SPECIAL OPERATIONS IN MEDICAL RESEARCH

The Vile, Unspeakable Crimes of British Science & Medicine

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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 likely medical and technological imperatives that I understand must have informed the alleged illicit 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 also now included (see pp.60-64). 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.109-116).

The identities of sensitive individuals 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 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 evidential 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 S”, 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 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 where 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 fifty-one 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 begged for some further elaboration and understanding. It is as if there was some significant causal link in events in 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 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 31/05/1968, 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, and 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, and 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 his 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

* 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 which 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: http://www.omniglot.com/writing/ita.htm]. 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 dyslexia.
first approaches to reading and writing. Children were then re-inducted to traditional orthography at age seven. The period of the mid-60s would 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 under the current title: University Hospital of North Staffs 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 effect 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). 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 nonexistent. 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 develop 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 quoted a minimal age expectation for diagnoses of shingles of 192 months (16 years). 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 age. 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

* Shingles and Postherpetic Neuralgia: http://www.prodigy.nhs.uk (2003). This article, from which the above statistics are quoted, is no longer available on the NHS Prodigy website. The available patient information is now found at: http://cks.nice.org.uk/shingles#scenario:1, where it no longer quotes probabilities according to age, simply 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 only occurs in cases where there is exceptional immunodeficiency, as a consequence of some other prior attendant 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.” From: Recommendations for the Management of Herpes Zoster, 2007, Clinical Infectious Diseases 44(Suppl 1), S1-S26: http://cid.oxfordjournals.org/content/44/Supplement_1/S1.full#p-25.

† 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.
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 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 an (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 have spent approximately ten of the last thirty years doing odd driving jobs (I have not been employed since 2003), although I did manage to complete a BA degree in my late twenties.
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 spasmodic 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 (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 to 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 the last few 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. In addition, I was temporarily homeless at the time, it was a cold night, and I knew I could rely on a good five-hour wait in A&E before I would be dispatched. They took two x-rays of my spine which I have obtained copies of (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, seventeen years 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 and 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 psycho-sexual 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, whose importance 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 relation with my mother, who has long displayed a compulsive, incorrigible guilt towards me, which I have always found rather repellant, 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 quiesced – 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 which 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, designed in answer to the demand of a highly specialised research imperative, and carried out without explicit medical approval (that is to say, covertly, in the absence of a medical testing and approval regime), it is conceivable that this would have resulted in a set of medical conditions not routinely predicable within accepted diagnostic paradigms; so that a GP, due to the routine constraints placed upon diagnosis, would be from the very start structurally incapable of arriving at a satisfactory diagnosis. Such a scenario might explain why 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, are significant indicators 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 accreditation 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 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 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 coincidently 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.

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 put 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. Many of them, considered in isolation from each other, 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 more than fifty years, 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 of

* 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.117-123. See also a synopsis of this research at: http://somr.info/rfr.
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 electromagnetic or 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, on 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 [and] 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 extraspinal, rather than intraspinal 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 diversity and apparent incommensurability of my symptoms might now appear instead as categorically 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, in terms of exposure to unprecedented levels of RFR, for my developing hay fever during the year following my tonsillectomy [Belpomme, 2011].

In the light of current research, and taking into account all of the medical, historical, and anecdotal evidence mentioned previously, 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), 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, origination, 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 (i.e., in addition to those devices revealed in my MRI scans – see Part 2, pp.48-50 & 60-64) 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 motivations 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 fifty-one 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; 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 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 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

* "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.”
[From: High-resolution radioscopy and tomography for light materials and devices, Lukas Helfen, Tilo Baumbach, Fraunhofer Institut für Zerstörungsfreie Prüfverfahren (IZFP), EADQ Dresden. John Banhart, Heiko Stanzick, Fraunhofer Institut für Fertigungstechnik und Angewandte Materialforschung (IFAM), Bremen. Peter Cloetens, Wolfgang Ludwig, José Baruchel, European Synchrotron Radiation Facility (ESRF), Grenoble: http://www.ndt.net/article/wcn00/papers/idn823/idn823.htm]

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) 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 – this being the only occasion when 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, even breakage, of this device, over a period of fifty-one 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:

What is the nature of its connection with the central nervous system?

What is the exact nature of its power source?

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

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

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 (there may of course have been further instances of this kind of operation, but I have no knowledge of them), requiring a unique opportunity, 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. This has serious consequences in terms of the autonomy of individual research subjects, for it negates the value of 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 in Edinburgh in October 2000.* A key feature of this code is 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, in direct ignorance of international protocols. 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 endorsed by 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 be 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 contra-indications, 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 Staffs 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 we are dealing with. 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 allowed to remain concealed, 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 which permits 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 the 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

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act in a way that is incompatible with the rights of the individual as they are laid down in the Convention. But what further protection has this incorporation given to the individual? Previously, victims of infringements of Convention Rights would have had to apply to the court in Strasbourg to have their case heard. The Human Rights Act now provides for such cases to be brought in the UK courts, saving considerable time and legal expense for the plaintiffs. But there remains the problem of the application and of 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 of the ‘ecological validity’ of any prescribed legal remedy – that it would depend on the capacity of the State to vicariously judge itself as acting (in this case) criminally 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 Health Service governance which 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. The function of consent in its current legal form is little more than a legal alibi. Taking the scenario of my mother’s
provision of consent as an example, supposing that my mother had raised any question (which it seems inevitable that she must have, however vaguely) as to the ultimate safety of the proposed implantation, 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 is in spite of 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 contra-indications – 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 lately to provide information on the

* The Ethical Conduct of Scientific Research, 1998, by Rod King.
implementation of the HRA within health service litigation, has suggested the 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 which 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? In addition, when such information arises from the reports of children, we are all too ready to disavow it, and to rely instead on the assumption of adult beneficence. 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 which 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 (even well-intentioned) 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 such a program of research could have been conceived at all – under what kind of direction or imperatives? What kind of goal or outcome can we detect as being implicit in such a proposal? Why could none of those involved find it in their power to speak out against it? Doesn’t it, by anyone’s standards, plainly and explicitly transgress the basis of our common morality? There are two possible motivations, it seems, when it comes to assessing individual accountability in this matter. Firstly, that those involved were motivated purely by considerations of self-interest, of financial gain. This motive explains how the complicity of certain members of my family was enlisted, for instance. But the desire for personal acquisition is simply the weakness through which those whose task it was to instigate the proposal could lever persuasion. Prior to the impulse of greed, there is a factor which is less of a basic human failing, and is more abstract and difficult to comprehend, but has something to do with the autonomous and terribly destructive power of *Science*.

In order to understand how and why such an event as this was possible during the mid-1960s, and not only possible, but which also came to be considered as an *imperative*, in terms of the advancement of prevailing scientific knowledge, one needs to speculate a little further on its probable technological value, and to situate it within an historical trajectory. Taking into account the enormity of the ethical transgression that it implies, the programme must have promised access to knowledge that could not have been acquired by any other possible means.

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 the neuropsychological study 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
exact order and sequence of cerebral processes. Likewise, microscopic examination of dead brain tissue led only to rather hypothetical conclusions about the activity of neurones and neurotransmitters in a living brain.

The postwar 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 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 which 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 what distinguished theoretically possible ‘intelligent machines’ from conventional machines, i.e., those limited to a fixed number of discrete states, or phases, was the ability of the former 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 ability 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 ability, 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]

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 subject(s) 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 on 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, 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. Contemporary neuropsychology 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 available (see Part 2, pp.48-50 & 60-64), that is, without more specialised training in neuroanatomy, and further dedicated scan procedures; in particular MRI scans of my 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 which 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 which 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 suspect that a key impetus for this research programme to have been provided by the UK Ministry of Defence, who are at least accustomed to expecting the lives of subjects as occupational sacrifices in the pursuit of national interests, and therefore might have fewer qualms over ethical constraints.

The burgeoning technocracy of the postwar 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 expedience 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

* 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.
technological advancement become so prepossessed with the idea of its own nobility, 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 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, so as to effectively inhibit the processes of understanding which could have enabled me to conceptualise what it was that had actually happened to me. The imperative of non-disclosure implied a policy of non-intervention and disregard towards an array of biological contra-indications 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 the 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. Without my mother’s consent I would not have undergone this fraudulent operation, and her consent was given with the implicit intention of deceiving both my father and myself. When my father realised from changes in my appearance and in my behaviour that something was seriously wrong with me, and concluded that these changes could only be as a consequence of my tonsillectomy, he challenged her. 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 allegation; however I have absolute confidence, based on my own thorough analysis of events, that this is the case, and that the evidence to prove the fact will be forthcoming.*

* 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
(2004-2018)
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 \textit{prima facie} evidence in my report, there was insufficient basis on which to pursue an investigation. I later learned, however, that officers from New Scotland Yard had visited my sister (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 \textit{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 from those holding responsibility, including, indeed, representatives of the medical profession. 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. In 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 02/10/2008. In April 2009, I received a consultation with the neurologist Dr. Thomasin Andrews at Guy’s Hospital over the scan, but 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.∗

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: http://somr.info/report/repz.php.
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 23/12/2008, 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 tortuositaities 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 which 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 predictable or identifiable within the 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.75-91). 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 to St. Thomas’ on 29/06/2012. I eventually received copies of my Guy’s & St. Thomas’ NHS Trust (‘GSTT’) medical records from the Information Governance Dept. on 02/10/2012. However, these did not include a copy of the MRI findings report. I then made an arrangement with the IG Dept. to view my records in person at the hospital on 13/11/2012. I also filed a complaint with the Information Commissioner’s Office to address the failures in the IG Dept.’s response. On viewing the online copy of my MRI scan, 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 23/12/2008. 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 06/10/2008; first typed by “RJ1RANV” on 02/10/2008). 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 Information Commissioner’s Office 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 office of the ICO advised me, on 14/03/2013, that it did not fall within the remit of the Data Protection Act 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’s office requested GSTT to 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 DPA, 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 12/04/2013, 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 19/03/2013, 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 20/03/2013, 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 16/04/2013, 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 14/05/2013. Following enquiries towards the end of May, I was informed that the response to my complaint had been written on 16/05/2013, 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

* The complaint, GSTT’s response, and subsequent correspondence are published online at: http://somr.info/report/rep6.php.
in the first week of June, dated 03/06/2013.

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, and, 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 reporting 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 its refusal to address the evidently anomalous nature of the object 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 in recognition of 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, and 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 images selected 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 28/06/2013 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 23/07/2013, expressing my dissatisfaction with their response to my complaint.*

I eventually received their response on 16/09/2013. This response however falls short of the “full investigation” of my further concerns promised in their letter of acknowledgement issued on 24/07/2013. 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 ‘problem’ of 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 08/05/2013, 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

* For details of this correspondence, see: http://somr.info/report/rep6.php.
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 23/09/2013.*

I received an initial decision on my complaint to the PHSO dated 18/11/2013. 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 (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 which had not been reported by St. Thomas’ Radiology and 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 the 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 to 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 25/11/2013. I judged that the reason for the apparently unrealistic 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 complaint to the PHSO, their initial decision, and the subsequent correspondence referred to below are published at: http://somr.info/report/rep6.php#phso.
my ability to make a coherent complaint before March 2013, they ought to have been persuaded there were sufficient extenuating circumstances which justified extending the time limit on the complaint. In my letter requesting a review of their decision, I tried to explain the extraordinary circumstances involving attempts on my life which I faced following my request for a copy of the MRI scan material from St. Thomas’ Information Governance Dept. – circumstances which 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 a complaint may be accepted 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 of their decision 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.78-81 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 which have persisted (with some periods of 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 31/12/2013, there is no indication however that the Review Team has given any serious consideration to the reasons set out in my letter of 25/11/2013, 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 conceivably 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 it.

In my request for a review I had concentrated on the reasons indicated above of the extenuating circumstances inhibiting my ability to make a complaint before March 2013. I had not presented an argument of the grounds 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 successful investigation of GSTT’s role in covering-up that evidence. Should the PHSO choose rather to exercise 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 which had, at this point in time, 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 which 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 have
waived 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 06/03/2013. 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

* These images are also published online at: http://somr.info/report/rep0.php.
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:
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 08/02/2013, 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 sufficient to explain the recent symptoms of occipital pressure.

I received a copy of Dr. Heaney’s letter to my GP dated 18/03/2013, 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 26/09/2013, 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 03/10/2013, 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 specific anomalies indicated by the two arrows; as it is patently self-evident that the rigid rectilinear character

* The correspondence with NHNN following the 2nd MRI scan, together with my subsequent complaint, is published at: http://somr.info/report/rep0.php.
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 knowledge or information required to accurately identify the objects in question, resulting as I allege they do from an illicit, unprecedented surgical implantation, in the absence of any explicit medical approval, it is inconceivable that he could honestly have not noticed these items, simply because they do not correspond 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 11/11/2013.

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 16/12/2013, together with a report on the complaint investigation from Prof. John Duncan, Divisional Clinical Director of the Queen Square Hospitals, dated 12/12/2013. 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 06/03/2013, 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 its non-biological origin beyond any 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 enhanced contrast), 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 which refer to the institutional context of the implied covert research program which gave rise to these illicit surgical implantations (i.e., that it occurred within an NHS Hospital), and which suggest an explanation for why it was that 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 his denial as: "We do not ‘see’ the box-like structure, because it is not one that is predicable within accepted diagnostic paradigms"; which in effect is 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 which 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, and one which is likely to challenge anyone’s faith in ethical medicine, and to bring 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 18/12/2013. The PHSO responded on 09/01/2014 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 05/03/2014, 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 three images presented 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 06/03/2014, 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: http://somr.info/report/rep0.php.
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 [my] 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 13/01/2014. 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 25/03/2014.

In my comments I had reiterated my understanding of the systemic constraints inhibiting disclosure of the evidence, and which had affected the reports of the three specialists at NHNN and, in light of the PHSO’s draft investigation report, suggesting that the same constraints now appeared to be affecting the attitude of the PHSO towards its own investigation, including the advice of the 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 04/04/2014. 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 13/01/2014, 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 09/04/2014, 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 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. 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 30/06/2014. I received a response to my request from Nicola Bubb, reviewer at the PHSO, dated 17/07/2014†. The response is to say 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 04/04/2014‡, 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 – that is, with regard to: 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

* For access to copies of the PHSO’s investigation reports, and additional correspondence, see: http://somr.info/report/rep0.php#phso. The PHSO’s response to my FOI request is available as a zip archive at: http://somr.info/lib/PHSO_FOI_response.zip.

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

not overlooked these major elements of my complaint.

Ms. Bubb’s response to my remarks (those on pp.4-6 of my review request) regarding the poor 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 request for a review does not address the fact, which was made clear in 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 13/01/2014. 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, experience so far 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 seriousness (and criminal) nature of the historical allegations over events in 1967, which were not the 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 which were provided in response to my Subject Access Request to GSTT (in November 2012), 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 20/03/2012, 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: “[W]e are not able to medically evaluate your scans”, despite having stated (paradoxically) in the preceding paragraph: “[T]he 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: “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)

In June 2015, I developed a set of aggressive symptoms in the region of my left shoulder blade. It is 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 in the area of my 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. The symptoms still persist, in a less acute form, and are increasingly troublesome, and worryingly complex. Moreover, despite the existence of two MRI scans of my spine made in response to my reports of these symptoms, the symptoms have been left 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, at the time it was unclear whether these new symptoms may or may not have developed as direct or indirect consequences of the experimental surgery I allege was the true purpose of my tonsillectomy operation aged five. Having given considerable thought to the matter over the past three years (encouraged by the enduring nature of the symptoms over this period), and within the context of a series of concurrent organised attempts on my life, I think I may have arrived at the most plausible explanation for the emergence of these quite mysterious symptoms.

In March 2015, having returned to the UK from Turkey (see pp.100-101 below for an account of my November 2014 application for asylum in Turkey), I had in my possession an early-model Sony smartphone. I was not in the habit of using a smartphone (for security reasons), but had occasionally used it as an FM radio (i.e., with no sim card installed and with all the location services switched off). I used another basic mobile phone for telephone purposes. The smartphone had at times been left charging unattended in the hostel rooms where I stayed, but for most of the time it was lying unused in my suitcase. When I began staying at my friend’s flat in May 2015, I started to cycle around London, and on two occasions I took with me the Sony phone to use as a radio while cycling. The smartphone was placed in the small top pocket of my backpack, where it would have been situated directly behind my shoulders. Having used it in this way just twice, I then stopped using it as
the reception was generally quite poor. I had never used the smartphone as a telephone, and have never carried it close to my person except on the occasions just described. It has only ever been used with headphones, and not held against the side of my head. I now suspect, due to the close association in time between my use of the smartphone as a radio and the development of the mysterious symptoms in my left shoulder area (and because there is simply no other adequate explanation for these symptoms) that I may have suffered from two bouts of damaging radiation to my shoulder from this device. It is possible – and one must bear in mind the persistence of attempts on my life at this time, as well as the organised and sophisticated nature of those attempts (see pp.75-91 below for further elaboration) – that the battery in the smartphone may have been exchanged for a battery modified to emit a damaging level of microwave radiation; that is, one modified to include a magnetron device. Such an exchange could have been made while the phone was left charging and unattended in my hostel room. I no longer have possession of the smartphone, and so it will not be possible to verify these suspicions. However, it may be possible for someone with the relevant medical expertise to determine from the spinal MRI scans whether this kind of injury (likely to be irreversible internal tissue damage – necrosis) has been caused to the area of my left shoulder.

In July 2015 however, in the absence of a satisfying explanation for the symptoms such as the one just offered, discussion with my GP soon appeared entirely hopeless of being able to approach any adequate assessment of the problem. If the GP were to rely upon seeking an explanation in purely conventional diagnostic terms (which after all is all s/he is actually trained to do), and as the symptoms were largely manifested as pain sensations, rather than anything obviously visible or physically debilitating, then the GP might reasonably have concluded, after excluding a range of possible conventional explanations, that the symptoms were more or less psychosomatic, or even phantasmal. I could only try to impress upon my GP, with reference to my earlier brain MRI scans (but in the absence of any expert corroboration of the fact), the unprecedented nature of my medical condition, as a potential backdrop to the development of the new symptoms. The GP successfully avoided any confrontation with the difficult subject of what might or might not be revealed in the existing MRI scans, by making two early referrals with the potential for 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 23/07/2015. 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.

The second scan was the result of my GP’s referral to the Neurology Dept. at the Royal London Hospital (‘RLH’) and was made on 11/09/2015. The scan was preceded by an initial consultation with a neurologist at the hospital on 18/08/2015, 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 an appointment letter from RLH’s MRI Dept. of 21/08/2015. 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 from the MRI Dept. of 21 August.

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), which is an utter perversion of the reports I had made of my symptoms during my initial consultation with the neurologist, which concerned only the left shoulder, and which was the reason for that doctor to specify a scan of the left shoulder in addition to the whole spine. 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. 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.

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”. I do not have the expertise to judge if there are anomalies revealed but left undisclosed in these scans (my judgements with regard to the earlier Brain MRI scans in the two earlier sections concern anomalies which are quite self-evident). I leave it to those with the relevant expertise to evaluate the spinal scans.*

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 in respect of their financial disposition, 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 10/12/2010. I telephoned her immediately, as she had asked me to. The call was quite short and to-the-point. Shortly afterwards (10-15 minutes) 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 is 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 12/12/2010 – 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 they had a reasonable fear of some impending consequences.

I made a report to the police on the night of 12/12/2010, 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 28/12/2010), 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.92-99, 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 is sufficient indication
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 from 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 determination and preparedness 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’. 
I now have numerous items in my possession containing various kinds of poison, collected between December 2010 and the present, including a bottle of water, which I now understand may contain a solution of radioactive polonium-210* (for reasons which are impossible to fully explain here, I was fortunate enough to be able to anticipate these attempts, and was able to distinguish, from the nature of the toxic effects of consuming a few drops of this water, and after researching the subject, 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 materialised in direct coincidence with the request I made to St. Thomas’ Hospital Information Governance Dept. for a copy of my Brain MRI scan in December 2010. It was only as a consequence of that request that there was an appreciable risk that I might come into possession of the prima facie evidence that would support 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

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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 from tasting a few drops of the water 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: http://somr.info/lib/polonium_210_story.pdf]
obtain 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 01/01/2011.

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.

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. Since that time and through until the autumn of 2012 I was unable to make regular use of my flat, in view of the inevitable threat to my life, 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.
More recently, 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 subsisted 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 10/01/2014 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, 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 a possible 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 and the numbness on the left side of my head persisted however, 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 placed under my door 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, 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 have no adequate defence against such an attack, and cannot determine to what extent my flat remains contaminated, and so have been unable to safely occupy the flat since this time.

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.100-101 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 26/02/2014, 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 had referred the report back to the police in Lambeth.

It became necessary for me return to the UK in March 2015, principally for financial reasons (see p.101 below). When I visited the flat for the first time to collect my mail on 07/03/2015, 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 is no one to my knowledge who has 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 my 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 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, 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

* There is an audio recording available of my conversation with PC Burgess on 13 March 2015.
anything obviously being removed from the flat, so that, 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 my neighbour’s testimony, the content of our conversation is 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’ 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 is no obvious visible sign of it. As the officer’s remit, as she understands it, ends 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 26/02/2014, and the emails from 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, means that the evidence of poisoning, which undoubtedly exists at my flat, will continue to go uninvestigated, and therefore will continue to prevent my occupation of the flat indefinitely. Having already been minimally exposed to that toxicity, I do not feel that I can safely dispose of the evidence that I know to exist in my vacuum cleaner for instance, and to do so would be to destroy the evidence of an attempt on my life. In view of the suggested illegal entry to my flat, I must also consider the possibility that my belongings, or fixed facilities within the flat, may have been ‘booby-trapped’ in my absence. Hence, until the Lambeth Police resolve to take seriously my reports of the existence of a serious toxic hazard at the flat, I remain unable to safely occupy my flat, or to remove my belongings from there. There has however been no further response from the Lambeth Police to the reports made in March 2015.

As I remained unable 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) which 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 July 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 which I have alleged that doctors at the Neurology Dept. of RLH deliberately misrepresented the reports of my symptoms and

* There was one notable exception to this that occurred before May 2015, involving the suspected replacement of the battery in a smartphone I carried (but rarely used) with a modified battery designed to emit a damaging level of microwave radiation. I have explained in the section Spinal MRI Scans (2015), on pp.72-74 above, that I have come to understand that this was the probable cause of the injury to my left shoulder (the symptoms of which still persist, and which have been left deliberately unexamined by health services); although my remarks here are speculative, since I no longer possess the smartphone and cannot prove the allegation.
were wilfully negligent towards the assessment of the problem (see the section: *Spinal MRI Scans (2015)* on pp.72-74 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; 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 28/12/2015 – 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 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 inactivity in the clandestine attempts to poison me.

In view of the increasing desperation behind these most recent attempts, I felt I had no choice but to leave the UK once more, which I did on the 08/02/2016, 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.101-103, 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 have had 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 at this point 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 this 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 into two separate hostels, and with the perpetrators apparently taking advantage of the length of my stays, my luggage was broken into on two occasions and attempts were made to poison food and toiletry items I kept there. There were signs on both occasions 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.79-80 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 which would be quite counterproductive, as the effect would be only 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. 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.103-108 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.103-104 below), and I returned to the UK on 02/12/2016. The following few months, until April 2017, were spent in much the same manner as before my departure in October 2016, i.e., 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” (similar to “Scotch Tape”), 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 which I had not frequented previously and while I was there I refrained from any 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 on 27/09/2017.

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.104-108 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 must have 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, 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 23/11/2017 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. I made the booking for New Year’s Eve at a hostel in Hackney online on 23/12/2017. 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 were poisoned, and I believe that the battery in my mobile phone was exchanged with a modified battery (including *magnetron*) designed to emit damaging levels of microwave radiation (identical to the method I have speculated was used in 2015 – see pp.72-74 above), and was intended to cause a significant brain injury. 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. Amongst other things, I noticed that my phone 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.

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 08/02/2018. 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 that might have indicated 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 or cause me serious bodily harm, 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 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 or cause me serious bodily harm, 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.

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 have been compelled to remain within the UK for most of this nine-month period, it has been 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 specific 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 appropriately 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 eight years (with some periods of relaxation) – requiring access to toxins not readily available in the public domain (including, indeed, *nerve agents* and *radiotoxins*), 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, 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 which I had cause to make to them with an approach of ‘blanket ignorance’, by ignoring 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 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 for 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 of that made in February 2011). My complaint, having been hampered by ignorance of the content of those records, was therefore ill-focused, and both the DPS and the IPCC were able to use the content of those records in order to subvert the grounds for my complaint, by simply reiterating the validity of the police’ 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 in blatant ignorance of the additional evidence I submitted to police on 28/12/2010, which explicitly undermined that initial assumption.*

Following this 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: http://somr.info/report/rep3.php.
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 might be 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 atrocity 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 respond to that evidence (including several major hospitals, the police, the GMC, and now the Heath Service Ombudsman) can persist in denial.

At the end of June 2012 I made a Subject Access Request 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, regarding 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 28/12/2010 (see above p.77-78). 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 22/11/2012, i.e., more than three months beyond the 40-day deadline prescribed by the Data Protection Act. The information I received did not include copies of the evidence I submitted to police on 28/12/2010. The information included the police incident log from the 12/12/2010 (the day the police had visited my flat in response to my allegation against my family), and CRIMINT reports from 12th & 28th 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 12/12/2010, and completely ignored the additional evidence I presented to them on 28/12/2010, 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 17/12/2012, 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 12/12/2010, 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 28/12/2010, 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 06/03/2013, with the grounds clarified as in the list above, the Appeals Unit decided to uphold my appeal, on 08/04/2013.* The decision letter by Sgt. Cochran of the Appeals Unit, recognises (on p2. para.6) 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 any 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’, in consideration of my arguments 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

* For access to the letter of the second complaint, the subsequent correspondence with the DPS, and with the DPS Appeals Unit, see: http://somr.info/report/rep3.php#dps.
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 investigation report in response to my complaint, dated 16/09/2013.*

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 06/03/2013, 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 28/12/2010, as this item is not specifically referenced in the summary, but however is unavoidable in the original complaint letter itself.

Furthermore, PS Scott’s investigation has missed key points of enquiry, and was conducted without any constructive interrogation of the two officers regarding the substantial elements of my complaint, but with a general acquiescence to the two officers’ unwillingness to recollect details of the events in question from December 2010; excusing the officers’ selective amnesia over these events on the basis of the gap in time between the events and the complaint investigation. 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 10/10/2013.

In their letter of acknowledgement of my appeal, dated 14/10/2013, the IPCC advised me that it may take “up to 36 weeks” to allocate my appeal to a Casework Manager. This compares 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.

* 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: http://somr.info/report/rep3.php#psu.
The IPCC’s appeal decision was eventually received dated 05/06/2014. Their review has 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 reinvestigate the complaint.

With regard to the first and key point, over the adequacy of the MPS investigation, my appeal had listed 3 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 06/03/2013, 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 28/12/2010.

In relation to the first ground, I understand that this failing resulted as a response by PS Scott to the directives given 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 08/04/2013. As detailed above, Sgt. Cochran’s directive to the PSU was that the new investigation should consider only the four grounds (see p.94) which had been summarised in my letter of appeal to the DPS (of 06/03/2013). The correct interpretation of this directive was that a reading of the original letter of the second complaint (of 17/12/2012) in terms of the grounds as summarised would permit a clear distinction 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 way 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 28/12/2010 (the fourth ground listed on p.94 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 28/12/2010 – I had made it reasonably clear on pages 2-3 of my letter to the DPS of 20/01/2013 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 28/12/2010, as well as the writing of the second CRIMINT report), as he will 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 fairly be 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 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 which contradicted their initial assumption that my allegations against members of my family were ‘delusional’. The key item of this evidence was the letter from social worker Jane Hughes attesting to my mental health, and dated 23/09/2010. It cannot be merely a matter of oversight or accident that the IPCC have chosen to ignore the repeated references to this item in all of my correspondence over the complaint, just as the PSU investigation report 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 this (with the exception of the MRI evidence) since 2003. It is also the case that there is no unequivocal medical statement to say that I suffer from any form of mental illness which could satisfactorily attribute my claims to delusional thought processes, and thereby discount objectively irrefutable medical evidence. The police are therefore obliged to pursue a proper investigation in the light of these 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 the overall secrecy surrounding the issue of my tonsillectomy in 1967, confident as I am of the police’ awareness of the substantiality 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.82 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. However, I needed to return to the UK in June of that year to renew my passport. I then 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 the two hospitals 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 discretely 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 strictly according to the terms of refugee status). 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 07/03/2015, and the events of the following eleven months, are in part reported on pp.83-86 above. In response to the resurgence of attempts on my life described there during January 2016, and the apparently increased desperation behind those attempts, I was forced to depart the UK once more on 08/02/2016. 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. I telephoned the Immigration Office while being held at the airport, but there seemed 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; implying that I was able to survive, that is 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 only 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 which 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.113-116 below) – in view of 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 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, and 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 25/08/2016) 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: http://somr.info/lib/07-complaint_OHCHR_25.4.16.pdf.
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 ignorance
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) – which 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 of course is that my movements were under constant observation, so that
local organised criminal networks could be alerted to my presence in their area, 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.87-88 above.
Due to the heightened urgency of 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 17/10/2016, travelling overland via Spain to Morocco, once again seeking the
relative sanctuary of a Muslim country, arriving there on 20/10/2016.

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 (in particular, with regard to the problem in my left shoulder, which had been refused
assessment or treatment in the UK – see pp.72-74 above), and with which to support an
application for asylum in Morocco. 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
09/12/2016. 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 in my bank 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 09/12/2016. I returned to the UK by plane on 02/12/2016, courtesy of a loan from the Foreign & Commonwealth Office.

The events in the UK following my return, and prior to my next departure in September 2017, are related on pp.88-89 above. In late September, I travelled by bus to Paris, and from there took a plane to Cairo, Egypt, arriving there on 28/09/2017. 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 should 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 10/10/2017 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, Michele 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

* 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: http://somr.info/lib/UNHCR_Rabat_documents.pdf.
seemed unlikely to me that this coincidence of two distinct errors in the details of my identity 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 and I had succumbed to a fatal poisoning attempt whilst in Morocco, 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 30/10/2017*, 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.

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 possible 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 certificate 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 unresponsive 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 30/10/2017, in the year since that date it has offered no information as to how it intends to resolve that complaint, or of its intended time frame for doing so.*

On 10/11/2017, 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 is 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.

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* See the email exchange listed as item 4 in the PDF folio of documents relating to my asylum application in Morocco: http://somr.info/lib/UNHCR_Rabat_documents.pdf.

† 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: http://somr.info/lib/UNHCR_PSRSD.pdf.
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), and from its refusal to respond with appropriate urgency to the medical issues involved, 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, seemingly in anticipation of my prospective return to renew my asylum application. In view of this and also in view of the possible 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 24/11/2017.

On 29/12/2017, I made a formal complaint by email to the UNHCR Inspector General in Geneva, intending to address (more explicitly than I had in my complaint to UNHCR Rabat – in view of the treatment I received at that office on 30/10/2017) the allegations of misconduct and corruption against an employee or employees of the office in Rabat. I then received a brief acknowledgement of my complaint by email from the Inspector General’s office (‘IGO’) dated 04/01/2018, but which included no indication of any time frame for resolution of the complaint.

On 11/02/2018, 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, asking that they postpone the assessment, while keeping the application open, pending the outcome of my formal complaint to the UNHCR Inspector General.

On 26/04/2018, 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 months I have still received no acknowledgement or response of any kind whatsoever to that enquiry, while my complaint is now nine months old. In their email to me of 04/01/2018, the IGO had acknowledged merely an allegation of “inappropriate behaviour” in my complaint. My enquiry of 26 April reminded the IGO that the complaint’s chief allegation is that of corruption, in addition to that of inappropriate behaviour. It seems likely therefore 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.

* 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: http://somr.info/lib/UNHCR_Rabat_documents.pdf.
Concluding Remarks

The preceding account of events, in particular those following my access to the *prima facie* 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 on the basis 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 resembles the 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) fifteen years ago, in 2003. In subsequent anticipation of this inevitable scepticism, and because these concerns have preoccupied my attention throughout the intervening fifteen years, I have had 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: “We 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

* See above, pp.70-71. Copies of the correspondence with the GMC referred to may be accessed at:
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 a correct established medical diagnosis in favour of 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 they do from a clandestine medical experiment, carried out without any explicit 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 doctors, by refusing to volunteer *any* information which 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 into a kind of systemic denial, the explanation for which is that the evidence disclosed to them reveals activities and undertakings within some of our most respected institutions, which are not explicable simply in terms of an 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, with a calculated contempt for ethical and humanitarian principles; and which are parallel, in microcosm, to some of the atrocious medical experiments committed under the Nazi regime. Such a disclosure therefore traduces some of the fundamental moral and ethical principles which we rely on.
institutions bearing a duty of care to maintain, particularly with respect to the treatment of vulnerable individuals (in this case a five-year-old child), and relativises the State’s commitment to humanitarian principles, when those principles are so easily circumvented by the State acting covertly.

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 disenfranchisement in which children 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.37-41).

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 which 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?

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 because of this), 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

* See my earlier discussion on the subject of a child’s autonomy, in the subsection Consent, Part 1, pp.37-41 above.
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. 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 which 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 04/11/2013.* 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.81-82 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

* Copies of my correspondence with the Commissioner’s Office may be accessed at: http://somr.info/#coe.
Commissioner for Human Rights responded to my November 2013 letter in May 2014 (letter dated 24/04/2014). However, I did not actually receive this letter until April 2015, 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 25/04/2015, to which after three 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 refusing to uphold the second (and that without even conducting an independent 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 Trusts, and between myself and the PHSO, 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 each case in letters being sent from both Trusts to the Community Mental Health Team (‘CMHT’). Each had deliberately misrepresented the substance of my respective complaints to suggest that I was suffering from a delusional
mental illness, in order to invoke a psychiatric response from the CMHT as part of a strategy of defence, shared between each of 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 the 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 any litigatory action within the UK in respect of my medical claims against several major hospitals, due to a systemic and 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 inexorably to the invoking of issues 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 country of the European Union since the end of the second world war.

Astonishingly enough, although it is now 29 months following the April 2016 submissions, and in spite of a number of supplementary submissions made since April 2016 with regard to the PHSO’s still unresolved decision over my second complaint to UCLH, I have yet

*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: http://somr.info/lib/07-complaint_OHCHR_25.4.16.pdf.
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 I now have 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, 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.
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