisfactorily to the explicit grounds of the complaint. What did transpire from the DPS’s and IPCC’s responses however, was the actual existence of police computer records of the reports made to them in December 2010 (but not that regarding the illegal entry to my flat made in February 2011). My complaint, having been hampered by ignorance of the content of those records, was therefore ill-focused, while both the DPS and the IPCC were nevertheless able to use the content of those records in order to subvert the grounds of my complaint, by simply reiterating the validity of the police’s initial assumption that my allegations against my family were ‘delusional’, and that ‘on the balance of probabilities’ there was insufficient evidence that any crime had been committed. Both responses however were made with blatant disregard to the additional evidence I submitted to police on 28 December 2010, which explicitly undermined that initial assumption.*

Moved by my frustration with the police and IPCC, in January 2012 I decided to send a copy of my first MRI scan and an updated version of this report to the Staffordshire Police, who had earlier responded (in 2003) that they would not pursue an investigation over my major

* The progress of my complaint to the DPS and subsequent appeal to the IPCC, including relevant correspondence, are reproduced in detail at URL: http://somr.info/report/rep3.php – accessed 27/05/2023.
allegations due to the lack of any prima facie evidence. This was duplicated to the Metropolitan Police at New Scotland Yard. I received a response from DI Pattinson of the Major Investigations Dept. at the Staffordshire Police two months after my letter (I received no response at all from New Scotland Yard). In his letter he states: “Having carefully examined the detailed information I have also come to the conclusion that there is insufficient evidence that would warrant the initiation of an investigation by Staffordshire Police.” He does not refer specifically to the key prima facie evidence – that of the MRI images – or state that he has sought the opinion of any medical expert in forming this conclusion, and we must assume that he hasn’t, or surely he would have mentioned it. It is clear that he felt unable to consider this evidence in the absence of expert medical corroboration, in spite of the fact that even to an inexpert eye the combined evidence is strongly suggestive of an illicit surgical implantation. The situation therefore appears irresolvable, in the sense that I am in possession of clear and distinct incontrovertible evidence pointing to an unprecedented medical crime, which however no medical professional is prepared to corroborate due to its extraordinary sensitivity, and over which, by virtue of that reticence alone, those institutions having a duty to acknowledge that evidence (including several major hospitals, the police, the GMC, and now the Heath Service Ombudsman) can persist in arbitrary denial.

At the end of June 2012 I made a subject access request under the Data Protection Act to the Metropolitan Police Public Access Office to obtain copies of the information held by the police in relation to the reports I had made to them in December 2010, with regard to the allegations that my family had conspired to send two men to my flat to harm me. This included a request for copies of the evidence I had submitted to police on 28 December 2010 (see above pp.83-84). This evidence should have given grounds for the police to revise their initial assumption that my allegations against members of my family were delusional.

I did not receive the information from the Public Access Office until 22 November 2012; i.e., more than three months beyond the 40-day deadline prescribed by the Data Protection Act 1998. The information I received did not include copies of the evidence I submitted to police on 28 December 2010. The information included the police incident log from the 12 December 2010 (the day the police had visited my flat in response to my allegation against my family), and CRIMINT reports from 12 & 28 December. Not only had the police refused to take the evidence of a formal statement from me, but from these reports it was clear that they had misrepresented the facts I conveyed to them on the 12 December, and completely ignored the additional evidence I presented to them on 28 December; which it appears has been mislaid or discarded. Therefore, as a consequence of my subject access request, it now appeared that I had fresh grounds for complaint over the events in December 2010, and so I submitted a second complaint to the MPS Directorate of Professional Standards, on 17 December 2012, on the grounds which may be summarised as follows:
1. That the content of the police CRIMINT reports and incident log misrepresent, both by omission and distortion, what was actually discussed between the two officers and myself on 12 December 2010, during their visit to my flat.

2. That the officers had relied upon a casual (as well as ill-informed) assumption that my claims were delusional in nature, and then used this assumption as justification for ignoring the factual content of my allegations against members of my family.

3. That due diligence was not shown by the officers in referring either to New Scotland Yard regarding that office’s earlier investigation of my sister in 2003-4; or to my social worker at the START Team for clarification over my mental health.

4. That no attention was paid to evidence I handed to the officers at Kennington Police Station on 28 December 2010, which is indicated by the failure of the Public Access Office to provide copies of this evidence in response to my subject access request.

The initial response from the DPS Complaints Team was to attempt to ‘disapply’ the complaint on the grounds that it was a) ‘out of time’; and b) ‘repetitious’. However, following my subsequent appeal to the DPS Appeals Unit, on 6 March 2013, with the grounds clarified as in the list above, the Appeals Unit decided to uphold my appeal, on 8 April 2013.* On p.2 para.6 of his decision letter, Sgt. Cochran of the Appeals Unit recognised the four grounds listed above as separate points justifying the recording of a new complaint. However, in his subsequent sentence Sgt. Cochran defines the complaint as: “a new complaint about the content of the [CRIMINT] reports” (only), in effect collapsing the substance of the four separate points into that of point 1 alone.

It seems that the concession of recording a fresh complaint is one that Sgt. Cochran felt begrudged to make, as the remainder of paragraph 6 goes on to forewarn of the likely ‘inhibited’ nature (“given the time frame concerned”) of any ensuing investigation (“should one occur”), in a manner which is difficult not to see as prejudging the outcome of an eventual investigation. It is also difficult to see how he can justify such a warning without undermining the substance of his own decision to uphold my appeal against the complaint being ‘out of time’; i.e., with consideration to my argument that all of the delays contributing to the extended time frame were exclusively the result of delays or failures in the provision of MPS services. The letter goes on to advise that the complaint will be forwarded to the Lambeth section of the MPS Professional Standards Unit (‘PSU’) for local resolution or investigation, and who should: “only address the 4 new points that you have raised”. Following the Lambeth PSU’s investigation lasting 23 weeks, I received their outcome and

* For access to the letter of the second complaint, the subsequent correspondence with the DPS, and with the DPS Appeals Unit, see URL: http://somr.info/report/rep3.php#dps – accessed 27/05/2023.
investigation report in response to my complaint, dated 16 September 2013.*

The PSU had delegated the complaint investigation to a police sergeant at Streatham Police Station – an officer not dedicated to the investigation of complaints, but whose role as investigator was additional to his normal operational role as a police sergeant, and who is, essentially, a close colleague of the two police officers under investigation. In view of his report, I suggest that PS Scott’s generally lax approach to the investigation was encouraged by the rather glib representation of the complaint made in Sgt. Cochran’s decision letter; which had effectively approved the use of inhibition as a method of eliding the substance of the complaint. The latter’s directive that the PSU: “should only address the 4 new points that [I had] raised” also provoked an ambiguity, as it appears that PS Scott then interpreted this strictly to imply that he should consider only the summary of the grounds given in my letter of appeal to the DPS of 6 March 2013 – i.e., in isolation from the original letter of complaint. Hence PS Scott’s investigation report manages to elide any reference to the key item of evidence (the letter from my social worker Jane Hughes) presented to police at Kennington on 28 December 2010, as this item is not specifically referenced in the summary, while reference to it is unavoidable in any reading of the original complaint letter itself.

Furthermore, PS Scott’s investigation has missed key points of enquiry, and was conducted in the absence of any constructive interrogation of the two officers regarding the substantial elements of my complaint; but with a general acquiescence towards their unwillingness to recollect details of the events in question from December 2010. PS Scott unfairly excuses the officers’ selective amnesia over these events on the basis of the gap in time between the events and the complaint investigation (considering the delay was the result of a succession of MPS failures). Having elided much of the substance of my complaint, PS Scott’s decision was, unsurprisingly, not to uphold the complaint against the two officers. Therefore, I saw the necessity of a making a second appeal to the IPCC, dated 10 October 2013.

In their letter of acknowledgement of my appeal, dated 14 October 2013, the IPCC advised me that it may take “up to 36 weeks” to allocate my appeal to a Casework Manager. This compared to a period of 4-5 weeks mentioned in their acknowledgement of my appeal against the outcome of my earlier complaint in October 2011. This would be to add a further nine-month delay to what was already (in October 2013) a two-year delay in the investigation of my complaints over events in December 2010 – this accumulated delay incurred principally due to failures in Metropolitan Police services.

The IPCC’s appeal decision was eventually received dated 5 June 2014. Their review

* For access to the outcome and report from the PSU, and my subsequent appeal to the IPCC, and the IPCC’s final response to that appeal, see URL: http://somr.info/report/rep3.php#psu – accessed 27/05/2023.
considered five points in relation to the complaint. Its response to the first of these – on the key question of whether the findings of the MPS investigation need to be reconsidered – has determined its response to the three subsequent points (whether there is a case of misconduct to answer; over the adequacy of the proposed actions of the MPS; and over the necessity of a referral to the CPS). The IPCC’s decision on this first point is not to uphold the appeal, having found that the findings of the police investigation were an appropriate/proportionate response to the complaint.

On the fifth point, over the question of the adequacy of information provided following the complaint investigation, the decision of the IPCC is to uphold the appeal, although its reasoning on this point (as well as that on the first and key point mentioned above) is rather obscure. Although it has upheld the appeal on the question of the adequacy of information provided in relation to the complaint investigation, it has not recommended that any further action is required on behalf of the MPS, having already decided on the adequacy of those actions in respect of point 3.

The IPCC’s response in respect of point 5 (p.4) is to state:

“The [Investigating Officer]’s report dated 16 September 2013 provides adequate information about the complaint investigation, but could have been clearer about the inclusion of the matters raised in your letter of 17 December 2012 in conjunction with your appeal documentation. Whilst the heart of your complaints have clearly been addressed this could have been communicated better.”

The effect of this statement is to interpret the clear inadequacies of the complaint investigation detailed in my letter of appeal to the IPCC – its failure to follow key points of enquiry by ignoring the text of my original complaint letter – merely as a lack of clarity in information provided, thereby granting a weak concession over the adequacy of information provided, in order to avoid a stronger concession over the glaring inadequacies of the investigation, which would have necessitated the IPCC directing the MPS to re-investigate the complaint.

With regard to the first and key point, over the adequacy of the MPS investigation, my appeal had listed three grounds, which were, succinctly:

1. That the investigation of my complaint has considered only the succinct grounds of the complaint, as stated in my subsequent letter of appeal to the DPS against its motion to disapply the complaint on 6 March 2013, in abstraction from the substance of the original letter of complaint.
2. The investigation unfairly excuses the general ‘lack of definitive recollection’ on behalf the officers involved, based on the length of time between events in December 2010 and the complaint investigation.

3. The investigation is incomplete with regard to the events at Kennington Police Station on 28 December 2010.

In relation to the first ground, I understand that this failure resulted from PS Scott’s response to the directives provided by the DPS in referring the complaint back to the Lambeth Borough for investigation. It is clear from section A.1 of PS Scott’s investigation report that he understands the complaint to be a repetition of the earlier complaint made in September 2011, in spite of the fact that the DPS had upheld my appeal against disapplication on the ground that the complaint was ‘repetitious’ on 8 April 2013. As detailed above, Sgt. Cochran’s directive to the PSU was that the new investigation should consider only the four grounds (see p.100 above) that had been summarised in my letter of appeal to the DPS of 6 March 2013. The correct interpretation of this directive was that a reading of the original letter of the second complaint (dated 17 December 2012) in terms of the grounds as summarised would permit a clear distinction to be drawn between the first and second complaints, so that the new complaint would not then appear as repetitious. It seems then that PS Scott has missed the objective here, as it is clear he still considers the new complaint to be a repetition of the earlier complaint, and has interpreted the directive glibly to imply that he should consider only the text of the succinct grounds set out in their summarised form, in isolation from the text of the original complaint; and as a method of eliding the substance of those grounds detailed in the original complaint letter. In reading his report of the investigation, this certainly seems to have been the effect of the directive from the DPS, as the report nowhere mentions the detailed substance of those grounds; i.e., with respect to the key points of enquiry regarding the issues from 28 December 2010 (the fourth ground listed on p.100 above) of the refusal by the officers involved to acknowledge the evidence I presented to them at Kennington Police Station on that date. I suggest this misinterpretation of the directive from the DPS amounts to a procedural error in the MPS investigation, but which has not been addressed in the IPCC’s response. The IPCC have touched upon this issue in p.2 para.8 of their response, where they acknowledge that the MPS have not referred to my complaint letter when addressing the investigation points; but the Casework Manager then mysteriously overrides this objection with the vacuous statement that: ‘I am confident that the relevant areas are covered and that the heart of your complaint has been addressed’.

In relation to the second ground listed above, the IPCC’s response generally excuses the lack of thoroughness in the MPS investigation based on the gap in time between events in December 2010 and the date of the complaint. The IPCC does not appear to have considered my arguments against this tactic expressed in my letter of appeal. Aside from the fact that it
is not really credible that the two officers involved should have no recollection at all of the salient details of events – particularly with respect to the issue of their refusal to take a statement, and the evidence of the letter from my social worker submitted on 28 December 2010 – I had made it reasonably clear on pages 2-3 of my letter to the DPS of 20 January 2013 that the combined delay in bringing the complaint was the result of a series of failures in MPS services (see also p.1 paras.2-3 of my appeal to the IPCC).* The refusal to acknowledge these arguments by the IPCC implies therefore that the MPS need only deliberately ‘drag its feet’ at each stage in the progress of a complaint to effectively scupper the chances of a complaint’s success.

In relation to the third ground listed above, my letter of appeal stresses that the investigation cannot reasonably be considered as complete in the absence of the testimony of SPCSO Cornelius (the desk officer responsible for photocopying the evidence I gave to the police on 28 December 2010, as well as the writing of the second CRIMINT report). Officer Cornelius would certainly be able to corroborate my submission of the letter from my social worker Jane Hughes, and the fact that PC Phipps had also seen and read that letter (my own copy of that letter should contain both officers’ fingerprints). I have tried to stress all along the centrality of this item of evidence to the substance of my complaint, as it ought to have undermined the officers’ overriding assumption that my allegations against my family were ‘delusional’.

References to this item are a key feature in all of my representations to the MPS and the IPCC – yet the item is significant in its absence both from the MPS investigation report, and from the IPCC’s response to my appeal against that investigation. This item of evidence appears to have been systematically suppressed by both organisations. PS Scott’s investigation report states (section B.4) that SPCSO Cornelius is no longer working in the Lambeth Borough and that he has not responded to PS Scott’s email contact with him during the investigation. Despite the fact that p.3 para.3 of the IPCC’s response states that no clear evidence of attempts to contact SPCSO Cornelius had been submitted in the background papers (itself an error in procedure), the Casework Manager concludes that: “it would not be sensible to send this case back to be re-investigated purely to obtain this account, which will not materially affect the findings”. As the letter from my social worker is material evidence that has so far been disavowed by both the MPS and the IPCC, it cannot be reasonably asserted that SPCSO Cornelius’ account will not affect the findings.

In not recommending that any further action over my complaint is required on behalf of the MPS, the IPCC’s response relies upon the repeated assertion of its confidence that “the heart

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of your complaint has been addressed”. If there was such a ‘heart’ to my complaint, it was that the two officers I spoke to on 12 & 28 December 2010 had wilfully ignored evidence I tried to present to them that contradicted their initial assumption that my allegations against members of my family were ‘delusional’. The key item of that evidence was the letter from social worker Jane Hughes attesting to my mental health, dated 23 September 2010. It cannot be merely a matter of oversight or accident that the IPCC’s investigation has patently disregarded the repeated references to this item made in all of my correspondence over the complaint, just as the PSU’s investigation before it had done.

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In view of the full content of the preceding report, it is clear that there is significant evidence in support of my allegations, and that the police have been aware of some of this evidence (excluding the MRI scans) since 2003. It is also the case that there was no unequivocal medical statement, or consistent medical opinion, to say that I suffered with any form of mental illness that might satisfactorily attribute my claims to delusional thought processes, and thereby justify the police discounting objective MRI evidence presented to them that may have supported allegations of a cover-up. The police were therefore obliged to pursue a proper investigation in the light of those allegations, but they have consistently failed and refused to do so. The unavoidable conclusion is that the police (amongst other putatively ‘independent’ regulatory bodies, including the IPCC, the GMC, and the PHSO) have been complicit in a regime of secrecy surrounding the issue of my tonsillectomy in 1967, confident as I am of the police awareness of the substantiability of the claims I have made repeatedly since 2003. In spite of the fact that the police now have clear evidence indicating that the true purpose of that operation was entirely fraudulent, the police continue to prevaricate over taking any meaningful action over the issue, in deference that is to the State’s prerogative to operate in secrecy, and hence without accountability to the law.
Applications for Political Asylum

Following the experiences at my flat in London on 17 February 2014 (see p.88 above), and my immediate departure from the UK on that date, I travelled overland across Europe, eventually arriving in Turkey during the first week of March; staying there initially on a tourist visa. In June of that year I needed to return to the UK to renew my passport, and following that I returned straightaway to Turkey on a fresh passport, arriving on 23 June, and obtained a fresh tourist visa on my arrival. Thereafter I remained in Turkey for the full 90-day period, and beyond. A short time after the expiry of that visa, during the first week of October 2014, I attended the office of the Immigration Department in Istanbul and made an application for political asylum in the Turkish Republic, on the grounds of having been a victim of a medical and state crime in the UK; of the wholesale suppression of the evidence of that crime amongst all UK institutions and regulatory bodies, including the police; and the clandestine attempts on my life there in response to my efforts to bring to light that evidence.

At the same time, I submitted copies of the two Brain MRI scans discussed earlier in this report to a total of four separate hospitals in Istanbul. I then notified the Immigration Dept. of the contact details of the Neurology Depts. at the four hospitals. Following these actions the Immigration Dept. accepted my application, granting me refugee status during November 2014, and following this I received some free medical attention from two of the hospitals. The purpose of this was really to exclude the possibility that I might have any incipient health problem requiring urgent medical treatment. There was no discussion between any doctor and myself at either hospital in which a doctor explicitly confirmed to me in person that the MRI scans revealed evidence of the illicit implants I have referred to in the scan images reproduced earlier in this report (pp.49-50 & 60-64 above). I judged that the key to this process was discretion, and I did not feel it was appropriate to try to force that kind of opinion from the doctors, who would thereby be compelled either to lie, or to expose themselves to extreme personal vulnerability. However, I think it is reasonable to assume that such corroboration had taken place discreetly between one or more of the hospitals and the Immigration Dept.; for otherwise it is most likely that, in the absence of such corroboration, the Immigration Dept. would have rejected my application for asylum on the grounds that it was frivolous and unfounded (i.e., for a citizen of an EU member state), inundated as Turkey was at this time with asylum applications from Syrian refugees.

In this context, I think it is highly significant that the British Prime Minister made an impromptu solo visit to the Turkish President early in December 2014. The arrangement appears to have been rather exceptional – it did not attract the fanfare of a formal state visit. Although it occurred at the time of a serious escalation in the Syrian conflict, and an efflux of refugees from Syria into Turkey and Europe, there were at this time other diplomatic
missions from the EU and UN (rather than from the heads of individual member states) to Turkey, ostensibly with regard to the Syrian and Kurdish questions. There was no explicit justification given, as far as I am aware, for the Prime Minister’s exceptional visit. There is considerable room for speculation therefore over the true purpose of that visit.

I remained as a refugee in Istanbul until March 2015. Throughout this period there was nothing to encourage me of the prospect of actually obtaining medical corroboration of the evidence I had submitted to the hospitals in Istanbul. In February 2015, I received information that a Notice to Quit had been served on my flat in London. In addition to that, there were indications of fraudulent activity in one of my UK bank accounts. Therefore, in order to protect my tenancy and the property in my flat, and also to obtain new cards from my bank, I had no choice but to return to the UK. The Immigration Dept. warned me that I would have to relinquish my refugee status if I wished to leave Turkey (I am subsequently informed that this is not in concordance with 1951 Refugee Convention, to which Turkey is a contracting party). However, as I still had no guarantee of obtaining any explicit expert corroboration of the MRI scan evidence by remaining in Turkey, and as I faced the prospect of remaining there without any control of my bank account, I was basically forced to do so.

The circumstances upon my return to the UK on 7 March 2015 and the events of the following eleven months are in part reported on pp.89-92 above. In response to the resurgence of attempts on my life during January 2016 described there, and the apparently increased desperation behind those attempts, I was forced to depart the UK once more on 8 February 2016. I travelled overland from London to Milan and then took a flight to Istanbul, hoping to resume my earlier application for asylum there. Upon arriving however I discovered that my entry to Turkey was now banned as a consequence of having ‘relinquished’ my earlier refugee status, although the ban was not explained to me in those specific terms. I telephoned the Immigration Office while being held at the airport, but there seemed to be no possibility of an appeal against the exclusion.

I was deported from Istanbul back to Milan, from where I travelled to Rome, and then took a flight to Tunis, where I stayed for the next eleven weeks, in relative sanctuary, and with some chance to recover from the effects of the attempts on my life in the UK.

During the periods of my stays in Turkey and Tunisia, I had experienced an almost complete absence of the attempts on my life that were so universally and persistently a problem for me across the whole of mainland Europe. The understanding I arrived at was that the organised clandestine forces (for the sake of argument, I will refer to them as ‘mafia’ forces), widely contracted with the task of my elimination across Europe, did not have the customary presence, or the logistical and distributive reach, within these mainly Muslim populations to effect their plans. This meant that I was able to survive, that is to eat and drink food products
normally, without needing to exercise the extreme caution and preliminary testing that had been so essential to my survival at home.

I was limited to the terms of a tourist visa in Tunisia, implying that I could remain there for a maximum of 90 days. To attempt an application for asylum in Tunisia would have meant approaching the office of UNHCR – an eventuality that I had avoided in Turkey (as Turkey has its own legal mechanism independent of UNHCR), and which I anyway thought it best to try to avoid at this point in time. It was during this stay in Tunisia, in April 2016, that I submitted my formal complaints to the Council of Europe Commissioner for Human Rights, and to the UN Office of the High Commissioner for Human Rights (OHCHR), over the regulatory conduct of the UK Parliamentary & Health Service Ombudsman (see pp.119-122 below). The substance of my complaint was the apparent complicity of the PHSO in the alleged cover-ups of the evidence of my MRI scans at two major London NHS Trusts – complaints over which to this day I have received no acknowledgement either from the EU Commissioner or from the OHCHR.*

I left Tunisia on 21 May 2016, taking a ferry to Sicily. Thereafter, I travelled north through Europe overland in the direction of Norway, intending to make an experimental application for asylum there, which I did at the end of May 2016.

Despite having given the Norwegian Immigration Dept. (‘UDI’) ample cause to understand why the exceptionally serious and unprecedented nature of my claims against the UK government meant that there was no effective prospect for the resolution of those claims by appeals to national institutions, and that consequently I had no protection from the law in the UK against a persistent clandestine threat to my life there, the UDI rejected my application on the principle that it was “obviously unfounded”, in view of my citizenship of an EU member state (a reactionary decision reflecting this rather chauvinistic policy shared between the so-called “safe” states of the EU and its affiliates – one that the Turkish Immigration Dept. had avoided in light of its respect, I assume, for the MRI evidence). This decision was subject to an appeal, pending the outcome of which I did not enjoy the protection of the Norwegian Government. The appeal was conducted following my departure from Norway therefore, and in view of the rather half-hearted and cautious position toward the case adopted by the Norwegian lawyer appointed by the UDI to represent me in the proceedings, the result of the appeal (given on 25 August 2016) was only to reinforce the original judgement to reject my application.

The Norwegian decision was essentially a prophylactic one, by a government department

* A copy of my letter of complaint to the OHCHR (excluding the archives of correspondence listed as enclosures in that letter) may be accessed at URL: http://somr.info/lib/07-complaint_OHCHR_25.4.16.pdf – accessed 27/05/2023.
unwilling to take ownership of the political import of my exceptional claims against the government of one of its economic associates, and could only be sustained with disregard to the content of my April 2016 formal complaint to the Office of the UN High Commissioner for Human Rights over the regulatory conduct of the UK Health Service Ombudsman (a copy of which had been supplied to the UDI in its entirety). The exceptional content of that complaint ought to have given the UDI reason to suspend its normal expectations over EU citizens’ access to justice by appeals made through their own national institutions.

I left Norway at the end of the first week of June 2016, following the initial rejection of my asylum application. I spent the next five weeks travelling overland through Eastern Europe, spending time in Romania, Moldova, and Poland, where at least I could survive relatively cheaply. In these countries, as might have been expected, I started again to experience attempts on my life through the ‘traditional’ method of indirect poisoning, meaning that it became once more important for me to keep changing my location on a daily basis. The implication here is that my movements were being constantly monitored, so that local organised criminal networks could be alerted to my presence in their region, and promptly engaged in the task of my elimination. I no longer had the financial resources to sustain this behaviour for any length of time. At the same time I seemed to have run out of options for seeking asylum in countries immediately outside the borders of Europe. Therefore, I determined I had no choice but to return to the UK to try to make my case more vocally at home. I returned from Krakow to London by a combination of trains and buses in mid-July 2016.

The events following my return during the next three months are related on pp.93-94 above. Due to the apparently heightened urgency behind the attempts on my life in October 2016, and the circumstance that I could no longer safely leave my luggage unattended in the UK, I left the UK again on 17 October 2016, travelling overland via Spain to Morocco; once again seeking the relative sanctuary of a Muslim country; arriving there on 20 October 2016.

I visited the International Polyclinic in Rabat, giving them copies of my MRI scans, hoping that I would be able to elicit from them some form of medical opinion in support of my claims with which to support an application for asylum in Morocco (in particular, with regard to the problem in my left shoulder, which had been refused assessment or treatment in the UK – see pp.72-80 above). After making enquiries at the Moroccan Immigration Office, I learned that I would need to approach the office of UNHCR in Rabat to apply for refugee status determination under UNHCR procedures. I attended the UNHCR office during November 2016 and was given an appointment to be registered as an asylum seeker on 9 December 2016. However, money I had been expecting to receive into my bank account whilst in Morocco had not been paid, leaving me stranded with insufficient funds to pay for accommodation, and unable either to afford the fare back to the UK. I had no choice but to
borrow money from the British Consulate in Rabat to pay for a flight back to the UK in order to sort out my finances; meaning that I would not be able to attend for the registration appointment on 9 December 2016. I returned to the UK by plane on 2 December 2016, courtesy of a loan from the Foreign & Commonwealth Office.

The events in the UK following my return and prior to my next departure during September 2017 are related on pp.94-95 above. In late September, I travelled by bus to Paris, and from there took a plane to Cairo, Egypt, arriving there on 28 September 2017. My intention was to attend the office of UNHCR in Cairo, to repeat the earlier aborted asylum application made in Rabat the previous year. The location of the Cairo office is completely opaque to anyone unfamiliar with the city, buried as it is among the backstreets of October City. When I eventually managed to locate the UNHCR office, during the first week of October, it was completely inundated with refugees apparently from sub-Saharan and East Africa. The two officers I spoke to were clearly unprepared to receive an application from a British refugee there (in spite of the grounds for my application being completely authentic) advising that in view of my declared need for medical assessment I might have a better reception if I returned to UNHCR in Rabat instead (the officer also informed me that my previous asylum application in Turkey was unfairly terminated simply for the reason that I needed to return temporarily to the UK). I could appreciate that the office there seemed completely overstretched, so I did not try to insist against their advice, resolving instead to leave Cairo and head for Morocco once more.

I took a flight from Cairo to Casablanca on 10 October 2017 and thereafter continued by train to Rabat the same day. On the following day I visited the office of UNHCR and was given a registration form and told to return to the office with the completed form in a few days to register my application. I returned there on 13 October with the completed form, together with a written statement explaining the reasons for my asylum application.* There was a preliminary meeting with a female officer during which I gave a verbal report of the contents of my statement, which she notated onto a computer. I was given a certificate of registration as an asylum seeker and told to go away and await the office contacting me by email (I had no fixed address in Morocco) with a date for a formal interview.

After leaving the UNHCR office, I noticed that there were two distinct errors in the details of my identity recorded upon the registration certificate: i) my name was recorded spelled as “JONES, Micheal Stanley”, rather than its correct form of JONES, Michael Stanley; and: ii) my date of birth was recorded as “16-04-1961”, rather than the correct date of 17-04-1961. It seemed unlikely to me that this coincidence of two distinct errors in the details of my identity

* My statement in support of my application to UNHCR Rabat is available as item 1 of the PDF folio of documents relating to my asylum application in Morocco, at URL: http://somr.info/lib/UNHCR_Rabat_documents.pdf – accessed 27/05/2023.
could have arisen as an innocent mistake. After all, the circumstances of my asylum application were exceptional and extraordinary, and, in view of the fact that it was unlikely there was any precedent for a British citizen seeking political asylum with UNHCR in Rabat, it seemed more likely that the errors had occurred as part of an attempt to obscure the fact of my application from detection by external agencies; although it was less clear to me at that time the motivation behind this concealment.

I did not address the errors in my registration certificate to the office in Rabat immediately for the reason that I was not staying in Rabat and frequently had difficulty in making contact with that office by telephone. However, during the two-week period following the date of my registration I was surprised to experience several attempts upon my life in Morocco of a similar nature to the attempts I had previously experienced in the UK and Europe; i.e., by methods of indirect poisoning. For the first time then, the organisation of attempts on my life had managed to assert itself within a predominantly Muslim population, where I had previously enjoyed relative sanctuary.

As the entire substance of the protection offered by my certification as an asylum seeker in Morocco depended upon the agreement of the details of my identity as recorded upon the certificate given me by UNHCR Rabat with the details of my identity shown on my passport, in view of these new attempts upon my life I became increasingly suspicious about the motivation behind the errors recorded upon the certificate. Had any of the attempts on my life been successful, then there need have been no correlation made with the fact of my asylum application (with its associated reports of attempts on my life by poisoning), since the person recorded as that asylum seeker did not exist as such. Hence, under these circumstances, the event of my death abroad need not have attracted any unwanted controversy.

I wrote a letter of formal complaint to UNHCR Rabat dated 30 October 2017*, and returned to the office on that date with the intention of delivering the letter and also demanding a corrected copy of the registration certificate to reflect the true details of my identity. My letter of complaint was intended to address UNHCR’s failure to process my application for asylum with the urgency it required (in view of the pressing medical issues involved, and also in view of my recent reports to the office by telephone of attempts on my life whilst in Morocco). In the context of my remarks upon the misrepresentation of the details of my identity on the registration certificate, p.5 of the complaint alleges UNHCR’s complicity by default (at least) in the organisation of attempts on my life in Morocco.

* My complaint to UNHCR Rabat is available as item 2 of the PDF folio of documents relating to my asylum application in Morocco (URL: http://somr.info/lib/UNHCR_Rabat_documents.pdf – accessed 27/05/2023).
In view of these emerging suspicions, prior to attending UNHCR to deliver my complaint, I had made a photocopy of the false certificate to retain for future reference. When I arrived at the office I was received by one of the G4S security staff. I told him my purpose was to obtain a corrected certificate and showed him the certificate with the incorrect identity details along with my passport. He told me to wait and returned after a short while with the person, whose name I am unaware of, but whom I believe is a Moroccan national, and whom I understand occupies a supervisory role at the UNHCR Rabat office.

I showed this person the incorrect certificate, pointing out the two errors, and asked him to provide me with a correct one. He asked that I give him the certificate so that he could find my registration and supply me with an amended one. At that point I was wary of handing over the original certificate (in view of my suspicions), as I felt sure it would not be returned to me, so I offered him the photocopy, suggesting that when he gave me the new certificate and returned my copy of the old one, I would then give him the original false certificate. He appeared to misunderstand me, stating that he would give me a new certificate along with a copy of the new one as well. I stressed that I wished to retain my copy of the original certificate with the incorrect identity details. He seemed unsettled, and was unsympathetic to my wish to retain my copy of the certificate. This tended to reinforce my suspicion that the errors on the original certificate had not been made accidentally.

I gave him my copy of the false certificate together with my passport. He went off leaving me to wait in the security office immediately inside the UNHCR building to return after 5-10 minutes with a newly printed, signed and sealed certificate showing my corrected identity details. The new certificate showed the revised date of 30 October 2017, but had the same case and dossier numbers as the certificate originally given me on 13 October. He also held in his hand a copy of the new certificate (it was clear he had not retained my copy of the old one to return to me). He handed me the new certificate and demanded the old one in return. I declined to give him the old certificate since he had not returned my copy of it, as I had specifically requested, and it was clear to me that he was unwilling to do so. He threatened that he would not return my passport to me unless I gave him the old certificate. I repeated that I would not give him the old certificate until he returned my copy of it. He was intractable and, as I was sorting the papers I held in my hand, he violently snatched the plastic sleeve containing the old certificate (plus another document of mine unconnected with UNHCR) from me, saying angrily “GIVE ME the certificate!”. He then turned to make off with it. I tried to grab the documents back from him but was intercepted by two G4S security staff who restrained me. I was then forced to leave the building.

From outside the building I asked the security staff to return my passport. I also asked that I could speak with the female officer who had first received me when I attended UNHCR a few days prior to my registration, so that I could submit my complaint letter to her. That
officer came outside to see me a little later (I was not allowed back inside the building). She accepted my letter of complaint; however, she was unreceptive to my report of what had just occurred between the supervisor and myself and I did not succeed in my request to get my copy of the old certificate returned to me. Neither did I succeed in getting back the other document held in the plastic sleeve which the supervisor had snatched from me.

Since I merely wished to retain my copy of the certificate given me on 13 October, and not the original certificate itself, the supervisor’s behaviour was aggressive, rude, and tyrannical. In the context of my registration as an asylum seeker, it was completely unacceptable. I am now without any copy of the original false certificate, on which there were errors in my recorded identity details that I allege were not made accidentally. The outrageous behaviour of the supervisor in response to my efforts to retain a copy of the false certificate adds indisputable weight to the allegation that the certificate originally given me on 13 October was material evidence of UNHCR’s attempt to conceal the fact of my asylum application from detection by external agencies; and is indicative of fraudulent and corrupt behaviour by an employee or employees of that office.

Although UNHCR Rabat has acknowledged its receipt of my formal complaint dated 30 October 2017, since that acknowledgement I have received no further correspondence from that office to indicate that it has any intention to formally address the complaint.*

On 10 November 2017, while still in Morocco, I sent an email to UNHCR Rabat pointing out its obligation (in view of the pressing medical issues involved) to treat my application under Accelerated RSD Processing, according to the requirements set out in Sections 3.4 & 4.6 of UNHCR’s publication Procedural Standards for Refugee Status Determination Under UNHCR’s Mandate. The RSD Team in Rabat replied by email on 23 November with an appointment for refugee status determination scheduled for 14 February 2018.† The implied three-month delay was indicative of that Team’s disregard for the arguments made on pages 6-7 of my letter of complaint with regard to the urgency of the medical issues detailed there, and of my need for immediate access to appropriate health assessment and care. I should point out that UNHCR Rabat’s corrupt handling of my asylum application had only facilitated the circumstance of my further exposure to attempts on my life by poisoning whilst in Morocco, and has therefore exacerbated the accumulated risk to my health through continued exposure to non-fatal doses of toxicity.

* See the email exchange listed as item 4 in the PDF folio of documents relating to my asylum application in Morocco (URL: http://somr.info/lib/UNHCR_Rabat_documents.pdf – accessed 27/05/2023).
† My email of 10/11/2017 is listed as item 5 in the above folio. The response from the RSD Team on 23/11/2017 is part of the email exchange listed as item 6. UNHCR’s Procedural Standards... is available at URL: http://somr.info/lib/UNHCR_PSRSD.pdf – accessed 27/05/2023.
As was clear from the general reticence of UNHCR Rabat in response to my complaint (I have yet received no considered response to that complaint), I now had no more effective sanctuary in Morocco than I had at home or across Europe. It seems that during the year between my two approaches to UNHCR Rabat, European ‘mafia’ forces had taken steps to enhance their influence there – an expansion which it is conceivable was motivated partly in anticipation of my prospective return to renew my asylum application in Rabat. In view of this and also in view of the consequent risk that I might simply be abducted and ‘disappeared’ whilst in Morocco, I resolved to leave and return back to the UK once more, which I did by bus and ferry on 24 November 2017.

On 29 December 2017, I made a formal complaint by email to the UNHCR Inspector General in Geneva alleging misconduct and corruption against an employee or employees of the office in Rabat, in view of the treatment I received at that office on 30 October 2017. I received a brief acknowledgement of my complaint by email from the Inspector General’s office (‘IGO’) dated 4 January 2018; but to this date have received no further response from that office. On 11 February 2018, three days prior to the scheduled appointment for RSD interview at UNHCR Rabat, I sent an email to that team notifying them of my absence from Morocco and hence of my inability to attend the interview. I asked that they postpone the assessment while keeping the application open, pending the outcome of my formal complaint to the UNHCR Inspector General.

On 26 April 2018, sixteen weeks following its acknowledgement email, and in the absence of any further communication from the Inspector General’s office, I sent them an email requesting a progress report on their investigation, and an indication of when the complaint might be resolved.* After five years I have still received no acknowledgement or response of any kind whatsoever to that enquiry, while my complaint is now 65 months old. In their email to me of 4 January 2018, the IGO had acknowledged merely an allegation of “inappropriate behaviour” in my complaint. My enquiry of 26 April 2018 reminded the IGO that the complaint’s chief allegation is that of corruption, in addition to that of inappropriate behaviour. Could it be that the implicit irrefutability of the corruption allegation suggested by my complaint is the reason for the IGO’s complete inertia and silence over the matter since my email of 26 April 2018?

* My complaint to the UNHCR Inspector General and its acknowledgement; my correspondence with the RSD Team in Rabat following the date of that complaint; together with my enquiry to the IGO’s office of 26/04/2018, are available as items 6-9 of the PDF folio of documents relating to my asylum application in Morocco (URL: http://somr.info/lib/UNHCR_Rabat_documents.pdf – accessed 27/05/2023).
Concluding Remarks

The preceding account of events, in particular those occurring subsequently to my acquiring the evidence of my first MRI scan in December 2010, reveals a persistent pattern in the responses to my allegations, both from the police and from the various health organisations and regulatory bodies I have appealed to. The tendency has been for those organisations to distance themselves from any factual consideration of the evidence, through the imputation that my claims appear to be the result of delusional thinking. This situation is not helped by the fact that any attempt at an initial succinct communication of the content of my claims sounds bizarre and improbable, and indeed resembles a caricature of a classical delusional syndrome. The first response to my reports is therefore invariably one of massive incredulity, and a tendency to ‘switch off’ attention to subsequent assertions of the evidence which actually proves the allegations.

This initial scepticism affected the police response to the evidence I presented to them in the form of the earlier edition of this report (excluding the MRI evidence) 20 years ago, in 2003. In subsequent anticipation of this inevitable scepticism, and because these concerns have preoccupied my attention throughout the intervening period, it has been necessary to maintain myself in social and familial isolation; for it has not been possible to discuss these issues with anyone other than prospective figures of authority, or members of the medical or legal professions, upon whom I depended for acknowledgement of the evidence. However, it has repeatedly proved to be the case that none of those professionals has either the courage, or the independence, to openly discuss an issue of such extraordinary sensitivity (and horror); and therefore no one dares (in fear for their own personal security) to offer explicit corroboration of the evidence, settling instead for the prophylactic response that my claims must be ‘delusional’. For this reason only, the evidence remains undisclosed (or rather, in view of its publication here, uncorroborated). This has meant that it has been impossible to initiate any process of civil or criminal litigation in the UK as such a process would have depended upon the engagement of lawyers and the enlisting of expert opinion. In particular, the General Medical Council of the UK has dismissed the grounds for a complaint on the basis of the MRI evidence presented to it (in the absence of additional expert corroboration) for the reason that, as stated by the GMC in their final response to my complaint: “[W]e are not able to medically evaluate your scans”.*

The allegations I have made have far-reaching implications, not only for the NHS, but for the reputation of the medical profession as a whole. Understandably, nobody wants to accept

that members of the medical profession, in whose care we must routinely entrust our lives, are prepared to act with such concerted disregard for their patient’s well-being, and under the direction of imperatives having nothing to do with the care of individual patients. It reminds us of a rather unnerving truth: that, in the absence of additional safeguards, the practice of medicine is not an inherently ethical vocation.

In an important sense therefore, it is difficult to see any individual doctor’s corroboration (or lack of corroboration) as being truly independent. It is also the case that any neurological expert, on examining the MRI evidence, would not simply be faced with the option of establishing a correct medical diagnosis in preference over an incorrect one, but rather of correcting the omission of a report of a serious medical anomaly with a disclosure of findings that would be completely unprecedented in the history of medical science, originating as I allege they do from a clandestine medical experiment, carried out without any certified medical approval. It is precisely because the items revealed in my two MRI scans did not find their way inside my neck by accident, but by an illicit and covert design, that any individual doctor finds him- or herself unable to discuss or disclose them, not wishing to be compromised professionally, and with a view to his or her own personal safety.

While it is perhaps understandable that those with the relevant expertise might have difficulty finding the words suitable to describe or categorise these phenomena, it is of a major concern that clinicians, by refusing to volunteer any information that might disclose the fact, can succeed in concealing indefinitely the worst excesses of the medical profession, with no independent authority having the expertise capable of overruling that reticence. On each occasion that I have sought medical consultation over my MRI scans, whether through NHS services or privately, I have come up against this ‘regime of silence’ – and this in spite of the fact that the visual evidence is clear and distinct, perhaps even to an untrained eye.

From the progress of my complaints to the GMC; to the Police and IPCC; to Guy’s & St Thomas’ NHS Trust; to UCLH NHS Trust; and to the Health Service Ombudsman, detailed in the foregoing report, it is apparent that all of those public bodies duty-bound to address my complaints are locked under a regime of systematic denial. The explanation for this is that the evidence disclosed to them reveals activities and undertakings within some of our most respected institutions which cannot be explained in manageable terms, as isolated instance of individual corruption or malfeasance, or otherwise in terms of bureaucratic mismanagement, but which must rather be understood as an organised and interdisciplinary enterprise, executed among offices of state and diverse public institutions, and with calculated contempt for all ethical and humanitarian principles. This disclosure therefore forces one to invert the respect previously granted to a wide range of public institutions, as many of those institutions are revealed to have actedconcertedly in defiance of common
ethical standards; and to have done so it seems with the assurance that all ethical objections would ultimately be annulled through the exercise of executive State privilege.

In particular, the case is instructive for what it reveals about the status of children’s rights in an advanced liberal democracy such as that of the UK. For instance, it reveals how the status of ‘legal incompetence’ in which children rather helplessly find themselves may be exploited to facilitate (in this particular case) the surgical ‘brain rape’ of a child for instrumental purposes, in the absence of the child’s knowledge or consent (but by soliciting the consent of one of its parents), while it is practically inconceivable that the same form of abuse could be successfully enacted against an adult (for further discussion see the subsection Consent above: pp.38-41).

In addition to that, it follows from the analyses in Part 1 above (pp.26-32 & 41-46) that such an unprecedented and technically sophisticated program of experimental research would undoubtedly necessitate a massive financial investment. It is inconceivable in economic terms that such an investment might have been risked upon the fate of a single research subject. That is to say, there must have been other victims of the same form of experimental surgery in addition to myself – probably a select few – as a means of balancing the risk, but also as a means of ensuring a minimal degree of representative sampling in the research data. I have no idea of the identities or the fates of these other research subjects; however, it is clear that my own case is inextricably bound-up with a series of currently unreported cases. The disclosure of my own case would therefore act as a precursor for the subsequent exposition of all other cases – a circumstance that reinforces the institutional pressure working against public disclosure of my own ‘individual’ case, and which suggests the need for all related cases to be treated collectively, as a ‘class’.

Britain was at the time of these crimes against humanity a key signatory to such international protocols as the European Convention on Human Rights (1950), and the World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (1964).* How is it then that the cynical contempt for these conventions evident in this particular abuse of the rights of a select group of children manages to remain perennially unnoticed, sequestered from the public conscience in a manner comparable to that of the interminable, Establishment-driven suppression of cases of historical sexual abuse of children, by members of the political elite no less?

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My own case does not fit the paradigm of that of a ‘conventional’ case of sexual abuse (which ultimately may always be blamed on the personal moral aberrations of individuals); but rather exposes something altogether more sinister, cold, calculated, and organised. It crucially reveals something deeply troubling about the ability of adults, both individually and collectively, and under the pressure of a certain kind of instrumental authority, to suspend all considerations of the rights pertaining to children, as if those rights were merely ornamental and non-obligatory.

It is certainly true that ‘children’s rights’, commonly conceived, are categorically different from the human rights which are supposed to accrue universally to adults. The rights of children are habitually conceived in passive-only terms, as limitations on the behaviour and actions of adults towards children. That is to say, we commonly fail to consider the rights of children as it were ‘in their own inalienable right’, independently of that censoriousness towards the risk potential in our own behaviour as adults. The Universal Declaration of Human Rights makes no detailed provision for interpreting its articles with respect to the rights of children; hence the additional requirement for a Convention on the Rights of the Child, which was ratified by the UK in 1991. Despite this UN treaty being the most widely ratified human rights treaty in the world (or perhaps in explanation of that fact), it appears as a rather high-minded and self-congratulatory document that, having succeeding in establishing several laudable principles on which to formulate a theory of child rights (with an emphasis on protection), has very little to say about how these ideals might ever be realised, or why the lived experience of countless millions of children worldwide continues to fail to live up to these high expectations.

Few of us, however, seem to be willing to frame the question of the rights of children along the axis of autonomy (as children themselves might be inclined to do).* Hence, while the principle of individual autonomy must appear as a fundamental guiding principle in the design of any human rights legislation, the limits upon a child’s autonomy that we accept as natural, and as a protective necessity, are not compatible with the limits set socially upon an adult’s autonomy. This essential incompatibility makes problematic the assertion of ‘universality’ in any legal definition of the scope of human rights.

Human rights, therefore, do not accrue in any absolute or unqualified way to children who, after all, are deemed not to possess a competent human volition. In the absence of a competent volition, a child does not quite come to possess the attribute of ‘humanity’ in the fullest sense of the word. Human rights will only effectively accrue to those who may will to protect them. And clearly, we cannot trust adults with the protection of the rights of children.

* See my earlier discussion on the subject of a child’s autonomy, in the subsection Consent, Part 1, pp.38-41 above.
We cannot even trust a team of suitably qualified adults with the task of a sincere and sustained inquiry into the conduct of adults-with-power alleged to have historically abused children (the UK Inquiry into cases of historical child abuse), without the integrity of that team being sabotaged from on-high by malicious rumour-mongering operating in the service of the accused.

We ought then to take a less reactionary position on the issue of the rights of children – that is, one that derives less out of the twin impulses of vanity and shame. There would then be less of an insurmountable barrier to the open public acknowledgement and discussion of the undeniable evidence confirming the UK government’s culpability in a series of historical medical atrocities, involving the surgical ‘brain rape’ of a select group of children, with a view to their lasting biological enslavement, for instrumental and technological ends, and within institutions providing state healthcare. Because essentially, without that discussion, no public body in the UK can claim with sincerity to have an interest in safeguarding the rights of children and in their actual protection from abuse by those individuals or institutions that maintain power over them.

With this in mind I sent copies of my first two MRI scans, plus an earlier edition of this report and covering letter outlining the substance of my allegations, to the Council of Europe Commissioner for Human Rights on 4 November 2013.* Corresponding submissions were also copied to each of: the Office of the United Nations High Commissioner for Human Rights (‘OHCHR’); the Council for International Organisations of Medical Sciences (‘CIOMS’); and the World Medical Association, during October and November 2013. Similar correspondence was also sent to the office of UNICEF in the UK.

After one week the World Medical Association returned the CD copies to me with a note to say that their organisation (which authored the 1964 Helsinki Declaration Ethical Principles for Medical Research Involving Human Subjects) did not have the capacity (nor the motivation, it seems) to conduct any inquiry into the evidence supporting my allegations.

From February 2014, faced with a renewed resurgence of attempts on my life in the UK (see pp.87-88 above for more detail), and the inaction from the police in response to my reports to them, I was forced to urgently depart the UK once more. Hence, I became unable to access mail sent to my home address. The Director of the Office of the Council of Europe Commissioner for Human Rights responded to my November 2013 letter in May 2014 (letter dated 24 April 2014). However, I did not actually receive this letter until April 2015,

* Copies of my correspondence with the Commissioner’s Office may be accessed at URL: http://somr.info/index.php#coe – accessed 27/05/2023.
following my next return to the UK. The response from the Director Isil Gachet was perfunctory, and served merely to excuse the Commissioner from any interest or action in response to my November 2013 letter by invoking the Commissioner’s mandate, which precludes the Commissioner from acting on behalf of individual complainants. The Director referred me instead to the services of the UK Parliamentary & Health Service Ombudsman.

I replied to the Director’s letter on 25 April 2015 – a letter to which, after eight years, I have still received no response. It seems that the Commissioner’s Office had paid scant attention to the details of my original letter from November 2013, and had underestimated the scale and seriousness of the allegations made in it. In referring me to the PHSO it failed to appreciate the points made clear in my 2013 letter, that all attempts at procuring expert corroboration of the evidence had failed, and that the prospects for resolution by regulatory process at the national level were therefore slim. My second letter had the advantage however of describing the progress of both of my complaints to the PHSO, and of the poor judgement and apparent complicity of that organisation in declining to investigate the first complaint, and, despite agreeing to conduct an investigation into the second complaint, declining to uphold that complaint – that is without conducting a necessary formal evaluation of the original MRI scan evidence. My letter also stresses the point that, as I cannot realistically be considered an isolated victim in this affair, and as the public disclosure of my own case would appear as a necessary precursor to the subsequent exposition of all other currently unreported cases, then it is unreasonable for the Commissioner to refuse to act on the ground that he is not mandated to respond to individual cases.

By April 2016, having received no further response from the Council of Europe Commissioner for Human Rights, and having received no response whatsoever to my corresponding submission to the Office of the United Nations High Commissioner for Human Rights, I assembled the combined complaint correspondence between myself and the two NHS Trusts alleged to have covered-up the evidence; as well as the further correspondence between myself and the PHSO over those complaints; and submitted the complete correspondence afresh, together with annotated lists of the documents, to both the Commissioner’s office and the office of the OHCHR during April 2016.

There were, by this time, two further complaints, one submitted to each of the same NHS Trusts (GSTT and UCLH), with regard to communications sent by doctors working within the two Trusts in response to each of my earlier complaints. My complaints over the two cover-ups of evidence had resulted in letters being sent between doctors in the two Trusts, and between the Trusts and my GP, in which the written allegations detailed in each of the earlier complaints had been deliberately misrepresented, in order that is to furnish the alibi that I was suffering from a delusional mental illness. The letters were intended as referrals to the Community Mental Health Team; i.e., in order to invoke a psychiatric response from that
Team as part of a strategy of defence, apparently shared between doctors across the two Trusts, against the serious allegations I had made against them.*

Each of the two further complaints had in turn been subsequently referred to the PHSO, and my submissions to the Commissioner’s office and to the OHCHR in April 2016 took the form of formal complaints over the regulatory conduct of the PHSO, in view of its series of clearly fallible decisions, now aggravated following its completed investigation in that same month of my second complaint against GSTT, and its decision also not to uphold that complaint. The PHSO had only managed to arrive at this decision by blatantly disregarding key items of evidence presented to it, in a process seemingly driven by an implicit imperative to avert at all costs the PHSO’s natural obligation of arriving at a finding against the Trust.†

It ought to be apparent, from a full appraisal of the evidence submitted either to the Commissioner or to the OHCHR, that I am unable to pursue litigation within the UK in respect of my medical claims against several major hospitals due to a systematic state-wide policy of non-disclosure, affecting not only the actions of the hospitals themselves but also those of the principle regulatory bodies tasked to oversee the actions of the National Health Service (the GMC and the PHSO), and extending also to the actions of the police in response to criminal allegations made to them. Not only that, but I do not have the option either of seeking judicial reviews within the British courts against the decisions of any of these organisations, because experience has shown that no legal advisor is prepared to engage, in an open and frank way, in a discussion of the details of the evidence, when to publicly advance that evidence would lead rather inexorably to a crisis of national security. As any process of litigation at the national level would depend upon some form of unilateral corroboration of the evidence, and as no individual medical or legal expert has the courage to take on that responsibility, there is a clear imperative for some form of multilateral response at the international level. Otherwise, there can be no satisfactory resolution in the public interest of what, on any open and frank view, can only be interpreted as the most serious, most protracted, organised humanitarian atrocity perpetrated within a western European country since the end of the second world war.

Astonishingly enough, although it is now seven years following the April 2016 submissions, and in spite of a number of supplementary submissions made since April 2016 with regard to

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* I have chosen not to publish online the correspondence relating to these two additional complaints, as the material is openly defamatory and injurious to my character.

† A copy of my letter of complaint to the OHCHR (excluding additional enclosures relating to the progress of my complaints against the two Trusts, and referrals to the PHSO) may be accessed at URL: http://somr.info/lib/07-complaint_OHCHR_25.4.16.pdf – accessed 27/05/2023.
the PHSO’s still unresolved decision over my second complaint to UCLH, I have yet received no form of acknowledgement whatsoever from either the Council of Europe Commissioner’s office or the OHCHR (I had specifically requested that both offices respond to me only by email, since at the time I had no reliable or safe access to mail sent to my home address).

Both the Commissioner’s office and the OHCHR are mandated to oversee and to investigate the actions of national regulatory bodies with respect to the exercise of humanitarian principles, and to receive formal complaints where there is evidence of the persistent abrogation of those principles by national institutions. The concerted refusal by each of these organisations to respond to just such evidence with respect to a series of decisions made by the PHSO is quite disconcerting, as it suggests that the principle ethical and human rights regulatory bodies within the EU and the UN are united with those of the UK in their intent to maintain non-disclosure of the evidence of these exceptional and unprecedented crimes against humanity. In view of this, one cannot avoid the conclusion that, in real terms, the exercise of international law in respect of humanitarian principles appears as a political instrument – as an arm of Western ‘soft power’ – to be employed principally against nations and governments non-compliant to the collective will of elite Western democracies, as a form of moral and political subordination, while at the same time both the Council of Europe and the United Nations are disinterested and effectively impotent towards applying the same principles rigorously amongst their own key member states.
Addenda
1. A Miscarriage of Civil Justice

The reference in the title to a ‘miscarriage of civil justice’ concerns the conduct of a civil legal housing possession claim brought against me by my landlord, following the landlord’s realisation (beginning in 2014) that I was no longer occupying my flat on a day-to-day basis, contrary to the terms of my tenancy agreement (which stated that I must occupy the flat as my principle residence for at least six months in any year). As a reminder, I had been compelled to avoid daily occupancy of my flat following a serious attempt on my life there on 17 February 2014, when I had been exposed to the presence of an unknown lethal toxic substance understood to have been introduced to the property through a small gap between the base of the front door and the hall floor (re: pages 88-89 above).

In spite of the fact that following my departure from the flat I had tried to alert the landlord, through its agent the Co-operative Development Society Ltd (‘CDS’), of the reasons for my apparent non-occupancy, and of a serious risk to life at the flat due to the presence inside it of a lethal toxic substance, the agent was unreceptive to these reports and responded to my perceived breach of tenancy agreement by issuing a Notice to Quit during February 2015. For various reasons this Notice was not acted upon and I managed to retain the tenancy and continued to pay the rent there. However, I had no success in persuading the police of the presence of a lethal toxic hazard at the flat, as the police were equally as unreceptive to my reports as either of the landlord’s agents had been (as discussed on pages 89-91 above).* My non-occupancy of the flat necessarily continued therefore, as I had no desire to become exposed a second time to the hazard I knew to exist within the flat, and to which I had been minimally exposed in February 2014, causing me to be ill for several weeks. This problem also inhibited any intention I may have had of trying to safely remove my belongings from the flat. In addition to that, there was some evidence of illegal entries to the flat during my absence between February 2014 and March 2015, and which had clearly not been for the purpose of removing anything from the flat. The police were similarly unreceptive to my reports to them during March 2015 of those illegal entries, and therefore maintaining my absence from the flat continued to be the only means for me to ensure avoidance of both known as well as unknown potential risks to my life within the flat.

I made further attempts during 2015 and 2016 to impress upon the landlord and its new agent MBM the very real circumstances that were preventing my occupation, and the reality that, so long as the relevant authorities would refuse to respond to reports of those circumstances

* This was a social housing tenancy I had occupied since May 2009 provided by the landlord Edward Henry House Co-operative Ltd, London SE1. I am uncertain of the precise date, but the role of the landlord’s managing agent changed hands from CDS to a company called ‘MBM’ during the early months of 2015 – I became informed of this change during April 2015.
with the appropriate concern, then I was powerless by myself to resolve the situation.

MBM’s response was eventually to issue a second Notice to Quit during December 2016. This however contained an error and so it was re-issued on 22 February 2017. Thereafter, the landlord issued its first claim for possession in the Lambeth County Court dated 13 October 2017. The sole ground of this claim was that of “non-occupation”, as a breach of my tenancy agreement, as there were no rent arrears at that time.

My legal defence against that claim proceeded until the date of the trial at Clerkenwell & Shoreditch County Court on 4 October 2018, whereupon a Possession Order was granted to the landlord. Thereafter, I was evicted from the flat on 28 January 2019, and shortly after lost possession of the entirety of the belongings I held at the flat, as I had nowhere I could store them, and was also unable to afford to pay for their storage indefinitely. Moreover, I could not take responsibility for physically removing my belongings from the flat, as that process would have exposed me to a known lethal toxic hazard. My genuine defence against the possession claim had not been heard in court however, and I spent the next two years – until December 2020 – trying to appeal the judgement of the 4 October 2018 in the London county courts. My conclusion that the conduct of my defence against the claim represents a ‘miscarriage of civil justice’ requires substantial support, and it would require the addition here of at least 100 pages of further explanation and documentary references to substantiate the claim, which I feel would be disproportionate in this context.

The conduct of the entire case however, from the initial claim in October 2017 to the final judgement made at Mayor’s & City of London Court dated 1 December 2020 was represented in a series of 39 email statements, sent between October 2018 and July 2021 to the Channel4 News Team in the UK, together with documentary evidence as attachments to those emails. The combined series of emails, together with their attachments, is available as an internet download,* so that the allegations of a wilful miscarriage of civil justice on behalf of certain legal entities (including the individual parties to my defence team) and of serial violations of Articles 6 and 8 of the European Convention on Human Rights made against certain offices of the UK Ministry of Justice, may be judged on the papers themselves.

The series of 39 email statements is presented in the form of a PDF folio, with their listed attachments as a series of accompanying numbered and dated ZIP archives, and is available to download as a combined single ZIP archive – Miscarriage_of_Justice.zip (143MB) at cloud source URL: https://shorturl.at/iAHX7 – accessed 27/05/2023. For reasons of confidentiality, certain of the attachments listed in the 39 emails have been excluded from the publication, and there are frequent redactions to some of the included material. This is both for reasons of confidentiality and also because some of the material is simply incorrect and misleading (including sections of my own statements), or otherwise potentially defamatory to myself or to others. I should point out that I have received no considered response to any of my emails from the Channel4 News Team, only its email auto-responses.
Motive and method of the alleged perversion of my defence case

As discussed in the section of Part 2 above detailing the series of attempts on my life I have experienced since coming into possession of the first MRI scan evidence in December 2010 (re: p.85 above), I had retained within my flat a collection of items suspected to contain various kinds of toxin. During a planned redecoration of the flat, the bedroom was being used temporarily as a spare-room, and within it I kept a large holdall containing numerous items routinely purchased by myself which were suspected to contain various lethal toxins, including certain items suspected to contain neurotoxins and radio-toxins (e.g., a bottle of water which was suspected to contain radioactive polonium-210). I understand therefore that my discussion of the existence of this evidence within this report and on the internet presented a significant risk of ongoing liability to those organisations potentially implicated by that evidence, or by my associated allegations against the government and health service in the UK (since my possession of that evidence provided de facto validation of my claims of being the victim of an historical medical atrocity).

Frequently within Part 2 above, I have described how it has been a typical response from clinicians in all the areas of health service practice I have had cause to make use of in recent years, but particularly within those departments that I have alleged have covered-up the evidence of my two brain MRI scans, to treat my suspicions regarding the purpose and intent of my tonsillectomy at age five as the products of a ‘delusional psychosis’, as a means of distancing current clinical practice, as well as the reputation of the NHS as a whole, from the effects of a seriously damning controversy. I am not so naïve not to have anticipated this as the most likely response on behalf of those clinicians – because the responsibility involved in voicing objective assent to the possible truth-value behind those historical allegations was simply too great for any individual clinician to assume. The false assertion that the allegations were the products of a mental pathology would always suggest itself as a convenient prophylaxis by which clinicians might defer that individual responsibility – it mattered little therefore that the allegations themselves had arisen only as a careful and reasoned response to substantive medical evidence. What is important to emphasise at this point is that this same assertion of a mental pathology had likewise been typically exploited by the police as their justification for disregarding and dismissing evidence presented to them of the attempts on my life – attempts which, ironically, had been provoked as an organised clandestine response to the very real threat of a public disclosure of the substance behind my historical allegations. This symmetrical response shared between police and clinicians meant therefore that I had no effective protection either from the law or from health services against those ongoing attempts on my life.

It is important to take note therefore that in the conduct of the housing possession case against me the parties to my defence against the possession claim themselves similarly
adopted, from the very beginning of my defence case, this identical set of false assertions regarding my mental health, and that those assertions were then employed, with the aid of an *inexpert* opinion on my mental capacity provided by my doctor, to deny me the legal capacity with which to give any instructions to my defence against the claim. I was effectively ‘gagged’, for the duration of the case, from making any statement in court about the very real series of attempts on my life which were nevertheless the only genuinely appreciable grounds for my apparent non-occupancy of the flat since February 2014.

In UK law, when a defendant has been assessed as lacking legal capacity, a “Litigation Friend” must be appointed to give instructions to his defence. This resulted in the Office of the Official Solicitor (a department of the Ministry of Justice) being appointed as my ‘litigation friend’ in the proceedings, which meant that my defence was thereafter under the control of an office of government; i.e., regardless of the inevitable conflict of interests this would entail given the context of my serious historical allegations against other offices of that Government. An expert opinion upon my legal capacity, which eventually restored legal capacity to me in May 2019, was not sought by my defence team (i.e., on the instruction of the Official Solicitor) until *after* the termination of the legal process which resulted in my eviction from my flat on 28 January 2019 and the irretrievable disposal of the entire contents of the flat (including the evidence of organised attempts on my life) by agents of the landlord on 4 February 2019. It is alleged therefore that the entire conduct of my defence, comprising three distinct legal entities (including the Official Solicitor’s office), was one organised in bad faith and intentionally against my own interests – indeed the detailed evidence now suggests that it was in fact motivated chiefly in the interest of ‘cleansing’ the evidence of organised attempts on my life from the flat.

**The conduct of my legal team in defence against the claim**

The issue is detailed and complex – an outline of the problems in the case is presented in my first email to Channel4 News of 19 October 2018 (item 01 of *Emails_C4-News_folio.pdf* in the download of documents); but essentially the case I have made in that series of emails is that the decision of the court on 4 October 2018 to grant possession to the claimant must be considered as the result of a miscarriage of civil justice, as it was the intended consequence of a concerted effort by the three parties to my defence team, who had contrived between them to suppress from the attention of the court any representation of the evidence in support of the genuine grounds for my non-occupancy of the flat.

‘Non-occupation’ was the sole ground of the landlord’s claim for possession. My contention is that this ground was not proven, in view of the facts that I had no other principle place of residence; that I had no choice but to not occupy the flat in order to avoid a persistent series of attempts on my life there (circumstances that were entirely beyond my control); and the
fact that each of the landlord, its managing agent, and the police, had shown an absence of
due concern in response to my reports to them of attempts on my life at the property.

My defence team were collectively simply averse to advancing any statement in my defence
that averred even the possibility of a real existing threat to my life, electing instead for their
preferred interpretation that my reports of attempts on my life were the products of a
‘delusional psychosis’; and opting on that basis for a defence based solely upon mental
disability criteria. This was in spite of the fact that there was a lack of available expert
medical opinion to support such a defence; while there was an existing expert psychiatric
opinion that had affirmed the possibility that I might have a valid reason to fear for my life
(i.e., in the context of claims I made since December 2010 of being the victim of an
historical medical crime).

The disability defence had a weak prospect of success, and so my allegation is that my
defence team deliberately sacrificed the option of a stronger defence (in the terms described
above), in order to ‘throw’ the chance of a successful defence against the possession claim in
court; and that they acted in a concerted manner to that end, under an inducement imposed
upon them externally, in the form of an organised imperative. In fact, no hearing of any
defence took place at the trial on 4 October 2018, as the Official Solicitor intervened by
telephone on the morning of the trial to accept a pre-trial offer made by the claimant, which
foreclosed the hearing of any defence in court. This was in spite of my expressing
protestations against the move – I was exactly gagged from giving any such instruction to
my defence by the Official Solicitor acting as my ‘litigation friend’. The result was that,
following the granting of a possession order at court that morning, I was evicted from my flat
on 28 January 2019, rendering me immediately homeless, and thereafter I lost possession of
all of the belongings I had retained there due in large part to the intractable difficulty posed
by the prospect of retrieving those belongings which I knew to contain a lethal toxic hazard.
The belongings were all irretrievably disposed of by contractors of the landlord on 4
February 2019, without any specific warning of that event being given me by the landlord.

The conduct of the courts during my efforts to appeal the judgement

In spite of my efforts during January 2019 to request that the court intervene to set aside the
planned eviction, by making representations to the court to bring to its attention evidence of
malfeasance in the conduct of my defence leading up to the trial, these arguments were
disregarded by the court, and no reasonable stay or postponement of the eviction was
permitted. Nevertheless, I continued during 2019-20 to pursue whatever litigation options
remained available to me – the most recent being my late application for permission to
appeal the court’s decision of 4 October 2018 to grant possession to the landlord. My
Appellant’s Notice was submitted to Clerkenwell & Shoreditch County Court on 27 August
2019 (re: item 18 of Emails_C4-News_folio.pdf). The application was eventually transferred to the Central London County Court on 11 November 2019, after a delay of eleven weeks.

From their management of this case during 2019, it is reasonably clear that staff at both county courts deliberately invoked a series of procedural delays which succeeded in obstructing any reasonable efforts that I made to challenge, either the trial decision of 4 October 2018, or the implementation of that decision; or at least they have succeeded in unreasonably deferring the results of those efforts. This is most clearly exemplified by the court’s conduct in response to my first Appellant’s Notice of 27 August 2019, which appears to have been sequestered by clerks at the court for the period 28 August 2019 to 8 November 2019, until that is I submitted a complaint to the court on 7 November 2019 over the very issue. Immediately following my complaint, the court finally acknowledged the application for permission to appeal (while the court’s published response window for dealing with such applications was “fifteen working days” – see items 19-21 of Emails_C4-News_folio.pdf).

The application for permission to appeal the possession order of 4 October 2018 was the subject of a hearing by Judge Hellman at Central London County Court on 12 March 2020, to which I attended. Permission to appeal was refused at that hearing; but, in combination with the fact that I had no access to impartial legal advice, this refusal was chiefly a consequence of further subterfuge by the clerks at the court, in disrupting the fair process of my application following the court’s decision to list the hearing made on 27 November 2019. Information regarding the decision to list the hearing was arbitrarily withheld from my attention by the clerks for a period of eight weeks following that decision, meaning that my preparation of the papers in support of the appeal was delayed beyond my control, with the result that I was unable to submit them before the 11 March 2020, only the day before the hearing itself. Hence, Judge Hellman had insufficient opportunity to appraise that evidence in advance of the hearing.

In the absence of legal advice, I made an ill-advised attempt to appeal Judge Hellman’s decision in an application dated 6 April 2020. The appropriate response to this application by the staff at Central London County Court (according to Section 3.9 §2(a) of Practice Direction 52A of the Civil Procedure Rules*) was to consult with a judge at that court upon the admissibility of the application, whereupon it might have been quickly established that an application to appeal specifically a decision to refuse permission made in the county court is not permissible under s.54(4) of the Access to Justice Act, 1999. The response from administrative staff at the court however, without consulting a judge at court, was to

misdirect the erroneous application to the Civil Appeals Registry, which administers applications to the High Court/Court of Appeal, where it took until 18 May 2020 for the inadmissibility of the application to be determined by the Master of the Court of Appeal.

After consulting s.54(4) of the Access to Justice Act, 1999, it appeared the Act did not prohibit a second application (on revised grounds) to appeal Judge Price’s original decision to grant possession to the claimant made at Clerkenwell & Shoreditch County Court on 4 October 2018. Therefore, I resolved to submit such a second fresh application to Central London County Court on 1 June 2020. The arguments and evidence in support of this application were expanded on 12 June 2020 (the content of the latest application is contained in items 31-32 of Emails_C4-News_folio.pdf, together with their corresponding attachments). Following these submissions, administrative staff at Central London County Court once again failed to observe correct civil procedure by diverting the application inappropriately to the Court of Appeal, without referring that application initially to a judge at the county court for a decision upon its admissibility. The Civil Appeals Registry eventually rejected the application on 9 October 2020 (as an appeal against the decision of a district judge in the county court cannot be heard in the High Court or Court of Appeal, and may only be heard in the county court itself) after itself delaying eleven weeks in referring the application to a judge. Thereafter, the application was resubmitted back to Central London County Court on 14 October 2020 (see item 35 of Emails_C4-News_folio.pdf). The latest application makes serious allegations of a criminal nature against the three parties to my defence team (one of those parties being an office of Government) (see in particular the attachments to email 32 in this collection).

The second application was eventually heard by Judge Hellman in chambers at Mayor’s & City of London Court on 26 November 2020, where he again refused permission to appeal (without any option for an oral hearing), in an order dated 1 December 2020. Since the grounds of the second application included substantive criticism of Judge Hellman’s reasoning in his decision on the first application, there are reasons to doubt the Judge’s impartiality in his latest decision. The entire legal process of the possession claim and my subsequent attempts to appeal its outcome then became the subject of an application to the European Court of Human Rights (re: pp.131-137 below), alleging against the UK serial violations of Articles 6 & 8 of the European Convention on Human Rights, citing the actions of various offices of the Ministry of Justice.

There are particular concerns arising out of Clerkenwell & Shoreditch County Court’s management of this case earlier in 2019 also (see in particular items 09-12, 15, 16, & 18 from Emails_C4-News_folio.pdf). There are specific allegations of fraud relating to the conduct of officials at the court, of the company responsible for producing court transcripts, and of a district judge at the court, in response to my application for a transcript of the
hearing at court on 25 January 2019 of my initial application to set aside the warrant of possession (re: item 15 of *Emails_C4-News_folio.pdf*). If proven, these allegations would seriously undermine the principle of the Judiciary’s independence of the Executive within the British Constitution.

Taken in its entirety, the information disclosed in the tranche of documents contained in the archive download reveals evidence of the effects of systematic corruption across the judicial system, and which has predetermined the actions, not only of the individual parties to my defence team (which included an office of the Ministry of Justice), but also those of officials at various county courts, including judges at those courts. I have argued in the various statements made in support of my applications to appeal during 2019-20, that it is only possible to comprehend a possible motivation behind such a degree of aggregated juridical malfeasance when it is viewed in the context of the enormity of my major historical claims against offices of the British Government and Health Service, and the consequent threat to national security (and in particular to the reputation of the cherished NHS) posed by the prospect of a public disclosure of the truth behind those claims. The trigger for this systematic corruption is therefore understood to have been any reference to my specific identity within the context of civil legal proceedings which presented a foreseeable risk of such a disclosure.

### Applications to the European Court of Human Rights

On 23 February 2021 I submitted an application to the European Court of Human Rights (‘ECtHR’) alleging violations of Articles 6 and 8 of the European Convention on Human Rights against the UK; i.e., in respect of the conduct and outcome of the housing possession case against me, and also with regard to the conduct of the courts in wilfully obstructing my attempts during 2019-20 to appeal the judgement made at Clerkenwell & Shoreditch County Court on 4 October 2018 which had originally granted possession of my flat to the landlord.

I received a response from ECtHR dated 18 March 2021 rejecting the application as ‘incomplete’ (reference: 12776/21), for the reason that I had not included within the bundle of supporting documents copies of the transcripts of the various court judgements referenced within the application. At that time I possessed only one of the missing transcripts, while ECtHR identified five such transcripts required to complete the application. I was determined to submit a complete second application, and so I then made requests to the relevant courts in London by email on 12 April 2021 for the outstanding transcripts. After having eventually received all but one of these (the court in question had responded to say that the relevant case file “cannot be located”), I then submitted a ‘complete’ second application to ECtHR dated 19 May 2021.
The material submitted to ECtHR in both my February and May applications was submitted by email to the Channel4 News Team on 15 June 2021 (re: item 38 in *Emails_C4-News_folio.pdf*). The difficulties and resistance I met with from the London courts in response to my four transcript requests of 12 April 2021 is described in detail in my subsequent email to the news team of 21 June 2021 (item 39 of *Emails_C4-News_folio.pdf*). The documents involved in those requests, including correspondence with three London courts and the transcription company Marten Walsh Cherer, is included in three PDF folios as attached to that email. There are further potential allegations of fraud which may transpire from this material, with regard to the interactions between the transcription company and Central London County Court, and which echo those remarked upon previously in this addendum (re: p.130 para.3 above, in reference to item 15 of *Emails_C4-News_folio.pdf*); i.e., in relation to my earlier transcript request made to Clerkenwell & Shoreditch County Court during May 2019. It had chiefly been my awareness of the sensitivity implied by my allegations in relation to that earlier transcript which had encouraged me to exclude it from my first application to ECtHR of 23 February 2021, in the expectation that this somewhat controversial material could ultimately be submitted to the European Court at a later date, following (so I anticipated) its initial acceptance of the first application.

**ECtHR’s eventual (backdated) dismissal of my second application**

On 27 May 2021 I received acknowledgement from ECtHR during a telephone call that it had received the second application on 25 May 2021 and was given the reference: 26495/21. The second application had been sent from Sweden, and included the address of the hostel where I stayed in Stockholm – *Interhostel* – as my address for correspondence. I waited for a response from the Court, occasionally checking the progress of the application at the Court’s searchable online *State of Proceedings* web facility (‘SOP’). The first entry to appear there in relation to the application was dated 21 June 2021, and showed the state of proceedings as: “Application awaiting first judicial decision”. In comparison, the Court’s response to my first ‘incomplete’ application had been its dismissal letter of 18 March 2021, before any information was recorded at the online database (there remains no information either at the SOP facility or at the Court’s online HUDOC database in relation to that first application).

Following the events of 12 July 2021 at *Interhostel* described in the second addendum below

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* However, the attachments associated with item 38 in *Emails_C4-News_folio.pdf* are not included amongst the bulk of the attachments found in the archive *Miscarriage_of_Justice.zip* linked in the footnote on p.125 above. The files pertaining to my two ECtHR applications are available in a separate archive: *ECtHR_Applications.zip* (41MB) available at cloud source URL: https://shorturl.at/stzFI – accessed 27/05/2023.

† ECtHR’s *State of Proceedings* searchable database is accessible online at URL: https://app.echr.coe.int/SOP/index.aspx. The HUDOC database is found at URL: https://hudoc.echr.coe.int (links accessed 27/05/2023).
(re: pp.154-155 below), I was hospitalised for a period of ten weeks, although I had limited
day-to-day mobility outside the ward where I stayed. In a decision which I understand to
have been largely driven by the disturbance of those events, the hostel was compelled to
finally close for business on 31 August 2021. It was necessary therefore for me to inform
ECtHR of a change in my correspondence address, and so on 26 August 2021 I sent a letter
to the Court advising it that correspondence should now be addressed to a poste restante
address in Stockholm instead of the hostel address given in my application form.

I had anticipated that the hostel premises at Kammakargatan 46 would be inaccessible
following its planned closure on 31 August 2021. However, it transpired that the hostel
management were to conduct a ‘firesale’ of the hostel’s domestic equipment at the premises
for the duration of September 2021, meaning that the premises remained accessible for that
period and I was able to telephone the staff there to check for any mail that might arrive from
ECtHR. This I continued to do, in addition to checking for mail at the poste restante address,
until I finally departed Sweden on 24 September 2021. No mail was received from the Court
however during that period at either of the given addresses.

From my new location in Novi Sad, Serbia, I sent a further letter to ECtHR on 29 September
to change once more my correspondence address with the Court, nominating the main post
office in Novi Sad as a poste restante address. In that letter, I tried to emphasise to the Court
the point that the UK’s alleged violation of Article 8 §1 of the Convention on Human Rights,
as detailed within my application, should be regarded by the Court as a “continuing
situation” with respect to Article 35 §1 of the Convention; and that as such the application
demanded a more urgent response from the Court than was apparent from its delay at that
point of four months in arriving at its initial judicial decision (the state of proceedings at this
time recorded at the SOP facility remained unchanged from that of 21 June 2021 – as:
“Application awaiting first judicial decision”).

After waiting a further two weeks, with no response from the Court, and no change in status
of the application at the SOP facility, on 16 October 2021 I decided to publish online at my
website my correspondence with Channel4 News regarding this alleged miscarriage of civil
justice. This was to include my correspondence relating to my two successive applications to
ECtHR (re: item 38 of Emails_C4-News_folio.pdf), and was also the occasion of the first
inclusion of this addendum to this report, as well as the first publication online of the archive
containing the two applications to ECtHR themselves (re: the first footnote on p.132 above).

Between 19 and 27 October, I made three further revisions to this report. The first of these
was to include the second addendum describing my asylum applications in Sweden (pp.146-
158 below). The fourth revision, dated 27 October 2021, included some minor textual
revisions and also included for the first time (as now in the second footnote on p.132 above)
a link to the ECtHR’s SOP online facility at URL: https://app.echr.coe.int/SOP/index.aspx, together with my remark that the Court’s apparent delay in providing a more effectual response to the application than the one recorded at the SOP facility was “unacceptable” in view of my allegation regarding the “continuing situation” of the UK’s violation of Article 8 §1 of the Convention. Naturally, immediately prior to making that entry to this report I had researched the link itself to check the current status of the application, which – on 27 October 2021 – showed no change to the status recorded on 21 June 2021 – i.e., that of: “Application awaiting first judicial decision”.

I continued to wait for a response from the Court to my most recent letter of 29 September. Ten days after my update to this report of 27 October, on 6 November 2021 I checked the Court’s SOP facility for the latest status of the application. I was surprised to find that a new current state of proceedings was now recorded as: “Application finished”, and there appeared a second entry in the list of major events: “Decision to declare a case inadmissible” showing the date “02/09/2021”. It appeared therefore that this entry had been added to the database after my publication of the application documents online – in the period between 27 October 2021 and 6 November 2021 – and that the decision had been in effect backdated to appear as if it had been made eight weeks previously on 2 September 2021.*

I telephoned ECtHR on Monday 8 November 2021 to query the timing of this recorded decision, and to verify the Court’s receipt of my two letters of 26 August and 29 September notifying it of changes to my correspondence address. I was informed during this call that a letter notifying of the decision had been sent from the Court to me “on 9 September 2021” at the address given in my application form (the Interhostel address), and that the Court had “not received” the information regarding my changes of correspondence address. I was advised that if I wished to receive a copy of the decision I should fax that request to the Court. I then sent the fax request to the Court on 9 November 2021, after searching several hours for a fax service.† During a telephone call to the Court later on 9 November it was confirmed the Court’s receipt of the faxed request.

I then waited for a response from the Court at the poste restante address in Novi Sad given in

* My correspondence with ECtHR following its receipt and verbal acknowledgement of my second application, beginning with my letter of 26/08/2021, is contained within a PDF folio comprising 4 items – ECtHR_folio.pdf – available to download at URL: http://www.somr.info/lib/ECtHR_folio.pdf – accessed 27/05/2023. This folio of correspondence is also included within the archive: ECtHR_Applications.zip linked in the footnote on p.132 above. The third item within the folio is a document showing two pasted screenshots from the ECtHR’s online SOP facility – the first representing the state of proceedings as viewed on 27/10/2021; the second that viewed on 06/11/2021.

† See item 4 of the folio ECtHR_folio.pdf referred to in the footnote above.
my faxed letter. Having received no such response at that address by 19 November, I telephoned the Court once more to query whether a response had yet been issued by the Court. On this occasion the call-handler stated that no information could be given by telephone and that any such request for information must be put in writing to the Court. This was inconsistent with the fact that exactly that kind of information had been readily given to me in response to my earlier calls.

I telephoned the Court again on 25 November, giving my reference number and explaining that I had still received no response from the Court to my faxed request of 9 November, and asking for information whether the Court had yet sent a copy of its decision letter in response. The call-handler stated again – inconsistently with the responses to my earlier calls – that she was unable to access the details of the case in order to confirm whether or not any letter had been sent from the Court.

No mail was received at the Novi Sad poste restante address by the 3 December 2021. As I was planning to depart that location the following week, on 7 December I telephoned the Court once more requesting the same information. I was told during this call that a response had been sent from the Court to the address given in my fax “on 19 November”. Why then could that information not have been conveyed to me during my call on 25 November? I checked at the post office on 8 December (the day of my departure for Albania), but there was no letter from ECtHR addressed to me – if the letter had not reached its destination within this 19-day period, then it was effectively ‘lost in the post’.

From this account of events there inevitably arises the suspicion that the Court has falsely represented the date of its decision to dismiss my second application – that suspicion is reinforced in view of the Court’s most recent failure to provide a response to my faxed request for a copy of its decision. In particular, it is not at all credible that all four of the letters sent by regular post – my two letters to the Court notifying it of the changes to my correspondence address, plus the two copies of the decision letter purportedly sent by the Court, the first on 9 September to Kammakargatan 46 in Stockholm, the second on 19 November to Novi Sad address – have all been similarly ‘lost in the post’ (however, this is necessarily implied if we accept the information given by the Court as truthful). The Court’s first letter ought to have reached its destination by the 17 September at the latest, where I would have been able to receive it, as I visited the hostel premises on 23 September, and I also had an arrangement with the staff there to email me with the news of any post arriving in my absence; so that had the letter arrived at any time during September I would have been informed of the fact.

The suspicion that the Court has falsely claimed both to have made and communicated its decision to dismiss my second application between 2 and 9 September 2021 is consistent
with the observation that no entry in relation to that decision appeared upon the Court’s SOP database until after 27 October 2021, following my somewhat controversial publication of the application documents online, together with a link to the SOP facility itself. It is inferred therefore that the Court was wise to the event of that publication and was provoked as a consequence into invoking a decision to dismiss the application, not for the reason of any inherent inadmissibility in the application itself, but essentially because the Court lacked the judicial will to proceed to a fair judgement of that application.*

Since my departure from Serbia for Albania, I have had no address consistent for a long enough period to make further requests to the Court. It is apparent anyway that the Court does not wish to comply with that request, and has exploited the temporary status of my previous correspondence addresses in order to evade reasonable compliance with it. In not acknowledging or responding appropriately to any of my three letters (the two sent by regular post, and the third sent by fax) the Court is applying a policy of selective opacity with regard to its decision to dismiss my second application, and is to all intents and purposes refusing to communicate the content of that decision or its justification to me.† The same policy of selective opacity has also been employed by its reception staff in response to my enquiries over correspondence, as on several occasions those staff have freely given the information requested; but with notable inconsistency on the occasions of my calls on 19 and 25 November explicitly refused to convey that information.

It is essential that ECtHR should communicate the reasons for its decision to find my second application “inadmissible”, and its failure to respond to reasonable requests for an explanation of those reasons means that its justification remains opaque. That it should have effectively refused to communicate its reasons suggests that the Court’s decision has been made arbitrarily, i.e., with positive disregard to the merits of the application. I am also unaware of the category of decision supposedly made by the Court (whether it is the decision of a single judge, a Committee of 3 judges, or a decision made by a Chamber of 7 judges). I understand however that a decision of inadmissibility is final and unappealable in all three categories. To compare with the timing of the decision in the case of my first application dated 23 February 2021, the inadmissibility of that application was established by the Court

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* After all, the violations of Rule 47 on admissibility criteria that were identified by the Court in its dismissal of my first application had all been resolved in the second application by the inclusions of the missing transcripts – the absence of the fifth transcript had been justified in terms of Rule 47 §5.1(a), by providing evidence of Mayor’s & City of London Court’s response that the case file relevant to that judgement “cannot be located”.

† As a further evidence of this policy, it is not possible to find a reference to either of the decisions relating to my first or second application within the Court’s searchable HUDOC database (accessible at URL: https://hudoc.echr.coe.int – accessed 27/05/2023), which is a transparent repository of all judgements and decisions made by the Court, i.e., including decisions of inadmissibility, and representing even those cases in which the applicants have requested anonymity. It appears therefore that the decisions in response to both my applications have been intentionally sequestered by the Strasbourg Court from its HUDOC database.
It is reasonable to conclude from the above that the ECtHR finds that it is simply unable to act according to its mandate in response to my application and has been compelled into a decision of ‘inadmissibility’ while being unable to provide substantive reasons for that decision. The behaviour of the Court in applying selective opacity in the case of my application, both with respect to its material correspondence and to its published case law, merely replicates a pattern of behaviour well established by the London county courts during 2019-20, in their responses to my efforts to appeal the possession claim, and which formed a substantial part of my allegation against the UK over its violation of Article 6 §1 of the Convention. In this case therefore the ECtHR appears incapable of acting to redress either that violation or the continuing situation of the UK’s violation of Article 8 §1 – the Court’s failure of judicial will serves to perpetuate both violations. This failure to respond with judicial rigour by an office of the Council of Europe, in the context of these quite egregious domestic European human rights violations, is consistent with that already observed following my approaches to the Council’s Commissioner for Human Rights between 2013-2016, as discussed within the Concluding Remarks to Part 2 of this report (re: pp.119-122 above).

**The conduct of my defence team during 2018 (revisited)**

Prior to my two applications to ECtHR (and within those applications), one of the key grounds of all of my attempts in the UK at legal action to appeal the judgement made at Clerkenwell & Shoreditch County Court on 4 October 2018, by which possession was granted to my landlord, was the fact that following the appointment of the Official Solicitor on 14 March 2018 to act as my ‘litigation friend’ in the proceedings, there had been an illegal restriction placed upon my access to the case papers, so that throughout the proceedings I was kept almost completely in the dark about the actions being taken by my defence team. The illegal restriction was maintained both by my solicitor and by my case manager at the Official Solicitor’s office (‘OSPT’), and it was only by virtue of this restriction that the confidence I naturally held that my solicitor would act in good faith and in the best interests of my defence was not seriously undermined well before the trial date of 4 October 2018.
I was unaware that such a general restriction was in place until the day before the trial, when the restriction was lifted with regard to a single document – a Confidential Psychiatric Report produced by the psychiatrist Dr. Chiedu Obuaya dated 16 July 2018, which followed my attendance for a psychiatric assessment by the doctor arranged by my solicitor at the offices of Philcox Gray Solicitors (‘PG’) on 9 June 2018. Dr. Obuaya’s report entailed a list of enclosures, which revealed to me the extent of the restriction in place upon my access to the case papers.* The restriction, which appeared to me quite arbitrary, was the subject of my complaint to the OSPT of 29 October 2018, on which date I also submitted a subject access request under the Data Protection Act to the MoJ for access to the papers in my OSPT case file.†

The OSPT’s response to my complaint followed dated 22 November 2018. In her response, Mbina Mir of the OSPT claimed that the papers had been restricted from my access on purported health grounds, to avoid causing “undue stress” to me as a “protected party” in the proceedings.‡ Ms Mir’s response did not however explain the discrepancy highlighted in my complaint letter which meant that the restriction upon my access to Dr. Obuaya’s report alone was lifted on 3 October 2018, while that upon my access to the remaining case papers listed as enclosures within that report was not lifted until 22 October (in effect, allowing me insufficient time to obtain advice and prepare an appeal against the judgment of 4 October before the expiry of the appeal window on 25 October).

Both my complaint to the OSPT and the OSPT’s response occurred before I had the opportunity to submit a subject access request to my GP Practice for copies of correspondence between PG and the practice following my initial appointment with PG on 8 January 2018. I submitted that request to Blackfriars Medical Practice (‘BMP’) by email on 10 December 2018, and thereafter I received a response by hand from my GP at an appointment with her on 12 December. My email #06 to Channel4 News of 9 January 2019 was informed therefore by the content of BMP’s response to my subject access request (re: SAR_BMP_folio.pdf, amongst the attachments to that email), and it was only in the light of that revealed correspondence that it became clear that the OSPT’s restriction upon my access to the case papers was illegal, as it had flagrantly ignored the advice of my GP in her letter to PG of 13 March 2018 that there was unlikely to be any detriment to my health from my access to any of the case papers.

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* See my first email to Channel4 News of 19/10/2018 for more detail – email #01 of Emails_C4-News_folio.pdf in the archive download linked in the footnote on p.125 above.

† See my email #03 to Channel4 News of 05/11/2018 & relevant attachments.

‡ See the attachments to my email #06 to Channel4 News of 09/01/2019 for a copy of this letter, as well as the email itself for an analysis of the OSPT’s response.
It is clear from the documentation that the restriction upon my access to Dr. Obuaya’s report was handled inconsistently with that upon my access to the other case papers, and there are major divergences in the explanations provided regarding my access to that specific item between the responses from both the OSPT and PG to my individual complaints to each organisation (both responses are included in the attachments to my email #06 to Channel4 News). PG had received the psychiatric report on 16 July 2018; it was then withheld from my attention for 11 weeks until just 20 hours before the trial hearing, despite my solicitor having offered to send me a copy of the report during a telephone conversation on 1 August 2018, and my having agreed to receive it. Prior to that call, while the report was still in preparation, my solicitor had played down its importance for my defence, declaring with words to the effect that: “we need not rely upon the conclusions of the report at trial”. So, even though my solicitor informed me that the report had concluded that my reports of attempts on my life were ‘delusional’, as her earlier statement had implied a degree of optimism regarding the remaining prospects for my defence independently of the report’s conclusions, I was discouraged during August and September 2018 from being overly concerned about the impact of the psychiatrist’s opinion on the outcome of the case.

I was shocked and angered by the contents of the report when I received it by email from my solicitor on 3 October 2018, following my return from Tunisia the previous day; i.e., in order to attend the trial on 4 October, which had been allocated a whole day’s court time. Not only had Dr. Obuaya’s report arrived at its diagnosis of “Persistent Delusional Disorder” by inconsistent reasoning, and with deliberate and unreasonable disregard both to the contents of my own report and to those of an earlier expert psychiatric report (which had not excluded as a possibility the reality behind my reports of attempts on my life), but his report also made far-reaching, unnecessary, and reckless conclusions regarding my alleged ‘incapacity’ to retain any tenancy or to enter into a new tenancy agreement. In effect the doctor’s report disqualified me from obtaining housing assistance from the local authority – it actually left little remaining option for my future accommodation other than detention in a mental health institution. It seemed to me that the report lacked objectivity and had been contrived with the express intention of minimising any prospect of my retaining my existing tenancy in the eyes of the court (I think this conclusion is unavoidable for anyone who has the misfortune to read the doctor’s report).

This, in conjunction with the advice of my solicitor pre-trial that it was ‘looking increasingly unlikely that we would be able to retain my existing tenancy at the trial’ (in the absence of any justification or reasoning for this radical change in expectation), and hence of my defence team’s intention to accept a pre-trial offer made by the claimant (thereby precluding the hearing of any evidence in court on the trial date), convinced me that this had been the intended outcome of my defence team all along, and that the entire conduct of my defence had been contrived in bad faith with the ultimate intention of ‘throwing’ any chance of my
successively retaining the tenancy. This conviction entailed the strong suspicion that Dr. Obuaya’s psychiatric report had been arranged corruptly, as a key instrument towards the diminution of my right to retain the existing tenancy in the eyes of the court.

However, in spite of the evidence emerging post-trial of an illegal restriction upon my access to the case papers already referred to, I had no clear irrefutable evidence to support such a strong allegation regarding the motive of Dr. Obuaya’s report. It was essential therefore, during the months following the judgement of 4 October 2018, and alongside my efforts to appeal that judgement itself, for me to investigate the allegation as far as possible and to submit various subject access requests to the parties concerned to try to elicit further data from them in order to throw more light upon the allegation (some of these requests have been referred to already in the foregoing discussion – p.138 above).

**New evidence to indicate fraud in the arrangement of Dr. Obuaya’s report**

What was most striking in the content of Dr. Obuaya’s report was the extent of his access to information contained in my entire medical record, revealing that he had somehow acquired the authority to conduct extensive keyword searches upon my GP records dating back at least as far as 1996. For a mental health consultant acting in a purely private capacity, and where the question of my guilt of any crime was not an issue, this unprecedented level of access was clearly disproportionate. The doctor had not identified the individual databases he had sourced the information from, and, as I have opted out of the sharing of my GP records on NHS national databases, there was no single source independent of my GP practice which might have supplied the information.

When I enquired with my solicitor post-trial on the subject, she suggested to me that Dr. Obuaya’s access to my medical records had been sanctioned on the authority of the OSPT, while denying herself any involvement in the authorisation. My subsequent subject access request to the OSPT of 29 October 2018,* while requesting a copy of my complete OSPT case file, had specifically referred to any items of correspondence in relation to the OSPT’s authorisation for Dr. Obuaya to access my medical records.

Although the MoJ made a total of three separate responses to my subject access request between 2 May 2019 and 21 February 2020, none of those responses constitutes, individually or collectively, a copy of my complete OSPT case file, and none of the information supplied reveals any correspondence in relation to the issue of Dr. Obuaya’s authority to access my medical records. The OSPT has admitted to having sequestered an unspecified number of

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* See item 07 of OS_MoJ_corres(1-7).pdf, amongst the attachments to my email #03 to Channel4 News of 05/11/2018, in the archive download linked in the footnote on p.125 above.
items from my attention on the basis of the ‘Legal Professional Privilege’ exemption – an exemption which, in the context of the OSPT’s role as my ‘litigation friend’, seems wholly inappropriate, as it can only imply a conflict of interest for the OSPT in that role.

Due to a 6-month delay in the OSPT supplying its first response to my request, on 15 April 2019 I also submitted a subject access request to PG to request a copy of PG’s letter of instructions to Dr. Obuaya in preparation for his psychiatric assessment and report, along with any other items of associated correspondence.* The requested data however was never supplied by PG; i.e., in spite of my having complained to the Information Commissioner’s Office on 19 September 2019 over the failure, and the ICO having written to the firm during November 2019 to encourage its response (ICO ref: RFA0875617)†. Following the OSPT’s last response to my subject access request on 10 February 2020 therefore, my quest for further information to explain Dr. Obuaya’s unprecedented level of access to my medical records remained unsatisfied.

By January 2023 I felt the time was appropriate to make a further subject access request to PG. The firm is obliged to retain case files for 6 years (i.e., in my case, until February 2025), although there is always the possibility that the firm might for whatever reason be ‘wound-up’ before that date, in which case I am unsure what the legal position would be regarding its retention of case files for data protection purposes.

I sent a request to the firm by email on 5 January 2023 asking for a copy of my complete defence case file, to be supplied in electronic format by email. The request was acknowledged the same day by a director at the firm with a promise to respond “as soon as possible”. After 20 weeks, I have still not received a full response to this request; however, on 24 February I received a partial response in the form of: “a complete copy of the trial bundle for the hearing on 4.10.18”. This was by no means a copy of my complete case file; however, as I had not been privy to the trial bundle either before or after the trial, this latest disclosure reveals that of the 42 documents listed in the trial bundle index, 10 items were previously unseen by myself, and were therefore items that had been withheld from my attention by the OSPT (i.e., under the ‘Legal Professional Privilege’ exemption) in its responses during 2019-20 to my subject access request to that office of 29 October 2018.

For the purposes of this specific enquiry over Dr. Obuaya’s authorisation to access my medical records, one of the 10 unseen items is of particular importance – being a letter from my solicitor at PG addressed to the practice manager at BMP dated 9 January 2018, in which

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* See item 05 of PhilcoxGray_folio.pdf, amongst the attachments to my email #11 to Channel4 News of 30/04/2019, in the archive download linked in the footnote on p.125 above.
† See my emails #19, #20, & #22 to Channel4 News of 06/09/2019, 03/11/2019, & 12/12/2019, together with their attachments.
she requests from the practice copies of my medical records held there. There is a further letter, also dated 9 January 2018 from my solicitor addressed specifically to my GP, as instructions for my GP’s proposed legal capacity assessment. Only p.1 of the second letter is previously unseen by myself, as p.2 of it had been included in Gillian Wildgoose’s letter of advice to me of 21 February 2018.* A third item previously unseen by myself is the claimant’s third witness statement to the court of 15 August 2018. This item is significant to the extent that it reveals the particular value of Dr. Obuaya’s report in securing and advancing the claimant’s claim for possession during the months leading up to the trial.†

The purpose of GW’s letter marked “URGENT” to the practice manager is to request a copy of my “full medical notes, computerised records and medical correspondence” in order to assist the firm in my defence – that is to say, a copy of my entire medical record as held by the practice. This was certainly without my consent, and although the letter claims to be accompanied by “signed authority” (it was not included with this received copy), at my initial meeting with GW on 8 January 2018, I recall that she had asked for my permission to access my medical records, to which I had declined, for the simple reason that I knew those records (in particular, those created following my request for a copy of my first Brain MRI scan in December 2010, and my subsequent complaint against Guy’s & St. Thomas’ NHS Trust over its alleged cover-up of the evidence revealed by that scan – re: pp.48-60 above) to contain frequent and misleading references to psychiatric diagnoses that I knew to be spurious and defamatory,‡ and therefore would have been counterproductive to my need to persuade anyone in the context of my defence of the seriousness of my reports of attempts on my life as the grounds for my ‘non-occupation’.

* See the attachments to my email #01 to Channel4 News of 19/10/2018 in the archive download linked in the footnote to p.125 above for a copy of this letter of advice – p.2 of GW’s letter to my GP of 09/01/2018 is included as p.10 of the file: G.Wildgoose_advice_21.2.18.pdf.

† Having recently acquired these items, they do not feature in the archive download of material linked in the footnote to p.125 above. The items may be accessed in the form of a PDF folio available at URL: http://somr.info/lib/Disclosure_2023_folio.pdf – accessed 27/05/2023. GW’s letter to the practice manager is item 02 of the folio. In addition to the previously unseen items described in this paragraph, the folio includes a copy of the claimant’s first witness statement to the court of 04/12/2017 (item 01) by way of a comparison with the unseen third statement (item 04), as well as a copy of my subject access request to BMP of 10/12/2018 (item 05).

‡ For instance, my attendances at my previous GP practice Waterloo Health Centre between November 2011 and November 2013 were repeatedly categorised within the GP-created notes there under the heading of “Paranoid schizophrenia (Review)”, despite that not being the cause of my attendances at the practice, and in spite of the absence of any consistent diagnosis to indicate that I had ever suffered with that condition. These were the subject of a complaint I raised to NHS England on 12/02/2014 alleging defamation against doctors at the practice, and which resulted in my change of GP registration to BMP in early 2014. BMP were aware of my sensitivity over this issue, as I had provided the practice with a copy of my complaint to NHS England, and I had even come to an agreement with BMP following my registration there for it not to continue to reproduce these false categorisations of my attendances at the practice in its own future note-making.
The only permission I had given to GW was for her to seek a capacity assessment from my GP – she did not persist with the request for access to my medical records following my refusal of consent for that access. It is possible that on the 8 January 2018 GW had asked me to sign my consent for the GP’s capacity assessment, and it is likely that I would have signed such an authority, having no reason on that occasion of my first meeting with GW to anticipate that she would act in any way other than in good faith and with due respect to the clear distinction between my consent given in respect of the proposed capacity assessment, but declined with regard to PG’s access to my medical records, at that first meeting in respect of the firm’s proposals to obtain information from my GP practice.

I was therefore shocked to discover GW’s letter to the practice manager in PG’s recent response to my subject access request, and having had no previous knowledge of GW’s aggressive and disproportionate request to BMP for access to my full medical records, it was not clear to what extent BMP had complied with it. The practice could not however have received any genuine authorisation for the request. For this reason, on 17 April 2023, I submitted a further subject access request by email to BMP asking specifically for a copy of the “signed authority” referred to in GW’s letter. Having received no response from the practice by 5 May 2023, I repeated the request by email that day.

On 11 May 2023, I received a response by email from BMP including an attached copy of GW’s letter to the practice manager of 9 January 2018 asking for a full copy of my patient file, together with a document displaying my signature being the purported “signed authority” for the request, although the form does not specify exactly what requested information the authorisation relates to. BMP’s response includes the statement that: “A paper copy of your full records were sent Special Delivery to Philcox Gray by Royal Mail on 17 January 2018”.

So my four-year-long dismay over the degree of Dr. Obuaya’s unprecedented access to my GP-maintained records is now relieved, in spite of the dogged resistance since 2018 amongst the parties concerned to disclosing any information that might have thrown light on that question. It seems to me that that resistance can only be explained in terms of the awareness on behalf of the parties concerned that PG’s request for access to my full medical records had been improperly authorised; and that GW had exploited an ambiguity between two distinct form of consent, one given, the other declined, in order to foist the former fraudulently in place of the latter as a form of discrete sanction for the declined request.

BMP’s revelation also throws into perspective the degree of dissembling implied in the advice given me by GW post-trial that Dr. Obuaya’s access to my medical records had been granted on the authority of the OSPT, as GW’s request to BMP in her letter of 9 January 2018 was made even before my GP had offered any opinion upon my legal capacity (dated
12 January 2018), and therefore prior to the engagement of the OSPT as my ‘litigation friend’ in the proceedings. As PG were not at the time of GW’s two letters to BMP of 9 January 2018 entitled to pre-judge the conclusions of my GP’s proposed capacity assessment, what possible justification could the firm have had, i.e., other than GW’s intention to act against my best interests, for such a disproportionate and aggressive demand for access to my full GP records?

Questions remain to be asked therefore, given that BMP were aware of my sensitivity over the issue of the content of my recent GP-created notes, over the degree of alacrity shown by the practice in its willingness to comply with PG’s abnormal request without first respectfully seeking my explicit unambiguous approval of it. The practice made no attempt to contact me during the period 9-17 January 2018 in order to verify my authorisation of the request or its content. It is important to point out that BMP had specifically overlooked each of GW’s letters to the practice of 9 January 2018 in its response to my earlier subject access request to it of 10 December 2018, in which I had requested: “Copies of all correspondence sent and received between Blackfriars Medical Practice and Philcox Gray Solicitors, SE1, following the appointment of that firm on 8 January 2018”. The response received by hand from my GP at an appointment on 12 December 2018 included only four items of correspondence – three from March 2018 and one from August that year.*

With regard to the witness statements provided to the court by Melanie Brennan at MBM (Edward Henry House Co-operative’s managing agent from early 2015 onwards), in MB’s first witness statement of 4 December 2017, she had not disclosed her awareness of my two emails to Nadra Ahmed at CDS (the Co-op’s managing agent pre-2015) of 3 March & 13 May 2014, in which I had expressed coherent reasons for my ‘non-occupation’ at that time, and had explained that these were out of my control (the emails were similarly disregarded, both by NA in her subsequent correspondence to me during 2014, and also by my defence counsel in his statement of my defence of 29 March 2018; as well as in his amended defence of 4 September 2018).† It appears therefore that, at least until after the completion of Dr. Obuaya’s psychiatric report, there was policy shared between both the claimant and my defence team simply to disavow the existence of those emails; since objectively, in any version of my defence which sought to act sincerely in my best interests, it was crucial for that defence to emphasise the claimant’s evident disregard for my attempts to inform it over

* My subject access request to BMP of 10/12/2018 is item 05 of Disclosure_2023_folio.pdf, linked in a footnote to the previous page. BMP’s response to that request of 12/10/2018 is available as: SAR_BMP_folio.pdf, found amongst the attachments to my email #06 to Channel4 News of 09/01/2019 in the archive download linked on p.125 above.

† All of the documents listed in this paragraph (with the exception of Dr. Obuaya’s report) are to be found amongst the attachments to my email #02 to Channel4 News of 24/10/2018 in the archive download – the two statements of my defence are items ‘e’ & ‘e2’ of the folio: CasePapers(a-g).pdf within those attachments.
the circumstances of my ‘non-occupation’ (i.e., whether the content of those emails was considered to be ‘delusional’ or otherwise), and which had pre-empted NA’s letter to me of 12 August 2014 in which the claimant first raised its concerns over the problem. In para. 7.1 on p.2 of MB’s first witness statement, she states that “No contact was made by the Defendant” in response to NA’s letter (exhibit ‘MB6’, p.28), which is a blatant disavowal of my two earlier emails, and of my simultaneous telephone calls to NA at the time of those emails. However, this crucial element of my defence was overlooked in the defence counsel’s response to it in para. 5(ii) on p.2 of each version of his statement of my defence.

In MB’s third witness statement dated 15 August 2018,* she included repeat copies of some of the 2014 correspondence from NA to myself that were included in her first statement, but in addition she now includes as exhibits my two emails to NA from March and May 2014, and makes explicit reference to them (re: paras. 8 & 9 on p.2); but only because it was by that time considered strategically safe to do so; since the statement later relies upon Dr. Obuaya’s Confidential Psychiatric Report to dismiss the reports made in those earlier communications as ‘delusional’, while also exploiting the reckless further conclusions of the doctor’s report with regard to my inability to maintain a tenancy or to enter into a tenancy agreement; i.e., in order to weaken any remaining right I might have had in the eyes of the court to retain the existing tenancy (re: paras. 17-20 on pp.3-4). It is clear therefore that the major import of Dr. Obuaya’s report upon the proceedings was the extent to which it figured as an instrument to be exploited by the claimant towards the ultimate success of the claimant’s possession claim. Indeed, the report could not have served the claimant's interests better if it had been ordered directly by the claimant according to its own bespoke instructions.

* Re: item 04 of Disclosure_2023_folio.pdf, linked in a footnote to p.142 above.
2. Swedish Asylum Applications

References are made in this addendum to relevant documentary items published in three individual PDF folios, which are available to download as a ZIP archive at my website:†

A. App1_Dec-2018_folio.pdf (15 items).
B. App2_April-2021_folio.pdf (16 items).
C. SWEPOL_May-Aug-2021_folio.pdf (4 items).

In December 2018, I travelled from the UK to Sweden with the intention to make a formal application for political asylum there. This followed two months after the decision by Clerkenwell & Shoreditch County Court to grant a possession order to my landlord (that order became enforceable on 18 October 2018), but before the issue of any eviction notice (as detailed on p.125 above, the eviction did not take place until 28 January 2019). I continued to face attempts on my life in the UK, and there were concerns over my health in respect of a previous such attempt in 2015 (re: pp.72-80 above), which tended to outweigh my immediate concerns regarding the threat of losing my flat along with all its contents. Although I was pessimistic about the prospects of being granted asylum in Sweden (in view of my experience of a similar request to the Norwegian UDI having been refused in 2016 – re: pp.108-109 above), it offered at least a potential route for obtaining appropriate medical attention outside of the UK and independently of the UK National Health Service.

The application was initially accepted by the Migrationsverket (‘MVKT’) in Stockholm on 20 December 2018, and I attended an interview there on 27 December, where I presented certain documents along with evidence in electronic format in support of my application (re: items 01 & 02 of folio A in the list above). I awaited a decision on the application from MVKT, but as an asylum-seeker I had no success in obtaining the level of medical attention required to assess the problem in my thoracic-spine/left-shoulder, which would require at least an MRI scan of the area. One problem I faced was that I did not possess a European Health Insurance Card (‘EHIC’), although I was eligible for one. I became increasingly

* This addendum forms a logical continuation to the events described in the section of Part 2 of this report dealing with my successive applications for political asylum in Turkey, Norway, and Morocco between 2014 and 2017 (pp.106-114 above). However, the processes of my two applications for asylum in Sweden occurred more or less simultaneously with events in the UK in relation to my defence against the housing possession claim, as discussed in the first addendum above. For this reason, the events in Sweden between December 2018 and September 2021 deserve particular attention in comparison and alongside those simultaneous events.

† The ZIP archive: SWEDEN_2018-2021.zip (14MB) is available to download at cloud source URL: https://shorturl.at/lmxQ3 – accessed 27/05/2023. Letters received from the Swedish authorities within these folios are in Swedish. For my own purposes I have made use of Google translations of the letters – there are no available official translations.
pessimistic about the prospects either of obtaining a solution to my particular medical problem in Sweden, or of the likelihood of success of my request for political asylum. Meanwhile, I was made aware by email correspondence of the process of the eviction going ahead at home in the UK.

**The forced withdrawal of my first application and return to the UK**

On 14 January, I returned to MVKT asking if I might be permitted to travel to the UK for the purpose of obtaining an EHIC card, while keeping alive my application for asylum in Sweden. I was not aware of the possibility of MVKT issuing a travel document, and was asking for temporary access to my passport. I was told by staff at MVKT that they would return my passport only if I withdrew the application for asylum. This I agreed to do essentially out of frustration, leaving Sweden for the UK by a flight later that day. I was without the benefit of legal advice which could have advised that my need merely to travel abroad should not have undermined my status as an asylum-seeker, should I want to continue to pursue that application.

The decision of the MVKT to refuse my request for asylum on the ground that I had withdrawn the application was made on 14 January 2019 (item 03 of folio A); however, I did not receive a copy of that decision until I next travelled to Sweden in September 2020. On returning to the UK on 14 January 2019, I applied for an EHIC card, which I received shortly prior to being evicted from my flat in a letter dated 21 January (item 04 of folio A). While in the UK I became engaged in the series of legal actions described in the first addendum above, which forestalled and postponed any intention I had of returning to Sweden to try to re-open my request for asylum; although for reasons of avoiding the persistent attempts on my life in the UK I did not remain there for the entirety of the period January 2019 to March 2020 – the time of the first coronavirus lockdown in the UK, after which I was compelled to remain in the UK.

Following the end of that first lockdown, during July 2020, I travelled through several countries of Eastern Europe. It was during this trip that I experienced a flare-up of symptoms in my rear-thorax, resulting in my visit to a clinic in Novi Sad, Serbia where the most recent MRI scan was conducted (as discussed in Part 2, on pp.77-79 above). I returned to the UK during August 2020. The response from my GP in London to the evidence of the latest MRI scan (as discussed on pp.79-80 above) only exacerbated my continuing frustration with UK health services. This, together with the ever-present attempts on my life while I remained statically resident in the UK encouraged me to return again to Sweden during September 2020 in the hope of re-opening my request for asylum there.
My return to Sweden in an attempt to re-open the asylum application

Upon returning to MVKT on 17 September 2020, I first received a copy of their decision document dated 14 January 2019 (item 03 of folio A). I was also advised of my right to appeal that decision, which I did in a letter to MVKT dated 21 September 2020 (item A-05). MVKT then referred the appeal to the Migration Court (‘MDS’), which acknowledged the appeal in a letter dated 28 September 2020 (item A-06 – page 2 of this letter is unfortunately missing from my scanned copy). I sent a further letter to MDS dated 21 October 2020 (item A-07) enclosing documentary evidence explaining why I had not been in the position to return to Sweden between January 2019 and March 2020. I was advised by staff at MDS by telephone on 21 October that it was likely to take up to four months for that court to make any decision on the appeal.

The court however made its decision to reject the appeal without any significant delay on 4 November 2020 (item A-08), which I received by post on 11 November. The letter includes advice on requesting leave to appeal to the Migration Court of Appeal. I received a further letter from MDS dated 12 November 2020 (item A-09) advising that the decision was deemed served by 25 November 2020. This allowed me until 16 December 2020 to request leave to appeal.

MDS’s justification for rejecting the appeal was: a) MVKT was justified in refusing asylum considering that I had personally withdrawn the application on 14 January 2019; and: b) the statements I have recently submitted as the reasons for withdrawing the application have no legal bearing upon the validity of MVKT’s decision. After researching the issue, I realised that the content of my appeal should have focused on the conduct of MVKT when I had approached them on 14 January 2019 seeking not to withdraw my application, but only the means of temporary travel outside of Sweden. MVKT had presented it to me that the only option by which I might leave Sweden was to withdraw my application for asylum, so to take back my passport. However, the right of refugees to travel outside the country of refuge, without negatively affecting their status as refugees or asylum-seekers, is guaranteed by Article 28 of the 1951 Refugee Convention, to which Sweden is a contracting party. In advising me as they had on 14 January 2019, staff at MVKT had clearly been motivated in encouraging me to withdraw the application, with disregard to MVKT’s obligations under the Convention. These were grounds to request leave to appeal MDS’s decision – grounds which became fully apparent to me by the end of November 2020 (my alternative option at this time was to attempt a new application for asylum, supported by the additional evidence of violations of human rights against me by the UK between January 2019 and December 2020, as detailed in the first addendum above).
Since my arrival in Sweden on 17 September 2020, I had stayed at a single hostel address – *Interhostel* – and managed to remain there in reasonable safety, without experiencing frequent organised attempts on my life, either from those with proximity to me in the hostel, or within the products I routinely purchased from shops, bars, cafes, and restaurants (this latter ‘indirect’ category of organised attempt on my life being one frequently experienced in the UK, for instance, but also one commonly experienced elsewhere in mainland Europe; and one which I have generally tried to avoid *logistically*, by the method of constantly changing my location – a method now made especially difficult in the context of the recent pandemic).

During the last week of November 2020, the temporary sanctuary I had enjoyed at *Interhostel* was interrupted when I was made aware of an organised plot to poison me (through food items of mine stored in a communal fridge) involving certain other guests recently arrived at the hostel, although it is difficult to substantiate these claims in this context. I assumed that this plot would follow me wherever else I might stay in Sweden, and so I decided I had no choice but to leave Sweden entirely at that point.

**Urgent departure from Sweden – 28 November 2020**

I left Sweden on 28 November 2020 on a flight to Helsinki, from where I caught a ferry to Tallinn, Estonia two days later. From there, on 8 December 2020 I submitted a request to MDS in Stockholm by email for leave to appeal its decision of 4 November 2020 (re: items 10-12 of folio A), reserving the option to return to Sweden at a later date, only if absolutely necessary.

I remained in Tallinn exclusively until the middle of April 2021, staying again at a single hostel address, one familiar to me from previous visits.* I received a decision from MDS in Stockholm by email on 18 January 2021 refusing my request for leave to appeal (re: item A-13). The decision was a flat refusal, with no explicit justification with respect to the grounds of appeal as stated in my letter to MDS of 8 December 2020 (item A-11). Unfortunately, I did not retain a copy of the decision letter itself, and the encrypted message service permits access to the letter from the email shown as item A-13 for a limited period of 30 days only. The decision to refuse leave to appeal was nevertheless a peremptory response from the court to the grounds of my request as submitted on 8 December.

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* It was from Tallinn that I had submitted my first application to the European Court of Human Rights dated 23/02/2021 (as discussed in the first addendum above, pp.131-132). It was also shortly before my departure from Estonia that I submitted my four transcript requests to the London courts (on 12/04/2021), following my receipt of ECtHR’s rejection letter dated 18/03/2021 in response to that first application.
While in Tallinn I was not immune to organised attempts on my life in the ‘indirect’ category described above – the length of my stay there rendered me logistically vulnerable, as it is a relatively small city, with limited options for varying one’s habits of consumption – the factor which those committed to my elimination by discrete methods tended always to exploit. The prevailing coronavirus situation however meant that I had few realistic options for changing my location. In early April 2021 I had been exposed to several non-fatal doses of toxicity from the consumption of regular food items purchased in Tallinn, and these became progressively difficult to avoid the longer I remained there. I was more or less compelled to make the rather desperate choice of returning to Sweden with the idea of making a second application for asylum, principally for the reason of Sweden’s relatively relaxed restriction policy with regard to the coronavirus pandemic.

My second return to Sweden in April 2021 and second asylum application

I took a flight to Stockholm on 14 April 2021 and returned to stay at Interhostel. I had limited options for a suitable place to stay – for reasons of economy I needed to stay at a hostel, and Interhostel was both inexpensive and, unlike most other hostels, enforced no limit on the length of one’s stay. As I returned there I received a letter dated 30 March 2021 from the Returns Unit at MVKT in respect of the refused first asylum application (item A-14). A second letter dated 14 April 2021 followed shortly after my return (item A-15).

The two letters from the Returns Unit were issued on the apparent assumption that I had remained in Sweden since MDS’s decision of 4 November 2020 to dismiss my appeal. I telephoned the Returns Unit following my receipt of the first letter and informed them that I had not been in Sweden since 28 November, that I had recently returned on 14 April, and that I wished to discuss making a second application for asylum, taking into account the exacerbation of the human rights violations against me by the UK during the period January 2019 to December 2020, which were now the subject of my application to the European Court of Human Rights (re: pp.131-137 above). I returned to MVKT on 20 April 2021 to formally register the second application, showing proof of my departure and absence from Sweden between 28 November 2020 and 14 April 2021. The application was accepted, oddly enough, since the MVKT will not normally accept such a repeat application within four years of a prior decision to refuse asylum (re: items 01-04 and item 12 of folio B).

I attended the initial assessment appointment on 21 April 2021 and was given a date for a full assessment interview on 12 May 2021 (re: item B-03). I attended the interview conducted by Josefin Dahlander and submitted a printed copy of my report. I offered to submit the documentary material and medical evidence in support of the application in the form of an SD card, which Ms Dahlander would not accept. I was asked to submit it in the form of a USB volume instead, which I agreed to do at a later date. I was told to expect a
decision on my application within two weeks. On 16 May 2021, I delivered by hand to the MVKT reception an envelope containing printed items 05a to 05d in folio B, together with an attached USB volume containing the data referenced within items 05c & 05d.

I awaited the MVKT’s decision. During the week following my interview, I received an ‘LMA’ card by post from MVKT showing my status as an asylum-seeker, with an expiry date of 31 August 2021 (I had received no LMA card during my first application prior to ‘withdrawing’ it on 14 January 19). Before I received anything further from MVKT, I began to experience attempts on my life by poisoning in Stockholm. The first of these was on 26 May 2021, when I experienced the presence of toxicity in a bottle of vodka I had purchased, although the source of the attempt remains obscure. After tasting a single drop of the vodka on my tongue (it is my habit to taste-test almost everything I consume in this way), I experienced an immediate significant swelling in the left-occipital region of my brain – I sensed the presence in the vodka of a substance intended to induce a haemorrhage on the brain (it was not the first time I have experienced the effects of this form of toxicity). I drank no more of the vodka and as the symptoms persisted for 1-2 days I made a report to the central police station in Norrmalm on 28 May 2021 about the suspected poisoning, producing my LMA card showing my asylum-seeker status as a form of identity. The police showed little interest in the report and would not accept the bottle of vodka from me as potential evidence of an attempt on my life.

As I had been advised during my interview at MVKT to expect a decision before the end of May, I visited the office on 1 June 2021 after failing to obtain any information by telephone. I was informed that a decision had been made to reject the application. The second application however shared the same case number as my first application; hence it was not clear to me that the desk officer I spoke to was not confusing the two applications. To resolve that ambiguity I asked that the officer provide me with a copy of the decision. For no apparent reason this was refused, and I was told to wait to receive the decision by post, after which I might use the option to appeal. This was irregular – as the officer could see the decision letter on his computer screen, there was no reasonable justification for him not to give me a printed copy of the decision immediately.

When I later searched the application case number at www.migrationsverket.se, it showed that a decision had been made upon the case on 28 May 2021, but the website permitted no access the content of the decision. I continued to wait for the decision by post, and every attempt I made to telephone MVKT for information was unsuccessful, as none of the people involved in the decision were available, and anyone else I spoke to claimed to be unable to speak English, which indeed was a rarity amongst the staff employed at MVKT.
**An intensification of attempts on my life in Stockholm**

I experienced a further attempt on my life on 8 June 2021, after obtaining a mobile phone sim card which had been handed to me in the street by a vendor. When opening the packet, I noticed that the glue which attached the sim card-holder to the packet was unusually sticky, requiring a lot of force to separate it. My fingers came into contact with some of the glue, and after placing the card in my phone I washed my hands. I was in a café in central Stockholm, and when I left I walked in the direction of Kungsholmen to do some shopping. After about 30 mins, I began to experience symptoms of sickness and faintness, becoming highly stressed, together with the sensation of a swelling once more in the left-occipital region and a pain in the centre of my skull. I washed my hands again urgently, drank 1.5 litres of water, and swallowed 2g of soluble vitamin C. This seemed to halt the progression of the symptoms, and I then continued to walk in the direction of St. Göran’s Hospital Emergency Department. At the hospital they conducted some blood tests; which they then informed me were normal. However, I received no copy of the results from the tests and as far as I am aware the hospital has not conducted any toxicological analysis.

The following day, I went to Norrmalm police station once again to report the suspected poisoning from the sim card, taking the card-holder with its residual glue with me as evidence. The desk officer made a note of the details and I was asked to leave the station. Again the police were unwilling to accept the physical evidence from me or to take any detailed statement of mine in support of the allegation. My reception at the police station was even more curt and disinterested than that I experienced on my visit of 28 May. This was the case in spite of this being my second report of an attempt on my life within the space of two weeks; and in spite of the police being aware (possibly also a symptom of that awareness) of my status as an asylum seeker.

During the remainder of June 2021, I received no letter from MVKT revealing the content of its decision purportedly made on 28 May 2021. At the same time I continued to experience attempts on my life by poisoning, following a similar pattern to those already described. I employed my usual method of defence against these intensified attempts, which was to rigorously test everything I consumed, frequently testing products on my skin when relevant before proceeding to an oral test. I had not experienced such a frequency and intensity of attempts on my life in Sweden prior to May 2021 – the escalation in these attempts was clearly aimed, as it had been previously in the UK and Estonia, at exploiting my lack of mobility due to the coronavirus situation in order to target me more effectively. It is reasonably clear that the motivation and source of the attempts originates internationally, external to Sweden, and acquired its recent impulse and urgency exactly in tandem with my efforts to submit a completed second application to the European Court of Human Rights (finally submitted on 19 May 2021 – re: pp.131-132 above). It seems that Sweden itself was
complicit by default (at least) in the attempts to eliminate me, as no action by either the MVKT or the Stockholm Police in response to my reports of those attempts allowed me the slightest measure of protection against them.

The intransigence of the Stockholm Police

On 1 July 2021, I returned to Norrmalm Police Station to report two consecutive attempts to poison me – on 12 & 30 June 2021 – for which I had retained evidence, should the police have been interested in examining it. I was given a reference number for this report (5000-K770674-21) but to this date have received no formal acknowledgement of this specific report from the police. The other purpose of my visit was to enquire why I had received no correspondence from the police whatsoever in respect of the two earlier reports made on 28 May 2021 and 9 June 2021. I was handed two letters in relation to the first report made on 28 May (ref: 5000-K612070-21 – re: items 01 & 02 in folio C). The decision in the second of those letters is not to initiate a preliminary investigation because “It is obvious that the crime cannot be investigated”. This was not obvious however, and it is only being stated as such to cover for the fact that the police were positively unwilling to collect any evidence that might facilitate an investigation. The police were equally unwilling to communicate the content of this decision to me, as it required my visit in person to the station to elicit these two letters (both dated 1 July 2021, six weeks after the event). When I enquired about the second report made on 9 June, I was told that the report had been sent to me by post on 9 June (which I had not received, and which seemed unlikely as that was the date on which I had made the report). I was informed that no action was being taken in respect of that report; but the desk officer then refused to provide a copy of the report or decision she referred to, and refused to provide me with the reference number of that specific report.

I returned again to the police station on 7 July 2021 to further enquire about the police response to the second report. I spoke to the same desk officer who had initially taken the report on 9 June. She handed me a copy of the recorded report dated 7 July 2021 (i.e., produced on that day, four weeks after the event – re: item C-03); but this was unaccompanied by any decision document. The reference number given in the report is: 5000-K668571-21. I eventually received a copy of the decision letter by post, dated 2 August 2021 (item C-04). The decision was that the preliminary investigation is now dropped because at that point in time (eight weeks after the event) existing evidential material cannot be used to prove who may have been guilty of the crime. However, the report includes only vague and inaccurate details about the event itself – the police were unwilling, either at the time of my report or since that time, to seek a more accurate statement from myself and were therefore not aware or even interested in what evidential material may have existed, as they were positively unwilling to record or collect that evidence.
The MVKT Returns Unit orders my departure from Sweden

During the week of 5-9 July 2021, I received three letters from the Returns Unit at MVKT, two dated 2 July and the third dated 3 July (re: items 07-09 in folio B). The first letter refers to the decision to refuse my second asylum application and urges me to purchase a flight ticket to depart Sweden and to contact the Returns Unit within 14 days. At this point however I had still not received the MVKT’s decision to refuse asylum referred to in this letter – i.e., that which, according to the MVKT’s website, was made on 28 May 2021, in spite of my efforts since 1 June 2021, both in person and by telephone, to obtain a copy of that decision. The third letter dated 3 July 2021 (item B-09) advised me of my right to appeal within five weeks of the order of the Returns Unit. I saw little point in appealing either the decision to refuse asylum or that of the Returns Unit, as it was clear to me at this stage that no public authority in Sweden was prepared to act in such a way as to afford me the slightest protection from the organised attempts on my life which it had been the purpose of my asylum application to avoid. There was simply no option available to me by approach to any Swedish authority that might succeed in discouraging or preventing the attempts on my life. Therefore, during the second week of July, I contacted the Returns Unit to discuss my intended arrangements to depart Sweden by the middle of that month.

An attempted murder at Interhostel on 12 July 2021

On 10 July 2021 I booked a flight ticket leaving Stockholm on 15 July 2021. These plans were interrupted however when I became one of three victims in a vicious random knife-attack (with a machete-type weapon) that occurred at Interhostel during the early hours of Monday 12 July 2021.* I received a total of nine separate injuries during the attack, one of which was a potentially life-threatening injury to my right temple (which resulted in air entering the skull and eye-socket causing a bleed on the brain); and three of which resulted in fractures to the bones in each of my hands including the left wrist. The police interpreted the attacks as attempted murders, and the perpetrator was arrested at the scene shortly after the attacks. I do not assume however that there is any plausible connection between this attack and the organised attempts on my life which were the cause of my seeking asylum in Sweden. Those attempts on my life are of an altogether different character and impulse; and as their motive remains essentially unchanged in view of my continued survival, I anticipated that they would persist independently and regardless of the fact of my having suffered these additional injuries.

* News of this attack made the national news in Sweden, as it was initially suspected that the attack followed the pattern of a terrorist attack (which it transpired not to be). I am not aware that the identities of the victims were made public in these reports. Two of the three victims (including myself) received life-threatening injuries; but there were no fatalities.
I was treated at the Karolinska Hospital in Stockholm, initially undergoing emergency surgery on 12 July 2021, and again on 19 August 2021. Between 15 July 2021 and 21 September 2021, I was located in a state hospital ward in southern Stockholm reserved for patients in convalescence, but was told on 20 September that I must leave that facility the following day. While there I received outpatient treatment at Karolinska Hospital for the injuries to my hands. In addition to the three bone fractures, the injuries resulted in the severing of several tendons in each hand, and further surgery is required to restore extensor ability in the left thumb and right fifth digit, although according to the hospital these are not considered to be medically urgent. The hospital however has refused to conduct the further surgery required to complete the treatment to my hands. As a consequence of the combined tendon and nerve damage I currently have degrees of disability in the use of both hands, some of which will be permanent, but for which there will be no significant improvement without the required additional surgery.

The order of the Returns Unit at MVKT for me to depart Sweden was suspended pending the legal process for the prosecution of the perpetrator on a triple charge of attempted murder and/or aggravated assault, and I was granted a six-month temporary residence permit by MVKT upon the application of the City Prosecutor’s Office in Stockholm (re: items 10 & 11 of folio B). The offender’s trial was completed at Stockholm’s Tingsrätt on 13 September 2021, although a verdict and sentence were delayed until 25 October 2021 pending a psychiatric assessment of the offender. The final verdict of the court was to find the offender guilty of attempted murder for the particular attack upon myself, and of aggravated assault in the case of each of the two other victims. The combined sentence of the court was ten years’ imprisonment – the apparent leniency of this sentence is possibly due to mitigation suggested in the defendant’s psychiatric assessment. I have no specific information regarding the findings of that assessment.

Unforeseen consequences of my second application for asylum in Sweden

There was no prospect of obtaining the additional surgery required to my hands by remaining in Sweden as my temporary residence permit did not allow access to any of the usual benefits of full residency, although the permit was valid until 17 February 2022. As I now have no reliable grip in my left hand, the dressings applied to my right hand and forearm during my second operation on 19 August 2021 had since that operation prevented me from the ability to transport myself along with my 20 kilos of luggage. Following the removal of those dressings, on 20 September 2021 I was told I must depart the next day from the hospital facility where I had been in convalescence for 10 weeks. At the same time I was experiencing a considerable intensification of organised attempts on my life through discrete, targeted attempts at poisoning in Stockholm, as a continuation of those attempts discussed on pp.152-153 above (i.e., of the kind by which I have been generally persecuted at home in the
UK, as well as elsewhere in mainland Europe and beyond, for more than 12 years). I was motivated therefore to depart Sweden as soon as possible, and arranged a flight ticket to Belgrade for 24 September 2021 (this was a rescheduling of my earlier Air Serbia flight originally booked for 15 July 2021, but which had then been cancelled with the option to reschedule following the injuries I received at Interhostel on 12 July 2021). My selection of this destination was influenced by the fact that the original flight booking was made in response to the Return Order issued by MVKT on 2 July 2021 (item 07 of folio B), which had forbidden my travelling initially to any destination within the Schengen territory.

Prior to my departure I telephoned my usual contact at the Returns Unit of MVKT, with whom I had previously discussed my intended departure in July. I wanted to take advantage of the availability of a voucher provided by MVKT to cover the expense of fit-to-fly Covid-19 PCR test (approx. €130), although I had paid for the flight ticket myself. My contact at the Returns Unit agreed to provide the voucher, and when I visited the office to collect it I was also given a letter to hand to border staff at the airport upon my departure, which would then be faxed back to MVKT as confirmation of my departure (i.e., this arrangement was that which would normally be required only in the case of my voluntary compliance with an existing return order, not in the case that I was still in possession of a valid residence permit). The circumstances however were exceptional and I saw little point in arguing with MVKT over the necessity of the departure confirmation, and so I complied with that requirement on my departure from Arlanda airport.

After arriving in Belgrade I spent the following 11 weeks in Serbia, staying in Novi Sad where I sought some medical advice from a hand surgeon regarding the treatment required to my hands. On 8 December 2021 I departed Serbia for Albania, and spent the next 4 weeks in Tirana, until early January 2022, when, being similarly motivated to depart that location in response to evidence of continued plots on my life there also, I bought a bus ticket to Athens on 5 January 2022. I did not anticipate a problem at this point in entering a Schengen territory, as I assumed that the earlier restriction had applied only to my initial departure from Sweden, and would anyway be irrelevant as the Order which prescribed that departure was suspended, and I retained a valid residence permit for a Schengen territory. At the Greek border however, I was refused entry to the country due to an apparent entry in the Schengen Information System notifying of an entry ban in force banning my re-entry to the Schengen territory.* The only conceivable explanation for the entry ban was that it had been imposed by Sweden as a consequence of my failed application for asylum there; but I had been given no warning or advice by MVKT as to its intention to impose the ban.

* Item 13 of folio B includes scans of my bus ticket for this journey and (on p.2) the document provided by the Greek border police confirming that my entry was blocked due to an entry in the Schengen Information System.
According to the standard information given by MVKT to asylum seekers (re: pp.2-3 of item B-12), Schengen re-entry bans are imposed either where an order for voluntary departure has not been complied with within the period specified in the order, or where the return order is effective immediately without specifying a period for voluntary return. As the return order in my case had allowed a period of 14 days for my voluntary compliance (notwithstanding I had been prevented from complying with the order only by reason of my involuntary hospitalisation), and had thereafter been suspended pending the City Prosecutor’s application for a temporary residence permit on my behalf, and was therefore not enforceable at the time of my departure, neither of the aforementioned conditions can reasonably be judged to have applied in my case.

Having been refused entry to Greece I returned to Tirana, where I remained until 24 January 2022. During the following week I made several telephone calls to MVKT in Stockholm enquiring as to the justification for the Schengen re-entry ban and how it might be lifted. I also emailed my usual contact there attaching a photo showing exit and entry stamps in my passport dated 24 September 2021 confirming my departure from Arlanda airport and my arrival in Belgrade on that date, along with a scan of the document supplied by the Greek border police showing the effect of the entry ban in force. The response from my contact at the Returns Unit was that the Schengen re-entry ban had been specified as a condition of MVKT’s original decision letter refusing my asylum application dated 28 May 2021, and that the letter had specified a ban lasting two years. As a reminder (re: p.151 above), I had not received that decision letter by post from MVKT at the time of its issue, and upon visiting the office on 1 June 2021 a copy of the decision letter had been explicitly refused me, without good reason, by the officer I spoke to during that visit (in spite of the fact that he was clearly able to view the decision letter on his computer terminal, and hence could easily have printed a copy of it). I pointed out to my contact at the Returns Unit that I had not received a copy of the decision letter, and he agreed to send me a copy by email. No such email was forthcoming however, and I have since been unable to make telephone contact with the same person (or his superior) at the Returns Unit.

According to the general information provided by MVKT itself (re: the top of p.3 of item 12 of folio B), a two-year Schengen re-entry ban applies automatically in those cases where return is ordered immediately, with no period for voluntary compliance specified. Although there is no available copy of the decision dated 28 May 2021 itself, the Return Order dated 2 July 2021 (item B-07) had followed after a delay of 5 weeks from the date of the decision, and had itself specified a period of 14 days for my voluntary return, so that immediate enforcement cannot have been a condition of the original decision – in which case (according to p.2 of B-12) a one-year Schengen re-entry ban would have been applicable only in the case that I had not voluntarily complied with the Return Order. This suggests that the ban could not, according to MVKT’s general policy, have been a regular stipulation of
the decision to refuse asylum. As I am informed by my contact at the Returns Unit that a two-year Schengen re-entry ban was specified in the decision, it is apparent that the ban had been applied as an arbitrary prerequisite to that decision, despite the fact that this overt penalty was both unwarranted and disproportionate in terms of MVKT’s own published policy, and regarding which therefore (so it appears) MVKT was committed to suspend its usual obligations with respect to reasonable transparency.

The relevant EU statute with respect to return decisions affecting asylum seekers and the imposition of entry bans is The Return Directive; together with The Returns Handbook. Both include references to the Schengen Borders Code.* Page 54 of The Returns Handbook makes it clear that the purpose of entry bans is to have a preventive effect upon those who disregard migration rules (something that I am not guilty of in Sweden), and while the Directive allows for discretion on behalf of member states in determining rules for when and for how long entry bans should be applied, it is clear that an essential prerequisite for a return decision and accompanying entry ban is illegal stay on a member’s territory (i.e., an entry ban cannot be imposed independently of a valid return decision). As I was not illegally staying in Sweden at the time of my departure (or indeed at any other time), and as the Return Order of 2 July 2021 (item B-07) had been suspended on 16 August 2021 (item B-10), then implicitly the entry ban should also have been lifted at that point. It would then be difficult to justify re-imposing the entry ban unless I was on a subsequent occasion found to be illegally staying on a Schengen territory. The entry ban may only now be lifted however by the country that imposed it, which would necessitate a legal challenge to MVKT in Sweden. Under my current circumstances that is practically impossible, since I do not possess a copy of the decision imposing the ban, and MVKT is clearly resistant to providing one.

There is a notable parallel here between the selective opacity being exercised by MVKT in its evident resistance to providing due notification of its decision to refuse my asylum application, including the justification for the apparently arbitrary penalty entailed within it, and that exercised simultaneously by the European Court of Human Rights in its effective refusal to do just the same in respect of its decision to find my second application to the Court “inadmissible” (re: my discussion of this in the final section of the first addendum above, pp.132-137). As the revealed conduct of each organisation is, according to their regular procedures, exceptional and inexplicable – both having occurred effectively in tandem with each other – one is led to suspect that both organisations were acting under some overarching external imperative jointly and systematically imposed upon them.

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[Unless otherwise stated the URLs listed below were last accessed on 16/03/2017; i.e., excepting those items listed as served by the Internet domain ‘www.somr.info’, which were all accessed on the date of the latest revision to this report.]


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