



អង្គជំនុំជម្រះវិសាមញ្ញក្នុងតុលាការកម្ពុជា  
Extraordinary Chambers in the Courts of Cambodia  
Chambres Extraordinaires au sein des Tribunaux Cambodgiens

ព្រះរាជាណាចក្រកម្ពុជា  
ជាតិ សាសនា ព្រះមហាក្សត្រ

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Nation Religion King  
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Nation Religion Roi

អង្គជំនុំជម្រះសាលាដំបូង  
Trial Chamber  
Chambre de première instance

**ឯកសារដើម**  
**ORIGINAL/ORIGINAL**  
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TRANSCRIPT OF PRELIMINARY HEARING  
ON FITNESS TO STAND TRIAL  
PUBLIC

Case File N° 002/19-09-2007-ECCC/TC

29 August 2011, 0900H

Before the Judges: NIL Nonn, Presiding  
Silvia CARTWRIGHT  
YA Sokhan  
Jean-Marc LAVERGNE  
THOU Mony  
YOU Ottara (Reserve)  
Claudia FENZ (Reserve)

The Accused: NUON Chea  
IENG Sary  
IENG Thirith

For the Accused: SON Arun  
Michiel PESTMAN  
PHAT Pov Seang  
Diana ELLIS  
ANG Udom  
Jasper PAUW

Trial Chamber Greffiers/Legal Officers:

SE Kolvuthy  
Matteo CRIPPA  
DUCH Phary

For Civil Parties: PICH Ang  
Élisabeth SIMONNEAU-FORT  
SAM Sokong  
Philippine SUTZ

For the Office of the Co-Prosecutors:

SENG Bunkheang  
Tarik ABDULHAK  
PAK Chanlino  
Sarah ANDREWS

For Court Management Section:

UCH Arun

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**List of Speakers:**

Language used unless specified otherwise in the transcript

<b>Speaker</b>	<b>Language</b>
MR. ABDULHAK	English
MR. CAMPBELL	English
JUDGE CARTWRIGHT	English
MS. ELLIS	English
JUDGE LAVERGNE	French
MR. NUON CHEA	Khmer
MR. PAUW	English
MR. PESTMAN	English
MR. PHAT POUV SEANG	Khmer
THE PRESIDENT (Nil Nonn, Presiding)	Khmer
MR. SENG BUKHEANG	Khmer
MS. SIMONNEAU-FORT	French
MR. SON ARUN	Khmer

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1 PROCEEDINGS

2 (Judges enter courtroom)

3 MR. PRESIDENT:

4 Please be seated.

5 A warm welcome to all parties present today. In my capacity as  
6 the President of the Trial Chamber and on behalf of my fellow  
7 judges, I would like to welcome the Co-Prosecutors, the  
8 co-lawyers for the Accused, the Civil Party Lead Co-Lawyers to  
9 this hearing.

10 The purpose of this hearing is to allow consideration of all  
11 issues arising, specifically, from expert report completed  
12 recently by Trial Chamber expert, Professor John Campbell, in  
13 response to challenges by several Accused to their fitness to  
14 stand trial and their ability to sit for lengthy periods during  
15 the trial proceedings. May I now declare the hearing open?  
16 Ms. Se Kolvuthy, please report the attendance of parties during  
17 this hearing.

18 THE GREFFIER:

19 Mr. President, parties invited in these proceedings today are as  
20 follows: prosecutors in attendance now and the defence for Ieng  
21 Thirith and Ieng Thirith is also present. The defence for Nuon  
22 Chea, Mr. Son Arun and Mr. Michiel Pestman, are present and  
23 defence for Ms. Ieng Thirith, Mr. Phat Pouv Seang and Ms. Diana  
24 Ellis, is present. Ms. Diana Ellis is present today and a  
25 representative for civil parties are present as follows and our

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1 expert, Professor Campbell, is also here. He is waiting for --  
2 to be invited by the Chamber. And experts will have to take an  
3 oath before the Chamber.

4 In today's hearing, there are -- there is also the Accused, Ieng  
5 Sary, and his defence lawyer, Mr. Ang Udom, as an observer to the  
6 hearing.

7 MR. PRESIDENT:

8 Thank you very much, Ms. Se Kolvuthy.

9 [09.03.29]

10 The Chamber would like to check for recognition of foreign  
11 lawyers if not previously recognized by the Chamber in Case 002.

12 In accordance with Rule 22.2(a), the Chamber would like to ask  
13 the national defence lawyer for Ieng Thirith to seek recognition  
14 of foreign lawyers whose recognition has not been granted by the  
15 Chamber.

16 MR. PHAT POUV SEANG:

17 President, Your Honours, Members of the Bench, prosecution and  
18 everyone around the room, my name is Phat Pouv Seang. I am a  
19 national lawyer for the Accused, Ieng Thirith. I would like to  
20 ask the Trial Chamber to recognize my learned colleagues to  
21 represent my client in -- during this hearing.

22 Thank you.

23 MR. PRESIDENT:

24 Ms. Diana Ellis, please rise. Ms. Diana Ellis, you are now  
25 recognized by this Trial Chamber as a defence lawyer for the

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1 purposes of the trial proceedings before this Chamber. Pursuant  
2 to this recognition, you enjoy the same rights and privileges as  
3 a national lawyer. Please be seated.

4 MS. ELLIS:

5 Thank you very much, Your Honours.

6 MR. PRESIDENT:

7 Having completed all formalities concerning the recognition of  
8 foreign lawyers, the hearing will now proceed.

9 [09.06.18]

10 On the 19th of January and the 2nd of February and the 21st of  
11 February 2011, respectively, the defence for the Accused, Ieng  
12 Sary, Nuon Chea and Ieng Thirith, filed motions before the  
13 Chamber challenging their fitness to stand trial and their  
14 ability to sit for lengthy periods during trial proceedings.  
15 In response, the Trial Chamber, in an Order dated the 4th of  
16 April 2011, appointed Professor John Campbell, a geriatrician, as  
17 an expert and requested him to conduct a medical assessment of  
18 all Accused who challenged their fitness to stand trial and their  
19 ability to sit for lengthy periods during trial.

20 The fourth Accused, Khieu Samphan, chose not to avail himself of  
21 this assessment and has confirmed the Trial Chamber -- that he is  
22 currently fit to stand trial.

23 Professor Campbell was requested to prepare a written report in  
24 respect of each individual Accused and to indicate whether expert  
25 medical or psychiatric examination and report, other than in the

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1 expert field of geriatrics, may be required to enable the Trial  
2 Chamber to reach a determination of their fitness to stand trial.  
3 Professor Campbell completed his reports in relation to all three  
4 Accused in June 2011. The expert reports of Professor Campbell  
5 concerning the Accused, Ieng Sary, concluded that this Accused  
6 was fit to stand trial and that no modifications to the Chamber's  
7 trial schedule are presently required in relation to him.  
8 And the Ieng Sary defence has since indicated to the Chamber that  
9 they do not intend to contest this assessment or otherwise  
10 challenge Professor Campbell's report in relation to the Accused,  
11 Ieng Sary. The Ieng Sary defence are accordingly present today  
12 in the capacity as observers only, and they may remain for any  
13 part of the hearing that is conducted in public.

14 [09.09.26]

15 The expert's reports in relation to the Accused, Nuon Chea and  
16 Ieng Thirith, were distributed on a confidential basis to the  
17 relevant parties on the 13th of June 2011 and the 23rd of June  
18 2011, respectively.

19 In his report concerning the Accused, Nuon Chea, Professor  
20 Campbell concluded that the Accused, Nuon Chea, is not presently  
21 unfit to stand trial. In July 2011, the Nuon Chea defence filed  
22 a number of objections to this report and the Co-Prosecutors,  
23 their response within the deadlines set by the Chamber.

24 In his report concerning the Accused, Ieng Thirith, Professor  
25 Campbell concluded that the Accused suffers cognitive impairment

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1 compromising her ability to participate fully in her trial and to  
2 exercise her fair trial rights. The Ieng Thirith defence teams  
3 have filed observations in relation to this report and the  
4 Co-Prosecutors, their response also within the deadlines set by  
5 the Chamber.

6 In relation to the Accused, Ieng Thirith, Professor Campbell made  
7 a number of consequential recommendations; the most significant  
8 of which was an authorization of her long "drug" regime in order  
9 to assess whether or not this would have any impact on the  
10 expert's earlier assessment.

11 Professor Campbell returned to Phnom Penh last week to reassess  
12 the Accused, Ieng Thirith, following implementation of this  
13 recommendation in advance and in advance of this hearing. And  
14 then, he conducted assessment on Nuon Chea, and then he will  
15 submit his written report in due course.

16 [09.11.57]

17 In consequence of Professor Campbell's report, the Trial Chamber  
18 has since appointed supplemental psychiatric expertise to examine  
19 the Accused, Ieng Thirith, pursuant to Internal Rules 31 and 32.  
20 Assessment of her by specialist psychiatrist will commence  
21 shortly.

22 The purpose of the present hearing is limited to consideration of  
23 all issues raised by the reports produced by Professor Campbell  
24 in relation to both Accused, Nuon Chea and Ieng Thirith.

25 To assist in preparation for this hearing, the Chamber compiled



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1 for the parties a list of relevant documents cited by the expert  
2 in his reports pertaining to Accused, Ieng Thirith and Nuon Chea,  
3 as well as a number of clarifications. Additional clarification,  
4 if required, may be sought by the parties from the expert during  
5 the hearing.

6 A few remarks regarding the structure and modalities for the  
7 conduct of this hearing: the Chamber is aware that while the  
8 expert reports pertaining to the Accused, Ieng Thirith and Nuon  
9 Chea, raise different issues and require consideration by the  
10 Chamber in separate hearings, many of the observations made by  
11 both teams in relation to their respective expert reports are  
12 similar or overlapping; for example, concerning for the experts  
13 methodology.

14 To avoid repetitious questioning of the expert, the Chamber will,  
15 therefore, commence this hearing as a joint hearing involving  
16 both defence teams. The Nuon Chea and Ieng Thirith defence teams  
17 were requested by the Chamber to collaborate and ensure that all  
18 questions common to both teams are put to the expert in a  
19 coordinated manner during this initial joint session.

20 [09.14.30]

21 At the conclusion of this joint session, the Chamber will then  
22 proceed to individualized hearings in relation to the expert  
23 reports concerning Accused, Ieng Thirith and Nuon Chea. The  
24 Chamber will commence with a consideration of the expert's report  
25 concerning Accused, Ieng Thirith, in the presence of her defence,

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1 the Co-Prosecutors and the Civil Party Lead Co-Lawyers; followed  
2 by a hearing on the issue raised by the expert report for  
3 Accused, Nuon Chea, in the presence of his defence, the  
4 Co-Prosecutors and the Civil Party Lead Co-Lawyers.  
5 At all stages, the Chamber will commence the questioning of the  
6 expert. The floor will then be given to the defence teams, Ieng  
7 Thirith and followed by Nuon Chea, and then followed by the  
8 Co-Prosecutors and the Lead Co-Lawyers may then speak.  
9 In the interest of efficiency, the Lead Co-Lawyers should limit  
10 their intervention only to areas where they differ from the  
11 Co-Prosecutors.  
12 Finally, the defence teams will be given the last response.  
13 The Chamber has been seized of several motions requesting  
14 confidentiality in relation to the expert reports. In accordance  
15 with Internal Rule 79.6, the Chamber advises that these hearings  
16 will be presumptively public and conducted to the maximum extent  
17 possible in open session. The Chamber has, however, indicated a  
18 need to balance the rights of the Accused to privacy concerning  
19 medical information against the public's right to know the basis  
20 on which an application on fitness to stand trial will be  
21 determined.  
22 [09.17.01]  
23 It has, therefore, agreed on the following modalities for the  
24 conduct of this hearing: all hearings will commence in open  
25 session; where any party considers there to be a need to proceed

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1 only in closed session, an oral motion may be made to the  
2 Chamber; these applications will be heard in open session and  
3 granted by the Chamber where the Chamber considers the interest  
4 of justice to so require.

5 Should the Chamber permit any hearing to proceed in closed  
6 session, the parties are requested to consolidate all matters for  
7 consideration in camera within a single, non-public session in  
8 order to ensure efficiency and minimize disruption to the public.  
9 During any in camera session, which may be granted by the  
10 Chamber, the civil parties actually in the courtroom may remain.  
11 They are, however, reminded that the information they will hear  
12 is confidential and must not be shared with anyone outside these  
13 proceedings.

14 [09.18.40]

15 Professor Campbell, you are invited to come to the seat that has  
16 been reserved for the expert before the Chamber, please.

17 MR. PRESIDENT:

18 Good morning, Professor Campbell. Your name is John Campbell.

19 Is that correct?

20 MR. JOHN CAMPBELL:

21 That's correct.

22 MR. PRESIDENT:

23 How old are you, Professor Campbell, now?

24 MR. JOHN CAMPBELL:

25 I'm 65 years old.

9

1 MR. PRESIDENT:

2 What is your nationality, Mr. Campbell?

3 MR. JOHN CAMPBELL:

4 I'm a New Zealand citizen.

5 MR. PRESIDENT:

6 Do you have any relation with any party in these proceedings?

7 MR. JOHN CAMPBELL:

8 (Recording malfunction) with any party in these proceedings.

9 MR. PRESIDENT:

10 Thank you, Professor Campbell. In accordance with Rule 31.2 of  
11 the Internal Rules, you are required to swear an oath before  
12 providing testimony before the Chamber.

13 [09.21.18]

14 MR. JOHN CAMPBELL:

15 I solemnly swear that I will assist the Trial Chamber honestly,  
16 confidentially and to the best of my ability.

17 QUESTIONING BY THE BENCH:

18 BY MR. PRESIDENT:

19 Q. Thank you. Thank you, Professor Campbell. Professor  
20 Campbell, could you please state your qualifications -- the  
21 relevant qualifications and experience in geriatric expertise and  
22 your practice in this field of expertise? If you can do it,  
23 please, you may now proceed.

24 MR. JOHN CAMPBELL:

25 A. I qualified in medicine in 1969. I then entered into

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1 post-graduate training as a physician specializing in internal  
2 medicine. In my training, I specialized in internal medicine  
3 with a particular interest in the care of older people -- in  
4 geriatric medicine. I undertook training in New Zealand and in  
5 the United Kingdom and in Canada before returning to a consultant  
6 post in New Zealand.

7 I then became a senior lecturer in geriatric medicine at the  
8 University of Otago Medical School in Dunedin and in 1984 was  
9 appointed as Professor of Geriatric Medicine.

10 I undertook post-graduate research in conditions affecting older  
11 people and gained my doctorate through thesis.

12 I'm a Fellow of the Royal Australasian College of Physicians and  
13 a Fellow of the Royal College of Physicians of London.

14 [09.23.25]

15 I've practiced in geriatric medicine now as a consultant since  
16 1976. Currently, I spend half my time in consultant clinical  
17 practice and half my time in teaching and research in geriatric  
18 medicine.

19 Q. Thank you, Professor Campbell.

20 MR. PRESIDENT:

21 I will now hand over to Judge Cartwright to further the  
22 questioning in relation to the expert reports. Your Honour, you  
23 may now proceed.

24 JUDGE CARTWRIGHT:

25 Thank you, President.

11

1 Professor Campbell, thank you for answering to the Expertise  
2 Order and also for coming to Court today for examination by the  
3 parties and by the Court.

4 As the President has said, this first part of the hearing on the  
5 fitness of Ieng Thirith and Nuon Chea to stand trial will be a  
6 general one. The defence teams for the two Accused have been  
7 asked to use this part to examine general issues, such as the  
8 methodology you used, the types of testing and the like. And  
9 they've also been asked to coordinate their questioning.

10 After the Judges have questioned you, the relevant parties will  
11 then put questions to you. So this -- in this part, we will be  
12 concerned primarily with the tests, assessments and the types of  
13 examinations that you conducted, and when we come to each  
14 individual Accused, we will look more closely -- we will look at  
15 your findings and examine them in more detail.

16 [09.25.32]

17 So, the purpose of this part of the hearing is to gain a general  
18 overview of the actions you've taken, and I'm going to focus on  
19 your first report in relation to each Accused and then go to your  
20 most recent report.

21 Now, I'm sure you understand the microphone system, but when you  
22 answer a question, could you wait until you see the red light on  
23 your microphone and speak slowly enough for the interpreters to  
24 translate into Khmer and French?

25 QUESTIONING BY THE BENCH:

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1 BY JUDGE CARTWRIGHT:

2 Q. First, dealing with the order appointing you as an expert;  
3 in that order, is it correct that you were asked to examine each  
4 Accused and to provide a report that would enable the Trial  
5 Chamber to determine if each was fit to stand trial?

6 Could we have the microphone? Thank you.

7 MR. JOHN CAMPBELL:

8 A. That is correct.

9 Q. Were you also asked to comment on the suitability of the  
10 physical conditions provided for the Accused and on the provision  
11 of audio-visual facilities or limits on sitting hours that might  
12 be appropriate to ensure that specific significant medical  
13 problems might be accommodated?

14 [09.27.06]

15 A. I was.

16 Q. And were you given authority to examine the Accused and to  
17 examine relevant medical reports, to conduct any tests that you  
18 deemed necessary and, if appropriate, to advise the Trial Chamber  
19 of any additional expert medical or psychiatric examination that  
20 might be appropriate to enable you to fulfil your mandate?

21 A. I was.

22 Q. Now, before we start this part, could you first explain in  
23 lay terms the specialized medical field of geriatrics?

24 A. Specialized field of geriatric medicine is to do with the  
25 health of older people. Almost all of the conditions that affect

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1 younger people also affect older people, and there are also  
2 specific conditions which become very much more common in older  
3 people

4 The key issues in geriatric medicine which distinguish it are  
5 that many of the conditions affecting older people have multiple  
6 causes, and there are very often multiple causes affecting the  
7 older person; whereas, in younger people, there is usually one  
8 cause of a particular condition and often only one condition.

9 [09.28.31]

10 The second key issue that is important -- slow down -- the second  
11 important condition with older people is that the conditions  
12 affect their function - that is, their mobility, their ability to  
13 care for themselves - so that change in function is very  
14 important to assess.

15 The third factor which is very important with older people is  
16 that their social circumstances also influence the presentation  
17 and the effect of their underlying medical conditions.

18 The complexity of cause, the influence on function and the  
19 importance of psycho-social factors all add to the complexity of  
20 assessing older people.

21 Q. Yes, thank you very much. Now, turning first to the  
22 methods that you used to examine Ieng Thirith - first, you  
23 examined her personally on the 11th and 12th of May of this year.  
24 Is that correct?

25 And did you have access to the following documents, and I'll read



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1 through the list? This is the list that you said in your report  
2 that you relied on before completing your first report. So the  
3 list goes like this: regular, written reports from Calmette  
4 Hospital from 20 December 2007; medical reports from Calmette  
5 Hospital on hospital admissions, appointments and investigations,  
6 including: CT head scans, CT scan of the thorax and of the lumbar  
7 spine and blood tests. So perhaps, you could acknowledge whether  
8 you reviewed those particular reports?

9 A. I had access to all those documents and also access to the  
10 CT scans themselves. I was able to review the films.

11 [09.30.53]

12 Q. Thank you. You also had the opportunity to discuss Ieng  
13 Thirith's medical care with the doctors from Calmette Hospital  
14 who have been treating her since her detention. Is that correct?

15 A. That is correct.

16 Q. You also reviewed medical expert reports from Dr. Sok  
17 Buntha and Dr. Patrick Keenan from June of 2009 and Professor Ka  
18 Sunbaunat and Dr. Philip Brinded November 2009. Is that correct?

19 A. That is correct.

20 Q. Now, you've already said you specifically reviewed the CT  
21 scans themselves, and I understand that you also reviewed those  
22 scans with a neuroradiologist. Is that correct?

23 A. I was given a CD of the scans and was able to take that and  
24 review it with a neuroradiologist in Dunedin.

25 Q. Now, you also looked at the video footage of Ieng Thirith's

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1 appeals against the Co-Investigating Judges' orders for extension  
2 of provisional detention. Those orders were made on the 24th of  
3 February 2009 and the 15th of February 2010. Is that correct?

4 A. That is correct. And I was also given a transcript of that  
5 hearing.

6 [09.32.33]

7 Q. Can you just pause there and explain why you thought it was  
8 useful to review the video footage of Ieng Thirith on those two  
9 occasions?

10 A. I thought it would be useful because it would be an  
11 indication of her demeanour and also of her memory and I -- there  
12 were problems with recall during that particular hearing, and it  
13 was useful for me to be able to see that.

14 Q. Now, since physically examining Ieng Thirith in May, did  
15 you then have access to Professor Ka's report dated the 9th of  
16 June 2011, which was given in response to the Chamber's order for  
17 further assessment of Ieng Thirith and also a later report dated  
18 the 4th of August, in which Professor Ka clarified certain  
19 matters arising from his earlier report?

20 A. Yes, I have had those documents.

21 Q. And, finally, in relation to this first report - did you  
22 also examine the medical report which summarized Ieng Thirith's  
23 admission and treatment during her time at Calmette Hospital  
24 between the 24th of May and the 2nd of June this year?

25 A. Yes, I have had the summary of that admission.

16

1 Q. Now, in relation to your first report – first, a very  
2 general question. Can you define for the Chamber and for the  
3 parties what you mean when you use the term "cognitive" in  
4 relation to your assessment of the Accused Ieng Thirith?

5 A. When I speak of cognitive function, I'm referring to the  
6 function -- a number of functions including: memory, reasoning,  
7 initiative, concentration; higher functions of the brain which  
8 have to do with our interaction with people and our memory and  
9 judgement of events.

10 [09.34.58]

11 Q. Thank you. Now, specifically, during your period when  
12 you've assist Ieng Thirith for your first report, you conducted  
13 some formal tests of cognitive function: the Folstein Mini-Mental  
14 State Examination and the Montreal Cognitive Assessment. Can you  
15 first explain briefly the structure and the purpose of these two  
16 tests?

17 A. These are formal, validated tests of cognitive function. I  
18 use them as a supplement. Most of my assessment of Ieng  
19 Thirith's cognitive function had to do with her history and my  
20 examination of her and her examination of her history. The tests  
21 that I used were used to supplement that. I did not use the full  
22 tests because of the circumstances under which I was seeing her.

23 Q. And on what did you base your decision -- on what factors  
24 did you base your decision -- to conduct these tests?

25 A. I decided that those were the most appropriate tests to use

17

1 in these circumstances. As I said, I used them as a supplement  
2 to the history which I was able to obtain from her notes and from  
3 her, herself.

4 Q. Can you tell us a little bit about these two tests? Were  
5 they developed in a European country, English-speaking,  
6 French-speaking, German-speaking country?

7 A. That's a very important question because the -- and it's --  
8 that is behind the reason why I did not use them in full. They  
9 were developed in English-speaking countries; the Montreal test,  
10 obviously, in Canada and the Folstein in United States. So, there  
11 may well be problems in the validation in a different country  
12 using a different language.

13 [09.37.16]

14 The other reservation about using them in full is that they are  
15 normally used when one is testing a person who wants to show that  
16 they are as good as they possibly can be. This may not be the  
17 circumstances when one is testing in this situation.

18 Q. And how far did you have to adapt these tests in a  
19 situation where it is clear that Ieng Thirith does not use  
20 English as her first language?

21 A. Yes, they needed to be administered through the interpreter  
22 and, therefore, there was always the question as to how fully the  
23 instructions are being understood.

24 Q. Are you aware of any comparable tests for Khmer speakers  
25 from the Cambodian cultural context?

18

1 A. No, I could find any tests that had been translated into  
2 Khmer for use. The Montreal test had been converted to  
3 Vietnamese, but not to Khmer.

4 Q. Now, you sent a letter to the Trial Chamber dated the 13th  
5 of May. That letter was completed before you proffered your  
6 written report. And in the letter, you recommended further  
7 assessment of Ieng Thirith by Professor Ka Sunbaunat.

8 [09.38.55]

9 Can you explain why you asked for that further assessment from  
10 Professor Ka Sunbaunat, please?

11 A. I had two reasons for asking for that additional  
12 assessment. The first was that Professor Ka Sunbaunat had  
13 already seen Ieng Thirith and I was interested in any change he  
14 may have noticed in her condition.

15 [09.39.13]

16 The second reason is, as I explained earlier, I was working  
17 across a different culture -- with a different culture -- and I  
18 felt there would be value in a person, an expert from that same  
19 culture, to also assess Ieng Thirith.

20 Q. Now, you received Professor Ka Sunbaunat's further  
21 assessment, which was dated the 8th of June, and the  
22 clarification that he later provided dated the 4th of August.

23 [09.39.48]

24 Did you amend any aspect of your methodology or your assessment  
25 of Ieng Thirith as a consequence?

19

1 A. No, I did not. I thought that his conclusions were  
2 consistent with mine.

3 Q. Now, there was some comment in Professor Ka Sunbaunat's  
4 further assessments about the Mini-Mental Status Examination.

5 [09.40.20]

6 Did you reconsider its usefulness as a tool for assessing Ieng  
7 Thirith's cognitive ability when you read that -- those comments  
8 from Professor Ka Sunbaunat?

9 A. I already had some reservations, as I've indicated.  
10 Professor Ka Sunbaunat's comments were consistent with that and  
11 influenced the weight I put on that formal testing.

12 Q. Well, that leads me to my next question. What weight did  
13 you put on that particular test relative to the other methods or  
14 tests used by you?

15 A. It was consistent with what I had already found in the  
16 history, so it did not change my judgement in any significant  
17 way.

18 Q. As part of your first report, you commented on the  
19 observations of other people who are close to Ieng Thirith,  
20 living or working near her.

21 [09.41.33]

22 Is that a usual part of an assessment of an older person's level  
23 of cognitive ability?

24 A. It is a very important part of the assessment because it is  
25 often in activities of daily living that problems with cognition

20

1 first become evident; for example, failure in the activities of  
2 cooking, of ordering groceries, of doing work about the place.

3 [09.42.01]

4 It is very often that other people working with the person  
5 observe this and the person is less aware of those problems him  
6 or herself. So, external observation is absolutely critical. It  
7 also gives a time course to the deterioration.

8 One of the difficulties has been that the environment over the  
9 last few years has been so undemanding that Ieng Thirith has not  
10 been tested in terms of daily living activity to any great  
11 degree. I was, however, able to obtain useful information from  
12 those who were in daily contact with her.

13 Q. Now, a feature of your first report was the emphasis that  
14 you placed on the reduction of certain medications then  
15 prescribed to Ieng Thirith. We're going to examine that aspect  
16 of your report in more detail when we come to the individual  
17 parts of the hearing.

18 [09.43.02]

19 So without going into any detail of the recommendations that you  
20 made at this point, can you just confirm that you discussed your  
21 recommendations with the treating doctors from Calmette Hospital?

22 A. Yes, we had an audio conference that was very useful and we  
23 were able to explore these issues at that time.

24 Q. And have certain modifications, in fact, been made to Ieng  
25 Thirith's medication regime more or less in line with your

21

1 recommendations?

2 A. Yes, they have. Ieng Thirith was on three medications  
3 which may affect cognitive function. Two of those have now been  
4 stopped, and she has been off those two drugs for a week, just  
5 over a week now.

6 [09.43.52]

7 The third drug, we have just started the reduction in dose.

8 Q. Now, I've been focusing mostly on your tests and  
9 assessments in relation to Ieng Thirith's cognitive function.

10 [09.44.10]

11 Can you just confirm that you conducted a full range of physical  
12 examinations to clarify her physical status?

13 A. I did. I examined Ieng Thirith to determine if there were  
14 any other physical problems that may affect both her cognition or  
15 her ability to participate.

16 Q. Did you find anything of any major significance?

17 A. No. The only other factor that may be important is that  
18 she has frequent pain in the knees and in the ankles. And that  
19 can, of course, lead to agitation, impaired sleep. And I've made  
20 recommendations on treatment for that.

21 Q. Now, last week you returned to Phnom Penh to assist Ieng  
22 Thirith again prior to this hearing, is that correct?

23 A. That is correct.

24 Q. And did you conduct any further formal tests - either for  
25 her cognitive or her physical status - or re-evaluate or evaluate



22

1 any materials that you had not seen previously?

2 A. I discussed change with the doctors who are looking after  
3 Ieng Thirith. I reviewed her CT scan of June and also some blood  
4 tests that had been suggested. I then saw Ieng Thirith and again  
5 discussed with her her condition and repeated some of the formal  
6 tests that I had done on the first occasion to see if there had  
7 been any change.

8 [09.45.51]

9 I also spoke with those caring for her to see if they had noticed  
10 any change in her mood or behaviour.

11 Q. What specific tests did you conduct again on her, Professor  
12 Campbell?

13 A. I conducted the tests of orientation in time and place. I  
14 repeated the trail-following test, which she had trouble with  
15 last time and trouble with again this time, and also the clock  
16 face drawing.

17 Q. Perhaps you could explain briefly to the Chamber how these  
18 tests operate?

19 [09.46.30]

20 I can understand a clock face test, but a trail test is a bit of  
21 a mystery for me.

22 A. Okay. The trail test is a test of the person's ability to  
23 sequence and of an assessment of the front part of the brain. And  
24 it requires the person to trail from 1 to A, from A to 2, from 2  
25 to B, and so one breaks the usual pattern of following 1, 2, 3, 4

23

1 and A, B, C, D.

2 [09.46.58]

3 And Ieng Thirith could not sequence in that way.

4 Q. And the clock face test - is that what it seems, that you  
5 asked her to show the time on a clock face?

6 A. Yes, it is a test of cognition and also the person's  
7 structural ability to organize things in space. And so the  
8 person is asked to draw a clock face and then to put the time on  
9 the clock.

10 [09.47.26]

11 And on this occasion, Ieng Thirith was able to draw the clock  
12 face using her own watch as a guide, but was unable to put the  
13 hands to indicate a particular time.

14 Q. Thank you.

15 Now we're going to turn to Nuon Chea and the tests, assessments  
16 that you conducted before completing your first report; and then,  
17 later, your second report, which was after your reassessment of  
18 him last week.

19 You examined Nuon Chea on the 9th of May this year, and you  
20 completed a written report dated the 13th of June, 2011; is that  
21 correct?

22 A. That is correct.

23 [09.48.15]

24 Q. And before completing your first report, did you have  
25 access to the regular written reports of the staff of Calmette

24

1 Hospital from 8 July, 2008 and the medical reports from Calmette  
2 Hospital on hospital admissions, appointments and investigations,  
3 including: reports on chest and lumbar spine x-rays; CT head  
4 scans completed on 21 September, 2007; 8th of June, 2010 and 22  
5 February, 2011; echocardiograms; ECGs and blood tests?

6 A. I had full access to all that material.

7 Q. And as with Ieng Thirith, did you also take the opportunity  
8 to discuss Nuon Chea's medical status with the doctors from  
9 Calmette Hospital who have been responsible for treating him  
10 since he was admitted to the detention centre?

11 A. I did.

12 Q. And there were a number of ECGs, x-rays and medical  
13 expertise reports completed by Professor Antoine Lafont and Dr.  
14 Sok Chour dated June and December of 2009 and July 2010; Dr.  
15 Nopparat and Dr. Liv Chhinh, a report dated October 2007; and Dr.  
16 Ka Sunbaunat and Dr. Philip Brinded, a report dated December  
17 2009.

18 [09.50.03]

19 Did you examine all of those reports and have full access to  
20 them?

21 A. I had examined all those reports.

22 Q. Can you summarize what tests, examinations and  
23 consultations you have personally undertaken from the time that  
24 you examined Nuon Chea until the time of your first report?

25 [09.50.31]

25

1 A. I examined Nuon Chea by taking a history of his physical  
2 problems and all his health problems, and then I conducted a  
3 physical examination of him on my first occasion.

4 Q. Now, so far as his physical status is concerned, are you  
5 satisfied that all relevant tests and examinations have been  
6 undertaken and they are sufficient to enable you to assist Nuon  
7 Chea's current physical status?

8 A. Yes. I do not feel there is a need for any further  
9 testing. I feel the testing has been complete, and certainly  
10 sufficient for me to make my judgement.

11 [09.51.22]

12 Q. So far as these tests, examinations and assessments are  
13 concerned, are you satisfied from your own examination of Nuon  
14 Chea and the documentation provided to you that they have been  
15 applied appropriately by you and by other experts on whose  
16 reports of tests you have relied?

17 A. Yes, I am.

18 Q. After reading the initial objection to geriatric expert  
19 report and requests for disclosure filed by Nuon Chea's defence  
20 team, do you have any further general comment to add at this  
21 stage, bearing in mind that, of course, his defence team may have  
22 specific questions to ask you at a later stage?

23 A. Yes. I felt the standards were set out in my order  
24 assigning expert in paragraphs 5 and 6 and the footnote there,  
25 and that is the standard against which I judged his fitness.

26

1 Q. Turning to Nuon Chea's cognitive status, in your first  
2 report you note that you assessed his cognitive function  
3 throughout the taking of the medical history and examination.

4 [09.52.43]

5 Did any aspect of this assessment cause you to consider applying  
6 any of the cognitive tests that you've described in relation to  
7 Ieng Thirith?

8 A. No, it didn't. He was able to give a good history and  
9 account of himself, and I did not feel there was a need to use  
10 the more formal tests because of the reservations which I  
11 indicated earlier: the need for the person to wish to score as  
12 highly as possible to demonstrate their cognitive function.

13 Q. As a geriatrician, when you're asked to assess a man of  
14 Nuon Chea's age, would you routinely conduct any specific  
15 cognitive testing?

16 [09.53.30]

17 A. It would be -- depend very much on the particular reasons  
18 for conducting the review. These are often used routinely, but  
19 not always.

20 Q. In the course of your examination of Nuon Chea, you noted  
21 that he had suffered a stroke in 1995. Did you assess any  
22 resulting cognitive impairment as a result of this event?

23 A. No. There was no cognitive problem as a result of that  
24 stroke, as far as I could detect.

25 [09.54.05]

27

1 The particular stroke that he had is what's called a lacuna  
2 infarct. It's a very small stroke affecting the white matter of  
3 the brain and not the cortical area, which has to do with  
4 cognitive function.

5 Q. And was there any other aspect of his physical condition  
6 that might have led you to consider applying cognitive testing?

7 A. No, there was no other problem other than his prior history  
8 of a stroke.

9 Q. Now, you returned last week to examine Nuon Chea again in  
10 preparation for today's hearing and you were able to examine some  
11 further documentation: some laboratory tests, a CT scan and some  
12 reports - a medical report and a neurological report prepared by  
13 Calmette Hospital dated 22 February, 2011.

14 [09.55.13]

15 Is that correct?

16 A. That is correct.

17 Q. And although some of those reports had pre-dated your first  
18 report, they had not been physically available to you at that  
19 earlier stage. Is that right?

20 A. That is correct.

21 Q. But I believe you've now seen everything that can be  
22 located in relation to Nuon Chea, whether held by the Court or  
23 whether held by Calmette Hospital, so far as you are aware.

24 [09.55.48]

25 Is that correct?

28

1 A. As far as I'm aware, that's correct.

2 Q. Was there anything arising out of those reports that made  
3 you think you should conduct some more examinations yourself?

4 [09.56.06]

5 A. No. In fact, those reports were useful in confirming my  
6 prior actions in that the CT scan had shown no change from  
7 earlier CT scans and the neurologist's assessment on the 22nd of  
8 February – the neurologist had used the Mini-Mental State  
9 Examination and found that Nuon Chea scored 30 out of 30, which  
10 is normal function.

11 JUDGE CARTWRIGHT:

12 Mr. President, that concludes the very general questions that I  
13 wanted to put to Professor Campbell, so I will now hand back to  
14 you.

15 Thank you, Professor Campbell.

16 MR. PRESIDENT:

17 Thank you, Judge Cartwright. I would like to know whether any  
18 other Judges of the bench would wish to put some questions to the  
19 expert.

20 09.57.04

21 Judge Lavergne, you may now proceed.

22 JUDGE LAVERGNE:

23 Thank you very much, Mr. President. I have a few questions to  
24 ask the expert.

25 QUESTIONING BY THE BENCH:

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1 BY JUDGE LAVERGNE:

2 Q. The first concerns the tests that we are discussing. I  
3 believe that MMSE signifies Mini-Mental State Examination, and  
4 that test and the Montreal test, on those, could you give us a  
5 little bit more of an idea what they involve?

6 [09.57.50]

7 We have heard talk about clock faces, sequencing tests, trial  
8 testing and so forth. Are these more or less the same thing, or  
9 are they completely different tests? A little bit of  
10 clarification on that would be welcome.

11 Thank you, sir.

12 MR. CAMPBELL:

13 A. The tests within the MMSE and the Montreal test test  
14 different functions of the brain. They test memory, and that's  
15 particularly tested in the Mini-Mental State Examination. They  
16 test the person's ability to structure and sequence events. And  
17 they also test frontal lobe function. They also test language.

18 Q. If I understood correctly what you were saying just before  
19 is that the use of such tests is reserved for people who want to  
20 demonstrate that they are in a state of adequate capacity and  
21 that there has not been any deterioration of their cognition.

22 [09.59.14]

23 Could you confirm that, and then I'll ask another question.

24 Is it possible to envisage the possibility of the tests being, in  
25 some way, distorted by a person wishing to use them for the



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1 purposes of simulation? Thank you.

2 A. They are normally used in the usual clinical circumstance  
3 where one is seeing a patient where the question of their  
4 cognitive function has been queried. And in that situation, the  
5 person normally wishes to score as well as possible and to do as  
6 well as possible with the tests.

7 [09.59.58]

8 As I indicated, one of the reservations about using them in this  
9 situation is the concern – you've indicated – that the person  
10 may not wish to demonstrate how good their cognition is.

11 I was aware of that and felt there was not any deliberate attempt  
12 to score lower on the tests that I used than the person was  
13 capable of doing. I agree that that is a clinical judgement, and  
14 it really requires assessing the person at the time they're doing  
15 the test.

16 [10.00.30]

17 In my report, I gave an indication of that in the number  
18 subtraction, for example. One of the tests in the Mini-Mental  
19 State Examination is to subtract 7 from 100 and 7 from the  
20 answer, and 7 from the answer. And Ieng Thirith was able to  
21 subtract where the number 7 did not cross into 80 down to 70, for  
22 example. Could subtract 79 -- 7 from that, but not across a  
23 particular number 10.

24 I did not feel that one would simulate that if one wished to  
25 demonstrate problems.

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1 Q. Thank you.

2 [10.01.26]

3 Can these tests be influenced by the education level of the  
4 person going through them or by their social or cultural  
5 environment?

6 A. Yes, they can.

7 Q. The principal purpose of the test is, first and foremost,  
8 to assess any possible deficiency in cognitive functions. Beyond  
9 that simple assessment, are these tests also a diagnosis method  
10 seeking to diagnose any form of disease of the person who's been  
11 through the tests?

12 A. No, they're not, and impaired testing may be due to a  
13 number of causes. Important is the time sequence and whether  
14 there is change over time, and that may well give an indication  
15 of the underlying diagnosis.

16 [10.02.35]

17 The diagnosis relies much more on the history of the  
18 deterioration, the findings on physical examination and the  
19 investigations which are conducted. These are more a measure of  
20 degree, not really indication of diagnosis.

21 Q. So your diagnosis was based on the personal medical history  
22 of the Accused springing from your own assessment, plus the  
23 medical reports that you received.

24 A. That is correct. The change over time gathered from both  
25 my history-taking and also the records which I had access to, my

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1 physical examination and the additional tests.

2 JUDGE LAVERGNE:

3 Thank you very much. I have no further questions of a general  
4 nature to ask the expert at this stage.

5 [10.03.48]

6 Thank you.

7 MR. PRESIDENT:

8 Thank you, Judge Lavergne.

9 We would like now to proceed to defence for Ieng Thirith to put  
10 questions to the expert concerning the reports he produced so  
11 far. The floor is theirs.

12 [10.04.30]

13 QUESTIONING BY DEFENCE COUNSEL:

14 BY MS. ELLIS:

15 Q. Professor Campbell, from what you've told us as to your  
16 qualifications, you've been in medical practice for now 42 years.  
17 And it sounds as if you have devoted yourself almost entirely to  
18 the care of the elderly.

19 MR. CAMPBELL:

20 A. That has been my primary professional interest.

21 Q. The discipline of geriatrics is often something that  
22 doctors come to later, but you started from a relatively early  
23 stage in your professional career.

24 A. That is correct. For most of my career, I have practised  
25 both geriatric medicine and acute internal medicine; more lately,

33

1 just geriatric medicine.

2 Q. Can you assess at what age does a patient become defined as  
3 "geriatric?"

4 A. I'm not sure I'd ever define a patient as geriatric.

5 [10.05.44]

6 Various services take different ages for their service provision.  
7 65 is very commonly the age taken. I think that's far too young.  
8 I think, by and large, people who are involved with the care of  
9 older people look after those age 75 or 80 years and over.

10 Q. In any event, from what you say, the people with whom you  
11 have had a clinical involvement for so many years have been of an  
12 age comparable to Ieng Thirith, or somewhat younger.

13 [10.06.27]

14 A. Yes, that is correct. And I think it's also important to  
15 point out that many of the patients that we deal with in older  
16 persons' service have both physical problems and cognitive  
17 impairment.

18 Q. Before coming on to your report, I just want to ask you a  
19 little more about your qualifications because you've told us  
20 you're a professor of geriatric medicine at the University of  
21 Otago.

22 [10.06.58]

23 You were also Dean of the Faculty of Medicine there for a time,  
24 were you not?

25 A. That is correct.

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1 Q. And not to embarrass you – that, in fact, is a position of  
2 -- showing a measure of -- both seniority and the respect with  
3 which you are held by your other professional colleagues.

4 A. That is correct.

5 [10.07.36]

6 Q. You have published widely in the field of geriatric  
7 medicine, is that right?

8 A. That's correct.

9 Q. You've also been involved in advisory work for a number of  
10 prestigious bodies; for example, the World Health Organization.

11 A. Correct.

12 Q. And you've been called upon to advise in a number of  
13 countries across the world, and I don't mean only in the United  
14 Kingdom and Canada where you were also trained.

15 A. That is correct.

16 Q. You were asked, as we've heard, to assist the Trial Chamber  
17 in determining whether Ieng Thirith is fit to stand trial, to use  
18 your expertise in that area.

19 [10.08.44]

20 Have you provided court reports elsewhere on the mental capacity  
21 and competency of individuals?

22 A. I have. This commonly arises in respect to testamentary  
23 capacity.

24 Q. And in that capacity of providing court reports, are you  
25 essentially again judging whether there is cognitive impairment,

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1 which prevents the patient properly understanding the documents  
2 that are in existence and may require their signatures?

3 A. That is correct. And the assessment is always related to  
4 the particular task involved.

5 Q. Have you also provided in the past expert reports for  
6 courts in the criminal field concerning whether an accused is fit  
7 to stand trial?

8 A. No, I have not.

9 [10.10.02]

10 Q. So your experience comes from, really, analogous work  
11 you've done in relation to testamentary capacity.

12 A. That is correct.

13 Q. When you were invited by the Trial Chamber to provide your  
14 expertise, did you feel that in any way you were not in a  
15 position from your professional experience to provide that kind  
16 of expert assessment?

17 A. No, I did not. Had I, I would not have taken on the task.

18 Q. As a geriatrician, you've told us that you spend 50 per  
19 cent of your time in clinical work and the remainder of the time  
20 teaching and undertaking research.

21 [10.11.16]

22 Do you see both in-patients and out-patients?

23 A. Yes, I see both in-patients and out-patients.

24 Q. In finding Ieng Thirith to be cognitively impaired, you  
25 consider it very likely that she's suffering from Alzheimer's

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1 disease.

2 Is that right?

3 A. I think there are a number of factors that may be  
4 contributing, and I think Alzheimer's is certainly one of those.

5 Q. It's always difficult to be precise, is it not? But she  
6 appears to present with a dementing condition?

7 [10.12.10]

8 MR. ABDULHAK:

9 Mr. President, I'm very reluctant to intervene. And if I may.

10 MR. PRESIDENT:

11 You may proceed.

12 MR. ABDULHAK:

13 And with the greatest reluctance, I just note that we might be  
14 entering an area that may well be involving confidential matters,  
15 such as specific medical disorders. And I just wanted to not so  
16 much object, but to seek Chamber's direction as to whether or not  
17 you wish to proceed with these matters in open Court.

18 (Short pause)

19 [10.13.20]

20 MR. PRESIDENT:

21 Thank you, Mr. Co-Prosecutor.

22 Just now, we observed your objection. However, the position by  
23 the defence does not really affect the public session. However,  
24 the defence should also be advised that any statement, oral  
25 statement being made right now in the public hearing shall be

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1 considered as the statement that -- appropriately used in the  
2 public session. Otherwise, we should really refrain from --  
3 these joint session any issues that shall be considered to be  
4 addressed during another individualized or separate session -- or  
5 closed -- session.

6 JUDGE CARTWRIGHT:

7 Yes, thank you, President. And may I add to that, that this part  
8 of the session is concerned with the qualifications, methodology  
9 and the like. It is not concerned with diagnoses. We will come  
10 to that later.

11 [10.14.49]

12 I don't want to muddle the hearing at this stage, and as the  
13 President has indicated, it's really nothing to do with  
14 confidentiality at this point. It's the question that we are at  
15 a preliminary stage, so if you wouldn't mind confining your  
16 questions.

17 Thank you.

18 MS. ELLIS:

19 Mr. President, if I can just say, we have fully understood the  
20 need for confidentiality and the Court will understand that from  
21 the documents that we have filed. And we will deal with general  
22 matters and then proceed to the specifics on application in a  
23 closed session.

24 [10.15.38]

25 I hope that it is, nevertheless, possible as part of the



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1 qualifications to explore with Professor Campbell, in general  
2 terms, the type of conditions that are encountered frequently in  
3 the elderly. And it is for that reason that I have sought to ask  
4 about dementia in the way that I did.

5 I'd be grateful if I am allowed to simply ask one or two  
6 questions about the prevalence of that condition in the elderly.  
7 That is the purpose for this line of questioning.

8 [10.16.30]

9 May I be permitted to do that?

10 MR. PRESIDENT:

11 Indeed, the Chamber allows you to proceed with your statement,  
12 but as the Chamber has already indicated that it is now the  
13 general issue session and that if matters specifically dealt with  
14 your client, then they shall be preserved to that particular  
15 session.

16 Thank you.

17 MS. ELLIS:

18 Thank you very much.

19 [10.17.28]

20 Q. Professor Campbell, cognitive impairments -- dementia is a  
21 type of cognitive impairment, is it?

22 MR. CAMPBELL:

23 A. Yes. By dementia, we're implying that this is a chronic,  
24 progressive problem which spans a number of areas of brain  
25 function.

1 Q. Now, when you are dealing clinically with elderly patients,  
2 is it common or uncommon to see people with cognitive impairment?

3 A. It is common. The overall prevalence of dementia in people  
4 80 years and over is around 20 per cent.

5 Q. A problem that is perceived more at a time people live  
6 longer. Would that be right to say?

7 A. That is correct. The prevalence increases quite steeply  
8 with increasing age.

9 [10.18.28]

10 Q. And in your clinical work, are you having to assess, on a  
11 frequent and regular basis, whether your patients are cognitively  
12 impaired?

13 A. That is correct. Because of the overall high prevalence -  
14 and of course, it is higher in a hospital population or in a  
15 population referred to out-patients - we commonly see people  
16 referred to out-patients because there is concern about their  
17 cognition.

18 Q. So when you were invited to provide your expertise in this  
19 case, in making an assessment of Ieng Thirith, the processes you  
20 followed were those that you are very familiar with and have  
21 followed day in, day out in your professional life.

22 A. That is correct. Although, clearly modified to suit the  
23 particular circumstances.

24 [10.19.31]

25 Q. Of course. But you were, from what you've said, aware of

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1 the need to take account of the slightly unusual circumstances  
2 prevailing in this case.

3 A. That is correct.

4 Q. So that anything -- any view you formed takes that fully  
5 into account.

6 A. Yes, that is so.

7 Q. Thank you.

8 Now, if I could just move on to the process and -- of assessment.  
9 You've indicated the manner in which you performed your task and  
10 that you were assisted, as you've said, by the provision of a  
11 number of documents.

12 [10.20.22]

13 One of those documents you've referred to was the 22nd of  
14 November of 2009 report that was prepared by Professor Ka and Dr.  
15 Brinded. And therefore, you've had an opportunity to read the  
16 contents of that report.

17 A. I have.

18 Q. As you've told us, your assessment was that there was  
19 cognitive impairment in the case of Ieng Thirith. According to  
20 the report of 22nd of November, 2009 - at that time, she was also  
21 suffering from cognitive impairment.

22 A. That was the conclusion at that time, two years previously.

23 Q. Yes, thank you.

24 [10.21.30]

25 In the body of that report, there was reference to an admission

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1 to hospital in Bangkok in early 2006. Do you recall that?

2 A. That admission was at the time of her femoral leg fracture.

3 Q. That's right.

4 Now, you've told us that you reviewed the CT scans, both yourself  
5 and with the assistance of a neuroradiologist.

6 [10.22.16]

7 Did you ever include in your review the report of the CT scan  
8 that was undertaken by the Bumrungrad Hospital in Bangkok on the  
9 6th of January of 2006?

10 A. I've seen a summary of that report, but I have not viewed  
11 the films themselves.

12 Q. Thank you.

13 [10.22.48]

14 MR. PRESIDENT:

15 Ms. Diana Ellis, could you please be reminded again that the  
16 Chamber has observed that the questions you are putting to the  
17 expert are considered as specific questions dedicated for an  
18 individualized session for Ieng Thirith. But now, we are in the  
19 midst of the session concerning the general aspects of the work  
20 of the expert. The Chamber wishes to make it clear that you  
21 should now be refrained from raising these specific issues  
22 concerning the health of Ieng Thirith because these matters can  
23 finally be raised in the appropriate session.

24 [10.23.58]

25 Without any further general questions to be put to the expert,

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1 the Chamber may ask you to stop putting such questions at this  
2 moment.

3 MS. ELLIS:

4 With respect, Mr. President, the question was simply, I hope, a  
5 follow-on to the question that was posed by the Court about the  
6 scans. I have not gone into any of the detail of what was noted  
7 or reported. It was, I hope, simply a factual question to  
8 clarify an earlier question asked by the Court.

9 Q. If I can then ask you a little more about the tests that  
10 you've done told us you undertook.

11 [10.24.55]

12 You've said that you carried out the MMSE test. You've told us  
13 your views that from your assessment, you felt the results, in  
14 fact, were a reliable indicator.

15 MR. CAMPBELL:

16 A. As far as I could judge.

17 Q. And then you carried out the Montreal test.

18 [10.25.26]

19 Did you consider that there were any other tests that you should  
20 have carried out in order to complete the assessment in the terms  
21 you were requested by the Trial Chamber?

22 A. No. As I indicated, I used selected questions from both  
23 those tests, and they're a supplement. They're not the basis of  
24 my conclusions.

25 Q. You were able to obtain a history, either through records

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1 or by other means, and that formed part of your assessment; as,  
2 indeed, you've told us you were assisted by the views of those  
3 that have spent much of each and every day with Ieng Thirith.

4 A. Not so much their views, as their observations.

5 Q. I'm grateful for that correction.

6 [10.25.48]

7 Their observations are, from what you've said, a very significant  
8 and helpful addition to the other means by which you're making  
9 your assessment.

10 A. They are useful, yes.

11 Q. Does family history form any part of your assessment? And  
12 again, I'm not asking for details. This is just a general  
13 question.

14 A. In some situations, family history is important, but much  
15 less important when there is cognitive impairment in people who  
16 are in the older age group.

17 MS. ELLIS:

18 Thank you very much. That completes my questioning at this  
19 stage.

20 MR. PRESIDENT:

21 Since it is an appropriate time for an adjournment, the Court  
22 will take the adjournment for 20 minutes. We will resume  
23 accordingly.

24 I have noted that the defence team for Nuon Chea is on his way.

25 You may proceed.

44

1 MR. PESTMAN:

2 Thank you, Mr. President.

3 [10.28.52]

4 I have -- one or two requests. My client would like to give a  
5 short -- a very short statement about his health in a public  
6 session and would like you to think about the right moment to do  
7 that. And I would like to add that my client would like to go  
8 back to his cell. He's not feeling very well. He could maybe  
9 give the statement before he goes back.

10 I would like to add that my client is willing to waive his right  
11 to be present during this hearing. So, there's no obstruction --  
12 there's no impediment to continue with the hearing, whether in  
13 public or in closed session.

14 [10:30:52]

15 MR. PRESIDENT:

16 Since there is a small alteration to the proceedings, in light of  
17 the request made by the defence team for Nuon Chea just now, the  
18 request is considered, and in particular the request concerning  
19 the waiver of the right of Nuon Chea to attend the proceedings.  
20 The Chamber will now proceed to hear the statement by Nuon Chea  
21 as requested.

22 [10.31.40]

23 Counsel for Nuon Chea, could you please make it clear to the  
24 Chamber now what particular request you would like the Chamber to  
25 entertain before we take the adjournment then?

45

1 MR. PESTMAN:

2 Well, the request is to allow my client to speak, and if now, I  
3 think that's a very appropriate time. And the request is to  
4 continue with the trial in my client's absence, and he agrees to  
5 that.

6 [10.32.18]

7 And I refer you to Rule 81, Section 5 -- which provides for the  
8 possibility to continue in the absence of my client. And as I  
9 said, he expressly waives his right to be present during this  
10 hearing.

11 MR. PRESIDENT:

12 Thank you, Counsel.

13 The Chamber will now hand over to Nuon Chea to proceed with his  
14 statement. Nuon Chea?

15 MR. SON ARUN:

16 Mr. President, Your Honours, may I request that my client make  
17 his statement while "remain" seated. Or in other words, may he be  
18 allowed to make such statement while sitting? And I apologize for  
19 not asking for such permission earlier.

20 MR. PRESIDENT:

21 Thank you for reminding the Chamber. Actually, it is a general  
22 rule already that the person of this advanced age can be allowed  
23 to do so without even asking for permission.

24 [10.33.52]

25 Nuon Chea, you may now proceed.



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1 MR. NUON CHEA:

2 Thank you, Mr. President.

3 Respected Monks and the President and Your Honours and my fellow

4 Cambodian citizens and everyone in and around this courtroom:

5 first, I would like to inform the Court that I would like to be

6 present during the proceedings at all stages so that all the

7 proceeding is fair and proper.

8 Number two, if my health condition is good, I will definitely

9 participate in all the proceedings during the hearings for the

10 interest of justice and fairness as required and wanted by

11 everyone.

12 [10.34.55]

13 Number three, it is my health condition, it is deteriorating, but

14 the most important thing is that I have problem concentrating and

15 I wish to make this clear to the Court as follows:

16 I can remain seated for about one hour and a half only. After

17 that, remaining -- seated for long will affect my eyesight and

18 also my head will become very heavy. And it also affect the

19 heartbeats of my heart and my blood pressure -- increases and my

20 back is aching. And this problem stops me from sitting for

21 longer than one hour and a half, as I indicated.

22 [10.36.07]

23 Even I try my best to concentrate or remain seated more than that

24 period of time, I cannot do that. And I will have problem

25 understanding or reading any material after this period of time.

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1 And I can see that the holding cell designed for me is "no"  
2 useful anyway, because if I have a problem concentrating after  
3 that specific period of time, it is pointless to hold me in that  
4 holding cell.

5 Mr. John Campbell examined my health condition -- assessed my  
6 health condition on the 9th of May, 2011, but he failed to assess  
7 this issue concerning my concentration. And later on, he came  
8 back for an hour to conduct another assessment. I asked him to  
9 help examine the issue -- my issue concerning my concentration.  
10 Point number six, to make sure this point is clear to everyone, I  
11 would like to request that another doctor or expert is assigned  
12 on top of Professor Campbell to conduct an assessment on the  
13 concentration -- my concentration.

14 [10.38.00]

15 That concludes my statement.

16 THE PRESIDENT:

17 Judge Lavergne, you may now proceed.

18 JUDGE LAVERGNE:

19 Thank you, Mr. President.

20 I wonder whether at this stage, we shouldn't put a question to  
21 the Accused, Nuon Chea, who says he has problems sitting for more  
22 than an hour and a half. May I ask him whether his situation  
23 will change if it was possible for him to lie down or to be in a  
24 position which he is half lying down in the courtroom or in the  
25 holding cell?

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1 THE PRESIDENT:

2 The defence for Nuon Chea, I would like to ask for clarification  
3 in relation to your request. Your first request was granted, and  
4 we have heard the statement by Nuon Chea and the second request  
5 on the voluntary waiving of the right to participate due to his  
6 ailing health and his inability to concentrate over one hour and  
7 a half time period.

8 [10.39.32]

9 So I would like to ask: do you want to waive this right, the  
10 entire right for the entire proceeding, or you want to waive the  
11 right only for the participation of today's hearing? So I would  
12 like to ask for your clarification so that the Chamber will have  
13 the basis for its decision.

14 MR. PESTMAN:

15 If you allow me to answer that question for my client. It's only  
16 for today's hearing, and we will assess the situation tomorrow  
17 again. But his intention is, as he made clear, to attend all  
18 hearings.

19 [10.40.11]

20 Thank you.

21 MR. PRESIDENT:

22 Thank you, the defence.

23 Once again, the Court will take a short recess -- until fifteen  
24 to 11:00.

25 And the Chamber instructs the security guard to bring the

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1 Accused, Nuon Chea and Ieng Thirith to -- Nuon Chea to the  
2 detention facility and please bring him to the courtroom tomorrow  
3 morning.

4 (Judges exit courtroom)

5 (Court recesses from 10:41H to 11:07 H)

6 (Judges enter the courtroom)

7 [11.07.27]

8 MR. PRESIDENT:

9 Please be seated. The Chamber is now back in session. We will  
10 now proceed to counsel Phat Pouv Seang.

11 MR. PHAT POUV SEANG:

12 Mr. President, since my client cannot tolerate the "conditioning"  
13 in the courtroom and due to her deteriorating health condition,  
14 can he -- be excused and allowed to be observing the proceeding  
15 from the holding cell because she indicated that the air  
16 conditioning really affects her health condition.

17 MR. PRESIDENT:

18 We have taken note of your request, and of course, it is the  
19 right of the accused person to do so.

20 [11.08.30]

21 Counsel Ang Udom, you may proceed.

22 MR. ANG UDOM:

23 Mr. President, Your Honours, I am on my feet only to report on  
24 the absence of Mr. Ieng Sary in the second session. He is not  
25 able to remain seated for longer periods. That's why he asked

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1 that he be allowed to observe the proceeding from the holding  
2 cell.

3 [11.08.56]

4 If condition changes in the afternoon, we will inform the Chamber  
5 accordingly.

6 Thank you, Your Honour.

7 MR. PRESIDENT:

8 Thank you, counsel.

9 Since Mr. Ieng Sary is participating -- these proceedings as an  
10 observer, we take your note. To preserve the rights of the  
11 Accused in participating in the proceedings, the AV unit is now  
12 instructed to connect the audio-visual recording and equipment to  
13 the holding cell so that the Accused person can observe the  
14 proceedings through remote participation.

15 [11.09.55]

16 Next, we proceed to the defence counsel for Nuon Chea to put  
17 questions, should they wish, to the expert concerning his  
18 reports.

19 MR. SON ARUN:

20 I am Counsel Son Arun, the lawyer for Nuon Chea. Before we begin  
21 by putting the questions to Professor Campbell, may I be allowed  
22 to make submissions -- the statement by Nuon Chea?

23 [11.10.50]

24 It is rather long, but are we allowed to do so or are we allowed  
25 to only put mainly questions?

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1 MR. PRESIDENT:

2 The Chamber already made this clear to the parties to the  
3 proceeding that this session is dedicated for general questions  
4 to be put to expert Professor Campbell concerning the fitness to  
5 stand trial. In particular, the reports he has already prepared  
6 and which have been challenged by the defence. Any other  
7 observation outside of this particular topic will not be  
8 entertained during this session.

9 [11.11.35]

10 Of course, you will be allowed to do so during the individualized  
11 session where each individual accused person will be heard  
12 respectively.

13 MR. SON ARUN:

14 Then I would like to hand over to my colleague to put questions  
15 to the expert.

16 MR. PRESIDENT:

17 Counsel, you may proceed.

18 MR. PAUW:

19 Thank you, Your Honours.

20 QUESTIONING BY DEFENCE COUNSEL:

21 BY MR. PAUW:

22 Q. Professor Campbell, good morning. Thanks for being here  
23 today with us. Thank you for providing the reports. We've read  
24 them with great interest. Am I clearly audible to the  
25 translators? I assume so.

52

1 [11.12.34]

2 Okay -- my first question relates immediately to a question that  
3 was put to you by my colleague for the Ieng Thirith team, and she  
4 asked you whether you had ever provided an assessment for fitness  
5 to stand trial before. And I understood your answer to be that  
6 you had not.

7 I have trouble hearing the answer. I can see what you're saying,  
8 but I ---

9 MR. CAMPBELL:

10 A. That is correct.

11 Q. Thank you.

12 [11.13.08]

13 This leaves me a little bit confused because the Trial Chamber  
14 has provided us with a document, E-62.1, in which it is stated  
15 that he - and they're referring to you - Professor Campbell:  
16 "He has also provided an assessment for the Court to enable it to  
17 determine if a person who had both physical and cognitive  
18 impairments was fit to stand trial."

19 End of quote. So, could you provide the clarification - have you  
20 done one assessment for fitness to stand trial or none?

21 A. I've not done assessments for fitness to stand trial in  
22 criminal cases.

23 Q. Then this -- I guess we will leave the question as to the  
24 problems of this document and this information to a later date.

25 [11.13.53]

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1 Then let's move on to your medical publications. I know you're  
2 an established academic and you have a long career also in  
3 academic publications. And I was wondering how many publications  
4 have you authored or co-authored? Could you give an indication?

5 A. Original publications and peer-reviewed literature - over  
6 100.

7 Q. Over 100. Okay.

8 And how many of those publications were on the topic of either  
9 concentration span or attention deficit or whatever the medical  
10 terms may be for that type of concern?

11 A. Some of the publications were related to dementia, but not  
12 specifically on the issues of concentration.

13 Q. How many of those publications were on forensic medical  
14 topics and then specifically related to criminal cases?

15 A. None were.

16 Q. I'd like to ask a few questions about your professional  
17 background, or at least the backgrounds that you have been  
18 practising medicine in, and I'm referring about -- I'm referring  
19 to New Zealand.

20 [11.15.16]

21 Is it correct that you've spent most of your professional career  
22 practising in New Zealand?

23 A. That is correct.

24 Q. And to your knowledge, is it up to the medical specialist  
25 in New Zealand to determine whether someone is fit to stand



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1 trial, or would that be an assessment to be made by the Trial  
2 Chamber or whatever the equivalent may be called in New Zealand?

3 A. I suspect that it would be determined by the circumstances  
4 of the case.

5 Q. And what do you base that conclusion on?

6 A. I think both the person's own doctor would give an opinion,  
7 and also there may be someone appointed by the Court to give an  
8 opinion.

9 Q. Do you know how many health assessors need to provide a  
10 report on an accused in New Zealand before finding an unfitness  
11 to stand trial in New Zealand?

12 A. I do not.

13 Q. And I'm not an expert on New Zealand law, so I'm -- kind of  
14 threading (sic) on thin ice here, but I believe to understand the  
15 New Zealand Code that you need the assessment of at least two  
16 independent medical specialists.

17 [11.16.42]

18 You're not familiar with that number?

19 A. I would defer that question to Dame Silvia Cartwright.

20 Q. Yes, I'm sure that she would be the most appropriate person  
21 in this courtroom to ask, but I'm asking you.

22 [11.17.04]

23 It's my understanding, and I will be gladly corrected by Dame  
24 Cartwright if I am wrong, that at least two medical specialists  
25 need to be consulted for a fitness to stand trial report.

55

1    Anyway, then let's proceed.

2    Do you think there's a rationale behind having two independent  
3    medical experts assessing an accused?

4    MR. ABDULHAK:

5    Your Honours, I must object.

6    [11.17.35]

7    I don't see how -- Professor Campbell's knowledge of the New  
8    Zealand legal system is relevant to the issues that he's  
9    testifying on today. Certainly, our understanding is that  
10   questions were to relate to method which he adopted and accepted  
11   methods of assessment of cognitive function.

12   Professor Campbell's knowledge of New Zealand or any other  
13   country's legal system is not relevant.

14   MR. PRESIDENT:

15   Thank you, Mr. Co-Prosecutor, for your observation.

16   The counsel for Nuon Chea is now advised -- reminded to  
17   concentrate your questions on the expertise of Professor Campbell  
18   and of a general nature concerning his reports at issue.

19   [11:18:32]

20   MR. PAUW:

21   Thank you, Your Honour, Mr. President.

22   I will, of course, limit my questioning to the medical expertise  
23   and the background of Professor Campbell.

24   But I beg to differ with the Prosecution that -- the status of  
25   these issues in New Zealand is irrelevant because Professor

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1 Campbell has been practicing in New Zealand for decades and --  
2 his experience in that system will be brought into this courtroom  
3 today. We have already established that he has not done any  
4 actual assessment to stand trial -- assessment of fitness to  
5 stand trial, but I would like to know if he can provide a medical  
6 reason for the fact that in New Zealand, one needs two medical  
7 opinions.

8 I'm saying this -- I can hint to the reason for this; it is my  
9 understanding that in many jurisdictions across the world, the  
10 medical assessments of more than one person will be required.

11 MR. ABDULHAK:

12 Again, Your Honours, I don't think this is the appropriate time  
13 for these matters to be canvassed. Counsel will have ample  
14 opportunity to make submissions. The matter's been ruled on and  
15 I think counsel should be invited to proceed with further  
16 questions.

17 MR. PAUW:

18 I will proceed with further questions.

19 I do think that the following question, even though it relates to  
20 New Zealand law, it is directly relevant to establish the  
21 expertise of Professor Campbell.

22 [11:20:07]

23 MR. PAUW:

24 Q. In the biography that was provided, it states that you have  
25 made assessments under the New Zealand's Protection of Personal

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1 and Property Rights Act, 1988. Is that correct?

2 MR. CAMPBELL:

3 A. That is correct.

4 Q. What exactly do you assess under that law?

5 A. Most of the assessments relate to cognitive function and  
6 one assesses the person in relationship to their ability to make  
7 their own decisions, to understand proceedings and to participate  
8 in those proceedings.

9 Q. Is there a certain legal presumption of fitness, if you  
10 want to use that word?

11 A. One assesses each individual according to the particular  
12 issue that is being assessed and uses the methods appropriate for  
13 that.

14 Q. Then let me rephrase the question in a slightly other way:  
15 is there a legal assumption that a person has the capacity to act  
16 in those assessments under the New Zealand Protection --

17 [11:21:09]

18 MR. ABDULHAK:

19 Again, I'll object to this questioning, Your Honours. It's a  
20 legal question, Professor Campbell cannot be expected to opine on  
21 whether or not New Zealand has a presumption of fitness.

22 MR. PRESIDENT:

23 Once again, thank you, International Co-Prosecutor for your  
24 observation.

25 And once again, the Defence Counsel is advised to frame their

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1 questions in order to be "straight" to the general matters  
2 regarding the reports prepared by Professor Campbell involving  
3 the accused person and also concerning the final report he made  
4 on the 26th of August 2011.  
5 Counsel is only allowed to put questions in the general context.  
6 Any specific questions relating to a particular client or accused  
7 person, for example, Nuon Chea, will be allowed to make -- during  
8 the individual session. I believe that this message is clear.  
9 MR. PAUW:  
10 Thank you, Your President, your message is totally clear.  
11 I will record for the record that I do think that these questions  
12 are relevant as they relate specifically to the expertise of  
13 Doctor - of Professor Campbell. According to his biography, he  
14 has provided many expert reports under this law and he, in that  
15 sense, is a) should be considered to be familiar with the  
16 medical issues that come up under that law and b) he will, in the  
17 process of preparing all these medical reports, have taken notice  
18 of the legal requirements. So, I will reserve the right to make  
19 further submissions -- on this issue in writing at a later stage.  
20 [11:23:19]  
21 But I've understood your message, so we will move on to other  
22 aspects of methodology.  
23 Professor Campbell, when you assess the physical and mental  
24 fitness of a patient, how long would you normally speak with him?  
25 Can you give an average?

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1 MR. CAMPBELL:

2 A. Normal -- consultations would take an hour, but they can be  
3 extended if necessary and can be repeated.

4 Q. Are they usually repeated?

5 A. Not usually repeated if the conclusions are quite clear.

6 Q. And does it make a difference whether you assess patients  
7 in your normal practice as a clinician or whether you make  
8 applications, such as under the New Zealand Protection of  
9 Personal and Property Rights Acts (sic)?

10 A. There will be differences in the approach.

11 Q. Could you elaborate?

12 A. When one is assessing competence, one is assessing with a  
13 specific objective in mind.

14 [11:24:29]

15 Q. Could you elaborate on that objective?

16 A. That is to determine competence in relationship to a  
17 particular task.

18 Q. And am I correct in assuming that usually, when you prepare  
19 assessments, "that" will be tasks related to this issue of  
20 capacity to act as a normal person?

21 A. It would relate often to the person's competence,  
22 cognitively, but also to their physical capacity.

23 Q. Am I correct in assuming that it relates to their capacity  
24 to act in a normal -- in a normal setting of society, to act as a  
25 normal citizen of New Zealand, in this case?

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1       A.     Yes, most commonly.

2       Q.     Do you normally test your patients to see whether they  
3     can understand complex court proceedings?

4       A.     We would normally test patients to determine what their  
5     overall cognitive function is.  And in terms of understanding  
6     complex court proceedings – would depend, as I said, very much on  
7     the task for which we're assessing them, the particular  
8     competence for which we're assessing them.

9       Q.     Have you assessed patients in order to establish  
10    whether they can understand complex court proceedings?

11       [11:25:58]

12       A.     Having relationship to the personal property issues  
13    that we outlined -- you outlined earlier.

14       Q.     Thank you.

15       Are you aware of which standardized cognitive tests are  
16    usually applied in assessing fitness to stand trial; or if not  
17    usually, in general, which tests could be applied in order to  
18    assess fitness to stand trial?

19       A.     I have been aware of those.  I have used the ones that  
20    I most commonly use myself.

21       Q.     And which ones are those?

22       A.     The ones that we discussed earlier.  The assessment of  
23    cognitive function depends less on the use of tests as one taking  
24    a comprehensive history and in determining history from other  
25    people as well.

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1 Q. Could you, for the record, repeat which are the tests  
2 that you use when, in this case, assessment of fitness to stand  
3 trial or which are used when assessing fitness to stand trial?

4 I'm sorry. This was a convoluted question.

5 [11:27:10]

6 You -- refer to the tests you mentioned earlier. Could you  
7 repeat the names of those tests, just for the record?

8 A. The test that I used earlier in processing: the  
9 Mini-Mental State Examination and the Montreal Cognitive  
10 Assessment.

11 Q. Could you give some names of other standardized tests that  
12 are used specifically for assessments of fitness to stand trial  
13 in jurisdictions all over the world?

14 A. Outlined in some of the documents, but I could not name  
15 them here now.

16 Q. Have you ever applied them?

17 A. I have not had the need to apply them.

18 Q. Moving on through my methodology questions, there's some  
19 general issues that came up when I was reading your report. A  
20 very straightforward question: did you discuss the outcome of the  
21 examination with Nuon Chea before preparing the report - the  
22 first report I'm referring to.

23 A. I did not discuss my physical findings with him.

24 Q. Before sending the report to the Trial Chamber, did you let  
25 Nuon Chea read the report for possible comments or corrections?



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1 A. No, I was never asked to do.

2 [11:28:49]

3 I might say that I did check a number of findings with him as  
4 I went to ensure that I had the correct answer. For example, his  
5 comment -- in my report on the length of time that he could  
6 remain sitting - and I did check that with him to ensure that  
7 that time of two to three hours, as he indicated, was correct.

8 Q. I'm sorry, I was -- what was this? You checked this during  
9 the second examination or was that part of the first examination,  
10 at least the afternoon session?

11 A. That would have been during that consultation, I would have  
12 verified it in the afternoon session as I indicated in my report.

13 Q. And how long did you -- say -- the assessment took,  
14 just to make clear, in the morning session? How long did you  
15 examine Nuon Chea for?

16 A. The morning session would have been an hour to an hour  
17 and a half, from memory.

18 Q. And how much -- can you give an estimation as to how  
19 much time would be lost during that morning examination by  
20 translating and possible confusion?

21 A. Very little time, actually. It was very efficient  
22 translation.

23 Q. Can -- you give an assessment in -- percentage?

24 [11:30:21]

25 A. That's very difficult to do. I would think probably

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1 about 10 per cent of time, probably not much -- anymore than  
2 that.

3 Q. Can you -- from memory -- can you assess how much time  
4 of the examination was reserved exclusively for a physical  
5 examination and how much time was reserved exclusively for a  
6 cognitive examination?

7 A. Physical examination would have taken around 20  
8 minutes.

9 Q. And the cognitive part of the assessments?

10 A. The rest of the assessment would have been on  
11 history-taking and determining the symptoms that he had,  
12 particular problems that he had, and how they affected him.

13 Q. And if we turn to the basis of your examination: you've  
14 indicated to the Trial Chamber earlier this morning that you  
15 studied the medical documents that exist on the case file and  
16 with Calmette's Hospital. Can you give an estimate as to how long  
17 you spent on studying those documents?

18 A. I had those documents before -- a number of those documents  
19 before I arrived in Phnom Penh and I would have spent a number of  
20 hours studying them then. And then when here, I was able to study  
21 them on the day that I saw him, along with the time spent with  
22 the Calmette Hospital doctors. And then I reviewed them when I  
23 reviewed all the case files of the Defendants later.  
24 Difficult to determine the number of hours, but it would have  
25 been probably -- at least three hours.

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1 [11:32:08]

2 Q. -- Can you read and understand French?

3 A. I read the documents in English.

4 Q. Am I correct in assuming then that you did not read any  
5 documents in the French language?

6 A. I read some of the documents in French language and the  
7 most recent documents are in French and their meaning is quite  
8 clear.

9 Q. So then to repeat the question: do you read and understand  
10 French?

11 A. I was able to read the documents and understand the  
12 documents that I had been provided, the most recent ones that  
13 we've indicated.

14 Q. Let's say the cognitive aspect of the examination - during  
15 the examination, did you test Nuon Chea's attention span and if  
16 so, how?

17 A. Attention span -- throughout the examination, my discussion  
18 with him, he was focused on this discussion, I never felt that  
19 his concentration was lapsing. I felt that I was getting  
20 accurate answers from him.

21 In terms of his own concern about his concentration, very  
22 difficult to assess that objectively; it is very much a subject  
23 of feeling and is not something that I could assess objectively.

24 [11:33:39]

25 Q. You say you cannot assess this objectively. Is that

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1 impossible for you or is that impossible for any qualified  
2 medically trained specialist?

3 A. It's really impossible to assess objectively, accurately.  
4 I mean, a person could complain of failure to concentrate, could  
5 make mistakes indicating a failure to concentrate; but that  
6 doesn't necessarily mean that the person could not concentrate.

7 Q. Then maybe you misunderstood my question. But my question  
8 is: are there medically trained specialists that can test  
9 attention span?

10 A. There are if the person is wishing to demonstrate that  
11 their attention span is as good as it is possible to be.

12 Q. So there are -- let me rephrase that. Are there  
13 standardized tests, again, to -- test the attention span of a  
14 certain patient?

15 A. A neuropsychologist doing a psychometric testing may well  
16 find that there's a deterioration in performance with the person  
17 and attribute that to their difficulty concentrating.

18 [11:34:51]

19 Q. Could you name any of the standardized tests that could be  
20 used to test attention span or concentration issues?

21 A. A neuropsychologist will use the standard tests of  
22 cognitive function and will examine performance during the time  
23 of the testing.

24 Q. Would you know of any names of specific tests that a  
25 neurophysiologist would use to assess this?

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1 A. Not that I can name here.

2 Q. Moving on to memory, rather than attention and  
3 concentration – did you test Nuon Chea's memory?

4 A. I did not myself because I did not have concerns, having  
5 taken his history from him and tested his accuracy of recall. As  
6 you will see in my second report, he did have a formal test of  
7 memory done earlier -- in which he scored normally.

8 Q. This is the MMSE that -- was referred to in the files, am I  
9 correct?

10 A. That's correct.

11 Q. Do you know in which language this MMSE was conducted?

12 A. It was done by a Cambodian neurologist, so I presume it was  
13 conducted in that language.

14 [11:36:29]

15 Q. Do you know this or do you assume it?

16 A. I'm assuming it.

17 Q. Have you looked at the actual test results?

18 A. No, I've seen the report from it.

19 Q. What does the report consist of?

20 A. The report provides the score.

21 Q. So am I correct in assuming that the only thing we know  
22 about this MMSE is the score as reported by the Cambodian  
23 hospital?

24 A. That is correct. And as there were no errors in it, the  
25 detail is less important.

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1 Q. You mentioned earlier that you could not find any tests  
2 that relate to cognition in -- Khmer. This was during the  
3 morning session. Were these actually your words? I'm not sure  
4 that I -- I don't want to misrepresent your position.

5 A. Yes, that is correct. I searched to see if there were any  
6 specific tests that had been translated into Khmer and could be  
7 used and could find none.

8 Q. Did you ask the Calmette Hospital to see if they had any  
9 Khmer-language MMSE?

10 A. The Calmette Hospital has used the MMSE. And as I  
11 indicated, that is probably a better test than if I was doing it  
12 because it's being done in the language of the person  
13 administering the test and in a situation in which it is not an  
14 obvious test, as it were, the person is impaired to the point  
15 that they cannot -- are not fit to stand trial.

16 [11:38:08]

17 Q. But if I understand you correctly, you assume that the  
18 Calmette Hospital has Khmer-language MMSE because that's the  
19 language the MMSE would have been conducted in. But you did not  
20 ask the Calmette Hospital for a copy of -- a Khmer language copy  
21 of the MMSE?

22 A. No, I did not; and it would not have been particularly  
23 useful because any test that I used would have been through a  
24 translator.

25 Q. As indicated of Ieng Thirith (inaudible).

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1 Okay, you say that you have assessed his memory throughout the  
2 assessments by interacting with Nuon Chea and looking at his  
3 files, his medical files, I would say. Could you differentiate  
4 with that method of assessment between his short and long-term  
5 memory capacity?

6 A. Yes, we could. And in both short and long-term memory  
7 there was no evidence of any significant impairment.

8 [11:39:21]

9 Q. Okay. You visited Nuon Chea your first day with a  
10 colleague from, I believe, the Calmette Hospital and a  
11 translator. Is this correct?

12 A. That is correct.

13 Q. And was -- the Cambodian doctor, the Deputy Director, was  
14 he present during the assessment of Nuon Chea?

15 A. He was present during the assessment -- throughout the  
16 assessment.

17 Q. With the permission of my client, I -- will reveal  
18 something from the confidential discussions we've had with Nuon  
19 Chea. And when we spoke with Nuon Chea last week, he had no  
20 recollection whatsoever about a third person being present during  
21 the examination.

22 Clearly, there could be an assumption that he is trying to trick  
23 us or it's some devious plan to misinform either his defence  
24 counsel. But I think that the defence counsel present had the  
25 genuine impression that he clearly did not remember that this

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1 third person had been present.

2 Can you give any medical explanation for such a loss of memory?

3 A. The accompanying doctor was in the background, kept very  
4 much in the background. It was -- me who conducted the  
5 interview. So, he did not take an active part.

6 [11:40:49]

7 My feeling would be that Nuon Chea's attention would have been  
8 very much on what I was doing, not on the other people -- any  
9 other person in the room.

10 Q. That's a very sensible answer I would say. Did the  
11 Cambodian doctor introduce himself at the beginning of the  
12 assessment?

13 A. I introduced everyone at the start of the discussion.

14 Q. In your medical assessments, putting it bluntly, do you --  
15 are you of the opinion that Nuon Chea could concentrate  
16 effectively for full court days?

17 A. As I've indicated in my second report, Nuon Chea has a  
18 number of physical conditions which will affect his ability to  
19 concentrate, and I can enlarge on those if you wish. An hour and  
20 a half he indicated that he could concentrate for and that seems  
21 very reasonable.

22 MR. ABDULHAK:

23 If I may, Mr. President, I think we're definitely entering in the  
24 area that deals very specifically with the assessment of the  
25 Accused, Nuon Chea. And in the scheduling order, the Chamber



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1 indicated that the first session would deal with common matters  
2 of method of assessment and expertise.  
3 And so some direction from the Chamber may be appropriate at this  
4 stage as I find that we're veering off-course with these last few  
5 questions.

6 [11:42:23]

7 MR. PRESIDENT:

8 Thank you, Co-Prosecutor, for your observation.

9 The defence counsel is once again advised to stick to -- focus to  
10 the issues being discussed now during the session. And again,  
11 reserve any specific issues in relation to Nuon Chea at a  
12 separate court session.

13 MR. PAUW:

14 Mr. President, I apologize. Actually, while asking the  
15 questions, I realized the same thing that my learned colleague on  
16 the other side was mentioning. So, I will stay away from  
17 referring to the personal condition of Nuon Chea.

18 I do want to move on to a more legal section, and before we get  
19 any interventions from the OCP, I would like to say that this is  
20 clearly relevant when assessing the expertise of Professor  
21 Campbell, but also his methodology because there simply is a  
22 legal definition that we need to work with today. And that legal  
23 definition influences the medical assessment of Professor  
24 Campbell, so if I may proceed

25 MR. PAUW:

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1 Q. Professor Campbell, you have indicated earlier this morning  
2 that you understood the Trial Chamber's instructions as given to  
3 you in the Order by which you were assigned as an expert.

4 MR. CAMPBELL:

5 A. That is correct.

6 Q. Could you repeat those instructions here today?

7 [11:44:09]

8 A. Those instructions are given in paragraph 5 and 6 of the  
9 Order, and there's a footnote there that details the  
10 requirements.

11 Q. Do you happen to know that that footnote is a -- relates to  
12 the Strugar decision? Do you realize this?

13 A. Yes.

14 Q. In the original Strugar case, there is a -- what is called  
15 a non-exhaustive list of questions that is used by the Strugar  
16 Trial Chamber to assess the fitness of an accused to stand trial.  
17 I wonder if you are aware of that non-exhaustive list of  
18 questions because it's not -- cannot be found in the Trial  
19 Chamber's Order.

20 A. No, I'm not.

21 Q. Did you get to read our urgent application for the  
22 assignment of an expert to examine Nuon Chea?

23 A. I did.

24 Q. In that urgent application, we raise a number of both legal  
25 and medical concerns relating to, in general, the assessment of

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1 fitness to stand trial. And I was wondering if you incorporated  
2 those comments and concerns in your -- either your examination or  
3 your report?

4 [11:45:47]

5 A. Yes, I was aware of those issues in my assessment of Nuon  
6 Chea.

7 Q. And did you incorporate them in your examination and/or  
8 your report?

9 A. I looked at the particular health issues that had been  
10 raised.

11 Q. Did you look at the specific concerns that the Nuon Chea  
12 defence raised in connection with -- with assessments for fitness  
13 to stand trial?

14 A. I was aware of those.

15 Q. And did you incorporate those in -- either your examination  
16 or your report?

17 A. I incorporated the concerns about his general physical  
18 health in my assessment.

19 Q. And did you incorporate our concerns with regard to medical  
20 assessments for fitness to stand trial in your report?

21 A. Could you be more specific?

22 Q. Yeah, excuse me. I realize I'm not being very clear.

23 [11:46:45]

24 We have -- in our urgent application, we have listed a number of  
25 issues that come up world-wide when assessments for fitness to

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1 stand trial are done, are performed by medical experts, and those  
2 are both legal concerns and medical concerns. And we -- our  
3 urgent application is quite broad on these issues, and I was  
4 wondering if you have addressed these issues in your -- either  
5 your examination or in your report.

6 I could -- get our urgent application and read them to you, but I  
7 think that would be very tedious for everyone involved.

8 A. Yes, I consider that I have reviewed the medical matters  
9 that were raised.

10 Q. But the general concerns that we've raised with assessments  
11 for fitness to stand trial in criminal court settings, have you  
12 incorporated those in your report?

13 A. I've incorporated my review of the medical matters against  
14 his fitness to represent himself adequately.

15 Q. Okay, I'll leave this issue lay then for now.  
16 Have you read our later objections to your report?

17 A. I have.

18 Q. Have you incorporated the comments and the -- I would say,  
19 criticisms that we raised in that report -- in your second report  
20 or have you taken it into account in your second examination?

21 [11:48:24]

22 A. I have. I've considered each of his conditions and his  
23 condition overall with respect to his requirements during the  
24 trial.

25 Q. Then let me repeat the question in a slightly different

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1 form. One of our main objections to your initial report was --  
2 that there was lack of objectified standards to assess his  
3 condition to stand trial. Have you incorporated an objective  
4 standard as to the fitness to stand trial in your second report?

5 A. The objective standard that I have used is that he -- in  
6 determining his physical and cognitive ability to participate in  
7 the procedures, to instruct counsel and to be present during the  
8 court time and to concentrate during that time.

9 Q. Now that's maybe just a question for clarification because  
10 in the original Order, the Trial Chamber asked you to include in  
11 your reports limits on sitting hours that might -- appropriately  
12 be put in place, and we see it in your second report. And I think  
13 they're sensible, but we do not find it in the first report. Can  
14 you explain why that is we're lacking?

15 A. In the first time I saw Nuon Chea, he had not raised the  
16 issues specifically in relation to the length of time he could  
17 concentrate. It did come up, as I've indicated, in the length of  
18 time he felt he could sit and participate in the proceedings, and  
19 I've indicated that on page 6 of my report.

20 Q. Is lack of concentration something that is -- common in  
21 people over, let's say, 80? Is that an issue that you see more  
22 often in your patients?

23 [11:50:20]

24 A. I wouldn't put the concentration down specifically to age;  
25 I think it is more in the physical conditions that the person has

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1 in this situation, and that means because of his cardiac disease  
2 and other problems, he would tire more easily.

3 Q. Does age affect concentration, from a medical perspective?

4 A. Age is one of the factors, coupled with physical problems,  
5 as I indicated in my second report.

6 Q. And somebody aged 85 – would you expect someone to have  
7 possibly mild problems of concentration?

8 A. It's very much an individual thing, and there are certainly  
9 a large number of 85 year-olds who would not; there are others  
10 who would have problems. It's very much an individual  
11 assessment, in which age may be a factor.

12 Q. Okay. I'm very much a layperson in medical issues, and --  
13 I wonder if you can give me the names of certain medical  
14 specializations that focus exclusively or predominantly on  
15 cognitive functions -- I mean, we can all come up with the  
16 psychologist and the psychiatrist, but beyond that, many of us  
17 would be at a loss. Could you provide us with the names of some  
18 medical experts in those fields?

19 A. The other areas, particularly in the older age group -- in  
20 geriatric medicine of course, and the other area with an internal  
21 medicine would be neurology, neurologists.

22 [11:52:06]

23 Q. And it's not -- I think, technically maybe not considered a  
24 doctor, but a neuropsychologist would also be able to comment on  
25 these issues?

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1 A. Yes, certainly, but it must be recognized that when one is  
2 dealing with someone in their mid-eighties, there are often many  
3 problems contributing. And the difficulty with people with areas  
4 of single expertise is that they may not be so aware and take  
5 into consideration the other factors that are contributing to the  
6 overall picture.

7 Q. Are there geriatricians that you are aware of that  
8 specialize in cognitive functions, impairments, concerns,  
9 disorders in the elderly?

10 A. Certainly within geriatric medicine, there are people who  
11 take a particular interest in specific areas, and there are  
12 people who take specific clinical and research interest in  
13 cognitive function.

14 Q. Do those types of specializations have any names that I  
15 should be aware of, which I could not find without your help?

16 A. No, not that I'm aware of.

17 MR. PAUW:

18 With your permission, Mr. President, I'm browsing through my  
19 questions because your initial round of questioning already  
20 addressed quite a few of the issues that we wanted to raise.

21 [11:53:46]

22 Q. I have some follow-up questions in response to some of the  
23 comments you made this morning. Again, I was listening and  
24 thinking at the same time, so if I misrepresent your words,  
25 please do correct me.

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1 You mentioned that you looked at video footage of Ieng Thirith  
2 during some of her court sessions and you -- I think you  
3 indicated you obtained some useful information from looking at  
4 those tapes. Have you looked at video footage of Nuon Chea  
5 during his court sessions?

6 MR. CAMPBELL:

7 A. No, I have not.

8 Q. Can you explain why not?

9 A. The problems of Nuon Chea have been primarily physical  
10 problems, and so I did not feel I would gain useful information  
11 from viewing that - the videotapes.

12 Q. But in the case file, in the medical documents that you  
13 have also studied, Nuon Chea has been complaining about memory  
14 loss and sometimes concentration issues. Was that -- not a  
15 concern for you --you would not have found anything -- you  
16 thought you would not find anything relevant in that video  
17 footage?

18 A. That's correct, and I've not found -- any evidence for that  
19 in my assessment of him.

20 [11:55:43]

21 Q. Some of those court sessions related specifically to his  
22 detention procedures and were specifically focused on Nuon Chea's  
23 assessment of his own detention condition and on his own health.  
24 Should that have changed your determination to not look at those  
25 videos?



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1 A. I did ask Nuon Chea about the preliminary hearing and how  
2 he'd found that -- any difficulties with it. His main concern had  
3 been the temperature of the room and concerns there. He had not  
4 raised other concerns.

5 Q. Let me clarify. I'm referring to numerous court sessions  
6 that were held throughout Nuon Chea's detention in which he was  
7 brought before the Co-Investigating Judges to establish how he  
8 was feeling in detention, whether there were any issues with the  
9 way he was detained, with his -- health, both physically and  
10 mentally. So these court sessions were specifically focused on  
11 Nuon Chea's wellbeing.

12 And so from that perspective, do you think it might have been  
13 useful to look at those videos in order to assess the physical  
14 and mental health of Nuon Chea?

15 A. Well, no particular concerns from those had been brought to  
16 my attention.

17 Q. Okay. You mentioned a concern, which is a straightforward  
18 concern, that accused in conditions like this, when they are  
19 detained and when they are being examined for fitness to stand  
20 trial are trying -- may not be trying to do their best; they may  
21 try to have more cognitive issues, or they may try to have more  
22 somatic symptoms than normal patients that you might see in your  
23 day-to-day practice. Is that a clear reflection of your words  
24 this morning?

25 [11:57:49]

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1 A. It is a concern.

2 Q. Do you know if there is any testing or any precautions that  
3 one could take to avoid such influencing by the subject, by the  
4 patient?

5 A I think the crucial thing is to look at performance outside  
6 that particular setting, when the person is not being  
7 specifically examined with a view to determine whether they're  
8 fit to stand trial, and that's why the previous records are  
9 important and (inaudible) specific concern raised that I was  
10 aware of.

11 Q. Do you know any medical approach in testing or otherwise  
12 that would preclude or at least detect patients, or in this case  
13 the Accused, that wants to fool the system so to speak?

14 A. There are certainly issues on physical examination which  
15 can be used to determine if the person is not cooperating fully,  
16 more difficult with cognitive function.

17 Q. Are you aware of any tests or medical approaches with  
18 regard to cognitive functions that might help to detect patients  
19 that act in that way?

20 A. I think in the testing, what would be looked for is any  
21 inconsistency in the testing.

22 [11:59:20]

23 Q. Let me repeat the question once more because -- I'm not  
24 sure that I'm making myself clear. Can doctors, when they are  
25 assessing a patient like this, take precautions in the way they

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1 test or in the type of test they administer to make it at least  
2 likely that somebody who fakes -- to use a very non-medical term  
3 -- whether that would be exposed?

4 A. There are no specific tests that I'm aware of. Again, as I  
5 said before, the more inconsistencies that were not -- that  
6 indicated that the person was not performing at a consistent  
7 level or if the tests were -- or if the tests were inconsistent  
8 with a person's overall performance and activities.

9 Q. All right. When discussing Ieng Thirith this morning, you  
10 mentioned that you wanted to have another expert assess her after  
11 you had seen her. And you gave some -- a few reasons for those.  
12 Could you repeat them because I don't want to -- again, I don't  
13 want to put words in your mouth? What were the reasons for  
14 seeing this particular expert?

15 A. This is Professor Ka Sunbaunat. I asked for the  
16 examination there because I had found impairment, and I wanted to  
17 know whether there had been change in time with that impairment,  
18 he having assessed her previously. And I also wished to know  
19 whether any impairment I found was due to problems of translation  
20 or cultural differences.

21 Q. In general, would you say that it would have been desirable  
22 to have also Nuon Chea be examined by somebody who comes from his  
23 own culture, in his own language?

24 A. He had already been examined by people from his own culture  
25 and from my reports from their examination, there had been no

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1 concerns raised.

2 [12:01:46]

3 Q. Had he already been examined by people from his own culture  
4 as part of an assessment for fitness to stand trial?

5 A. No, and that was one of the advantages of the previous  
6 assessments.

7 Q. I'm not sure I follow. I'm sorry.

8 A. The advantage was that these assessments can be done in a  
9 normal clinical setting.

10 Q. Would there have been a benefit to have Nuon Chea assessed  
11 also by somebody from his own culture in the context of an  
12 assessment for fitness to stand trial?

13 A. I did not think so, and that's why I did not suggest it.

14 Q. Also in speaking about Ieng Thirith, you mentioned that you  
15 have spoken to people outside her direct -- let us say, within  
16 our direct surroundings -- people that deal with her on a  
17 day-to-day basis and you -- and I have written it down here, but  
18 again, correct me if I'm wrong -- I've written down that you said  
19 that external observation is critical when assessing cognitive  
20 impairments like that. Are those the words you used?

21 A. Yes, outside observations are very important.

22 Q. Did you get any outside information from people in the  
23 direct environment of Nuon Chea?

24 [12:03:19]

25 A. I did, but it's very difficult to obtain and there was a

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1 reluctance to provide information from those who are looking  
2 after the defendants on a daily basis. I obtained -- I obtained  
3 most of the information from the -- written records and also from  
4 the doctors who've -- seen Nuon Chea on a regular basis.

5 Q. Did you talk to his wife, by any chance, regarding Nuon  
6 Chea's condition?

7 A. No, I did not.

8 Q. One question before I will ask the Trial Chamber to  
9 possibly adjourn to confer with my colleagues to see if there's  
10 any additional questions, but one last question that I would like  
11 to ask you in this -- open court session; you mentioned that  
12 you've studied the underlying medical reports of Nuon Chea as  
13 they are on the case file. Is there anything you can say about  
14 the quality of those reports and then specifically, in the  
15 context of the cognitive assessment?

16 MR. ABDULHAK:

17 I might object, Your Honours.

18 Again, I believe -- we're starting to deal with very specific  
19 questions. We've refrained from objecting. There were a series  
20 of questions, some on method, some specific to Nuon Chea and we  
21 felt -- we didn't want to break our colleague's rhythm. But  
22 again, Your Honours, we're back on very specific aspects of Nuon  
23 Chea's conditions and the assessment.

24 [12:05:22]

25 The Order is clear. Any -- questions arising from the challenge

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1 to the assessment are only appropriate in the third session, and  
2 we invite Your Honours to remind counsel that they need to focus  
3 on general matters on method and general assessments, as opposed  
4 to specific to Nuon Chea.

5 MR. PRESIDENT:

6 Thank you, Mr. International Co-Prosecutor.

7 I think your observation is consistent, and this happens time  
8 again during the time when defence counsel for Nuon Chea is  
9 having the floor. May the counsel be advised again to  
10 distinguish the general matters, as opposed to the specific  
11 issues, concerning Nuon Chea.

12 I would like to know for now, how many more questions would you  
13 like to put to the expert before the adjournment, or would you  
14 wish to proceed until you have completed all the questions and  
15 that -- we then should adjourn?

16 MR. PAUW:

17 Thank you, Mr. President.

18 As I indicated earlier, I think this would be the last question  
19 before we adjourn, also to reorganize our -- questions based on  
20 the answers that Professor Campbell has provided.

21 But I do wish also, in general, I would like to say for the  
22 future of these proceedings, whenever the prosecution objects,  
23 they're totally entitled to an objection, but I do feel that the  
24 defence should be given the chance to at least answer the  
25 position by the OCP before the Trial Chamber takes a stand on

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1 this issue. Otherwise not -- both sides are heard, and  
2 specifically in this case, this is a question about underlying  
3 methodology of reports on which Professor Campbell has based  
4 himself.

5 [12:07:24]

6 So, it is totally on point, and it relates specifically to  
7 methodology. So, I disagree with the intervention of the OCP,  
8 and I would respectfully ask Your Trial Chamber to be able to  
9 pose this question in this open court session at this point.

10 MR. PRESIDENT:

11 Is that your last question, or would you proceed further, or  
12 would you like to hand over to your colleague to put some more  
13 questions because it's now already six past 12 and it is, of  
14 course, appropriate to take a lunch adjournment.

15 MR. PAUW

16 It was my last question, and I'm happy for Professor Campbell to  
17 answer it after lunch. I understand everyone is tired and  
18 hungry. And my colleagues will have further questions depending  
19 on our assessment during the break.

20 MR. PRESIDENT:

21 Thank you. Please be seated.

22 [12.09.22]

23 Mr. Phat Pouv Seang, we have just now received a request from  
24 your team that your client is not able to attend the proceedings  
25 personally, and that she asked to be excused and observe the

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1 proceeding from the holding cell through remote participation,  
2 and such equipment has already been installed. But the Chamber  
3 would like to know whether this afternoon session shall proceed  
4 with the status quo, or if you wish to ask that the accused  
5 person be returned to the courtroom. Your position at this  
6 moment will be very important for our determination concerning  
7 her attendance during this afternoon session and the remainder of  
8 the session.

9 [12.10.58]

10 MR. PHAT POUV SEANG:

11 Mr. President, I think our team is not very certain yet. We will  
12 communicate this message to you, definitely, after the lunch  
13 adjournment.

14 MR. PRESIDENT:

15 Thank you.

16 The Chamber will now take the adjournment from now until 1:30,  
17 when the afternoon session will be resumed. The detention  
18 facility officials are now instructed to take Ieng Thirith back  
19 to the courtroom by 1:30.

20 (Judges exit courtroom)

21 (Court recesses from 1212H to 1340H)

22 (Judges enter the courtroom)

23 MR. PRESIDENT:

24 Please be seated

25 [13.40.47]



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1 The Court is now in session. Counsel for Ieng Thirith, you may  
2 now proceed.

3 THE INTERPRETER:

4 Counsel mic is not activated.

5 MR. PHAT POUV SEANG:

6 Since my client's health is not good, she cannot attend this  
7 session, and she would like to waive her right to attend this  
8 proceeding and that we still can proceed with "both" of us.

9 MR. PRESIDENT:

10 Thank you, counsel, for your clarification on this. And, of  
11 course, according to our Internal Rule, she can fully exercise  
12 her right to do so, and that request is granted. And that the  
13 accused person can follow the proceedings through remote  
14 participation, the audio visual equipment "installed" to her.  
15 The AV officials are now instructed to make sure that the  
16 equipment is connected to her cell, so that she can follow the  
17 proceedings.

18 Before we commence, the Chamber would like to remind counsels  
19 that from now on, if you are making any application concerning  
20 the waive of the rights of your client, could you please make it  
21 very clear at each particular session, so that the Chamber has  
22 appropriate ground for determination. For example, like during  
23 today's session, if the Chamber had received any clear indication  
24 of such exercise of the right to waive the right to participate  
25 in the proceeding, we would handle it before the commencement of

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1 these sessions. So, we hope the counsels are well-advised on  
2 this.

3 MS. ELLIS:

4 Mr. President, I'm sorry to have to raise this matter further,  
5 but could I just clarify the position regarding Ieng Thirith?  
6 Her request, when we actually adjourned for a short period at 11  
7 o'clock, was to be returned to the detention centre. She was  
8 suffering general pain in her legs, but she also had,  
9 specifically, a very bad headache. She has, since 11 o'clock,  
10 been downstairs in the holding cell as directed. She is, in  
11 fact, unable to take advantage of the facilities that have been  
12 provided there and follow the proceedings on the screen. And her  
13 request over the lunch adjournment was, again, to be allowed to  
14 go back to what she sees as her home, namely, the detention  
15 center. So that, in fact, is the request that we make on her  
16 behalf

17 [13.45.02]

18 That she has, of course, by virtue of that request, accepted that  
19 she waives her right to be present for the current proceedings  
20 today.

21 MR. PRESIDENT:

22 It is the same issue. This morning, we already heard the request  
23 by counsel Phat Pouv Seang concerning the waiver of the right to  
24 participate in the proceeding, and that she would -- it was a  
25 request that she would follow the proceedings through remote

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1 participation at the holding cell. But counsel Phat Pouv Seang  
2 failed to indicate this during the time when he was on his feet  
3 to state that position.

4 The Chamber, therefore, would like to advise the counsels to  
5 really include this as well in their requests, for example. And  
6 we would like to also seek clarification from the counsel – where  
7 is Ieng Thirith now, and how can you really proceed to request  
8 Chamber with your application?

9 MR. PHAT POUV SEANG:

10 Your Honours, Ieng Thirith is now at the holding cell. As my  
11 colleague already indicated, she requests that she be returned to  
12 the detention facility because she was unable to take the  
13 advantage of the facilities equipped at the holding cell.

14 [13.47.12]

15 (Microphone not activated)

16 [13.47.31]

17 JUDGE CARTWRIGHT:

18 Yes, thank you, President.

19 When you say she is unable to take advantage of the facilities in  
20 the holding cell, I'm a little unclear. She has a bed; she has a  
21 table. She can watch the proceedings. She does not need to sit  
22 up. Is there a specific reason -- and she can also have medical  
23 attention there. Is there a specific reason for returning her to  
24 her cell in the detention centre that we are unaware of?

25 MS. ELLIS:

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1 Firstly, what we convey is her request that she is in discomfort.  
2 Perhaps, the Court noted that she was dozing off this morning.  
3 She is in pain. Being within more familiar surroundings is,  
4 therefore, more comfortable. When she is downstairs, as best we  
5 can ascertain – although, it's right to say she is lying down on  
6 a bed – she doesn't follow what is actually happening in the  
7 courtroom. The screen is on; she sees it, but from all the  
8 information that we have gleaned from our own observations and  
9 from others, it appears that there is no benefit to her from  
10 being there and watching the screen because she is not able to  
11 take in, in fact, who the personalities are that she's observing  
12 and what is happening in this courtroom. And therefore, as she  
13 is suffering discomfort and pain and wishes to be returned to the  
14 place she's familiar with, our application is that that is  
15 allowed.

16 JUDGE CARTWRIGHT:

17 And what would -- one of the main reason for having the holding  
18 cells in close proximity to the courtroom is to enable the Trial  
19 Chamber to have particular accused back in court quickly should  
20 the need arise or, rather, more quickly than it would be the case  
21 is she was in the detention centre. So, there's got to be some  
22 thought given to the other side of the coin as well, Ms. Ellis.

23 MS. ELLIS:

24 Your Honour, I certainly understand the comments that are made by  
25 the Court in that respect. The reality of the situation is that

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1 her presence here, it may be understood, will not significantly  
2 affect anything that is happening in this courtroom at the  
3 moment. I certainly appreciate it takes longer were she to be  
4 required to come here, but I personally have difficulty in  
5 envisaging any situation where her attendance would be necessary  
6 here for her participation in anything that is going on at the  
7 present time.

8 [13.51.02]

9 (Judges deliberate)

10 [13.52.38]

11 MR. PRESIDENT:

12 Regarding Ieng Thirith's case, the Chamber has already decided,  
13 in light of the request by the defence counsel, that she be  
14 excused from attending this courtroom and, at the same time,  
15 observe "that" the proceeding from the holding cell where the  
16 audio-visual facilities are provided properly. The Chamber,  
17 therefore, maintains the Bench position.

18 Next, the Chamber would like to proceed to the defence counsel  
19 for Nuon Chea to proceed with questions, the general questions  
20 that the counsel would wish to put to the expert. Some of the  
21 questions that are not related to the topic have already been  
22 rejected, so the expert can refrain from addressing those  
23 questions.

24 MR. SON ARUN:

25 Mr. President, Your Honours, I have just a few questions - five

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1 in total to Professor Campbell. My colleague has already put  
2 several questions to him.

3 QUESTIONING BY DEFENCE COUNSEL:

4 BY SON ARUN:

5 Q. First, I would like to know the profession -- the different  
6 skills Mr. Campbell possess and the skill Dr. Ka Sunbaunat  
7 possesses because you are specializing in geriatrics, while Mr.  
8 Ka Sunbaunat specializes in psychiatry. So, could you please  
9 elaborate on the difference between these professions please?

10 [13.55.23]

11 MR. CAMPBELL:

12 A. My specialty area is in the physical health of patients,  
13 but also, as I indicated earlier, I see a large number of  
14 patients with cognitive impairment also. The majority of  
15 patients with cognitive impairment will be looked after by a  
16 physician, such as myself, when they are seeking secondary care.  
17 Psychiatrists are more likely to be involved if there are  
18 significant behavioural problems associated with a dementia or if  
19 the person has a clear psychiatric illness, such as schizophrenia  
20 or depression.

21 Q. Question number two: according to your statement to the  
22 Court, you indicated that you practised your skills, for example,  
23 in teaching mainly and researching -- you said you spent most of  
24 the time teaching and researching. Can I ask whether you already  
25 exercised your skills in assessing clients like -- or patients

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1 like (inaudible) clients in your practice, or it's only part of  
2 your research and lecturing?

3 A. No, you're incorrect. I spent the majority of my time in  
4 clinical care of patients. The majority of the teaching I do is  
5 around patients and on my own patients, and my research is also  
6 clinically based.

7 [13.57.10]

8 Q. I just wish to know exactly by asking this question  
9 because, for example, when it comes to people of advanced age at  
10 the level of this particular hybrid nature (sic), have you ever  
11 conducted such practices in your career, or it's only part of  
12 your teaching, lecturing or research?

13 A. The assessment of patients with problems similar to Nuon  
14 Chea constitutes the great majority of my work.

15 Q. So far as I know, you have met Nuon Chea on three  
16 occasions. First, you met him -- you met him twice on one  
17 particular day -- a few minutes in the morning and in the  
18 afternoon about 15 minutes. And later on, you met him for an  
19 hour. During such meetings with Nuon Chea, who is of very old  
20 age, do you think that such brief meetings with him could give  
21 you significant objective observation regarding your assessment  
22 concerning this person in your report?

23 A. I met with Nuon Chea for longer than you indicate in your  
24 question. I met him both in the morning and in the afternoon,  
25 and then I met him again this Thursday. As well as my meeting

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1 with him, I also had considerable amount of preliminary  
2 information from other doctors' reports. Had I felt that  
3 additional time was required to complete my assessment, it had  
4 always been made clear to me that I could seek such time. I felt  
5 that I had adequate time to make a full assessment.

6 Q. After meeting Nuon Chea, and as I am the counsel for Nuon  
7 Chea, I have met him on several occasions -- and according to  
8 these observations, I can tell you that such brief meetings you  
9 had with him is not really significant to assess his situation.  
10 It is his observation -- I mean -- Nuon Chea's observation, as he  
11 told me. The question that I was putting to you is also to see  
12 whether you also have -- will have an opportunity to see him  
13 again?

14 [14.00.29]

15 A. I do not -- feel the need to see him again at this stage. I  
16 have completed my assessment of him and, as I indicated, did not  
17 feel that I required further time.

18 Q. Another question, please. You indicated that you met the  
19 doctors who are on duty at the court, and you have consulted with  
20 them. Have you had an opportunity to consult with these doctors  
21 on several occasions, or you only rely heavily on the documents  
22 obtained from the Calmette Hospital instead?

23 A. No, I had ample opportunity to discuss Nuon Chea's health  
24 with them, both at the time of my initial assessment and also on  
25 my reassessment on this visit.



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1 Q. I would like to just -- seek clarification, and I stand to  
2 be corrected if I am straying outside this topic. I have  
3 observed closely "regarding" the reports, medical reports, by the  
4 doctors who regularly supervise the accused person. Every week,  
5 there would be regular medical report, and in the reports, there  
6 are some shortcomings or inaccuracies. For example, on the 8th  
7 of August - in the report, my client is of good health, but at  
8 the same time, in the same morning, Nuon Chea experienced  
9 hypertension.

10 MR. PRESIDENT:

11 Counsel for Nuon Chea, could you please hold on, since the  
12 International Co-Prosecutor is on his feet.

13 You may proceed.

14 [14.02.46]

15 MR. ABDULHAK

16 Thank you, Mr. President. We're again compelled to object on the  
17 same basis. I think Your Honours' instructions are very clear  
18 that we're not to deal with the specific assessment of Nuon Chea.  
19 An entire session has been set aside for that purpose. And I  
20 think it assists everyone if we keep with the orders of the  
21 Chamber, and we follow Your Honours' instructions and deal with  
22 matters to do with Professor Campbell's qualifications and  
23 general matters dealing with assessment of cognitive impairments.  
24 I'll just ask again that counsel be instructed to refrain from  
25 putting further questions in relation to the assessment of Nuon

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1 Chea.

2 MR. PRESIDENT:

3 Thank you, Co-Prosecutor, for your observation.

4 The Chamber would like to remind counsel that questions at this  
5 moment shall be framed to any matters of general aspects, and  
6 that any specific questions concerning your client should be  
7 reserved to be asked or put to the expert during the scheduled  
8 session allocated mainly for this purpose.

9 [14.04.23]

10 Also, it is observed that there should not be any subjective  
11 observation concerning these matters, and we should allow the  
12 expert to express his -- make his own statement concerning his  
13 expertise that we can use as ground for our decision in the  
14 future. I hope the counsel is now properly advised before  
15 putting questions to the expert.

16 MR. SON ARUN:

17 Thank you, Mr. President and the Co-Prosecutor. I have the final  
18 question.

19 Q. My colleague put a question to Doctor -- Professor Campbell  
20 rather, and we also observe that question put from Ieng Sary's  
21 team. And you responded by saying that you also consulted people  
22 who supervised the accused persons, and that you said outside  
23 source of information -- also vital to this work. However, you  
24 also indicated that you have not had an opportunity to consult  
25 with any close person to the accused person, Nuon Chea. Can you

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1 elaborate on this?

2 MR. CAMPBELL:

3 A. Throughout the reports on Nuon Chea's health, there has  
4 been no concern raised about his cognitive function, his memory.  
5 It has been reported in all the medical records that his memory  
6 has been intact, and there were no visual-spatial problems or  
7 problems particularly with concentration. That was consistent  
8 with my findings when I saw him, and therefore, I did not see  
9 that there was a need to consult any of his family or other  
10 people.

11 MR. SON ARUN:

12 I have no further question. I am grateful.

13 MR. PRESIDENT:

14 Next, we would like to proceed to the Co-Prosecutors to put  
15 questions to the expert Professor Campbell.

16 MR. SENG BUNKHEANG:

17 Thank you, Mr. President.

18 [14.07.39]

19 QUESTIONING BY THE CO-PROSECUTORS:

20 MR. SENG BUNKHEANG:

21 Q. Good afternoon, Professor Campbell.

22 I would like to seek some clarification concerning your  
23 profession. Before you graduated, you wrote a thesis. And could  
24 you please elaborate on the topic in your thesis, whether it is  
25 also related to the current position you're holding?

1 MR. CAMPBELL:

2 A. The topic of my thesis was an epidemiological study of the  
3 major conditions affecting older people in a particular community  
4 and included both physical problems, as well as determining the  
5 prevalence and associated factors with dementia.

6 Q. Thank you. Apart from your general geriatric profession,  
7 have you also -- rather, beyond your general training in medicine  
8 and specialization in geriatrics, have you undertaken any  
9 specialized study in the diagnosis and treatment of psychiatric  
10 conditions?

11 A. Clearly, patients with psychiatric conditions do have  
12 medical problems, and I am involved on occasions in their  
13 physical care.

14 [14:09:30]

15 Q. Given that you do not specialize in psychiatric conditions,  
16 per say, what types of psychiatric or behavioural disorder would  
17 you normally treat with referral to psychiatrist?

18 A. I think one of the issues here is whether or not one  
19 regards dementia as a psychiatric illness, and I do not. It is a  
20 physical illness associated with brain changes. And the majority  
21 of patients with dementia would be looked after in secondary care  
22 by a physician such as myself.

23 If the person with dementia has behavioural problems, for  
24 example: anger, unable to control, hallucinations - problems such  
25 as that - then they would be referred often to a psychiatrist for

1 his or her opinion.

2 Q. Thank you. How much time have you spent learning these  
3 skills that you're "having"?

4 A. The whole of my professional life and formal training --  
5 formal training after graduation is around seven to eight years  
6 before gaining post-graduate qualifications, and then the rest of  
7 one's career is spent learning as well.

8 Q. You indicated that you conducted research regarding this  
9 "skill" for how many years; could you please elaborate on this?

10 A. I graduated in 1969 and began my first research project in  
11 the early 1970s. I completed my doctorate between 1976 and 1980,  
12 and I have been involved in on-going research since then as part  
13 of my academic position.

14 Q. Thank you. When did you start using your skill?

15 [14:12:17]

16 A. Which particular skills were you referring to?

17 Q. The skills you have already indicated (inaudible) in  
18 particular, the skill that is not related to the treatment of the  
19 old age people.

20 A. Well, I already began practicing as soon as I graduated,  
21 but that was clearly under supervision. And it was in 1976 that I  
22 was appointed as a consultant physician. So, I was then in a  
23 position where I took primary responsibility for patients, and I  
24 have been practicing as a consultant physician since then.

25 Q. Thank you. You indicated you have treated "for" patients.

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1 What kind of medicine -- or have you ever prescribed any kind of  
2 medicine to the patients? Or can I ask that how many patients  
3 have you treated during the last three years, and what kind of  
4 medicine regime have you provided to them?

5 A. That's a hard question to actually provide the number. I  
6 have in-patient -- a number of in-patients, and I also have  
7 regular out-patient sessions each week. So it would be well into  
8 the thousands.

9 MR. BUNKHEANG: Thank you, Professor Campbell. I would like now  
10 to hand over to my colleague to proceed with further questions.  
11 Thank you.

12 [14:14:41]

13 QUESTIONING BY THE CO-PROSECUTORS:

14 MR. ABDULHAK:

15 Q. Good afternoon, Professor. I feel as though your  
16 qualifications, as extensive as they are, have been dealt with in  
17 great detail, so my questions will be only a few.

18 And if I may, during the break, I asked the court officers to  
19 prepare for us Document E62.1. And perhaps, just before that is  
20 shown, I'll just explain. This is the document to which counsel  
21 referred -- counsel for the Accused, Nuon Chea -- and it's a  
22 document which contains a brief summary of Professor Campbell's  
23 qualifications. And so, with the President's leave, I would like  
24 to show that document to the professor. Would that be  
25 appropriate?

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1 MR. PRESIDENT:

2 Your request is granted.

3 And the court officer is now instructed to make sure the document  
4 can be projected.

5 MR. ABDULHAK:

6 Q. And this is that document. Of course, it is here in the  
7 English language so I may -- just refer to a section and perhaps  
8 paraphrase the relevant part for the benefit of the Khmer  
9 speakers, and perhaps you can comment on that for us. If we just  
10 may scroll down to the second last paragraph on this page. Thank  
11 you.

12 Professor Campbell, are you familiar with this document?

13 MR. CAMPBELL:

14 A. It would have been some time ago I saw it if I did see it.

15 Q. Is it something you prepared or was it prepared -- do you  
16 know if it was prepared on your behalf?

17 [14:17:22]

18 JUDGE CARTWRIGHT:

19 It was prepared on his behalf, just to clarify.

20 MR. ABDULHAK:

21 Q. Very grateful. In that case, we'll just focus in on one  
22 sentence, which was the subject of some questions by the Nuon  
23 Chea team. It essentially indicates that -- the very last  
24 sentence of that paragraph -- of the larger paragraph on the  
25 screen ---

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1 MR. CAMPBELL:

2 A. Yes.

3 Q. It states:

4 "He has also provided an assessment for the Court to enable it to  
5 determine if a person who had both physical and cognitive  
6 impairments was fit to stand trial."

7 And of course, this is at the end of a paragraph which deals with  
8 the expert testimony that you explained in more detail this  
9 morning.

10 A. Yes.

11 Q. Can you comment on that last sentence?

12 A. Yes. I cannot recall where I've assessed a patient in a  
13 similar way to what we are here.

14 Q. Okay. Thank you very much.

15 [14:18:18]

16 And if I just may return very briefly to your academic work, you  
17 stated this morning that you've written more than 100 articles  
18 over the course of your career, and you said that some of those  
19 dealt with issues of dementia. Are you able to give it a general  
20 estimate as to how many -- how often that would come up in  
21 academic research?

22 A. No, a small number directly to do with dementia - early  
23 papers on the prevalence of dementia, some related to the use of  
24 psychotropic drugs, but not detailed work otherwise on dementia.

25 Q. Thank you. And thank you court officer, we won't require



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1 that document anymore.

2 In your practice, you've explained that over the last three  
3 years, you may have seen thousands of patients. But more  
4 specifically, how often might you make an assessment as to a  
5 patient's cognitive functioning? Is that something that you do  
6 on a weekly basis or is it less frequent than that?

7 A. In a clinical setting - really on a daily basis.

8 Q. So, it would be -- correct to say that you encounter cases  
9 of different stages of dementia on a fairly regular basis?

10 A. Yes, that is so.

11 Q. And, Professor, you've explained a little bit earlier some  
12 of the differences between the types of treatment that a  
13 geriatrician might provide and the types of treatment that a  
14 psychiatrist might focus on. In your practice, when would you  
15 consider it fit to refer your patient to a psychiatrist?

16 [14:20:07]

17 A. I would refer if there were significant behavioural  
18 problems that required management; if there was concern about  
19 depression playing a major role in the person's cognitive  
20 function, particularly in those circumstances.

21 Q. Thank you. Now, I don't want to get into the specific  
22 assessments of the two Accused, and of course, we've objected to  
23 questions along those lines earlier, but I do wish to ask you one  
24 question simply by way of clarifying the record. I think you  
25 indicated, and please correct me if I'm wrong, that you felt that

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1 your assessment was consistent with the assessment of Dr. Ka --  
2 this is in the case of Ieng Thirith.

3 A. Yes, that is so.

4 Q. And that relates to his assessment that was provided upon  
5 request in June of this year?

6 A. That's correct. I mean, one of the issues is around  
7 whether one describes this as a mild or moderate impairment, and  
8 he described it as mild. There isn't any firm standard by which  
9 one says it is either mild or moderate.

10 Q. And that's -- you've half answered my question already. I  
11 just wanted to bring out the differences in the terminology used.  
12 I think you referred -- in your report, you describe it as  
13 moderately severe dementia, and I think Dr. Ka described it as a  
14 cognitive function impairment within the extreme limit of mild.  
15 Is it your evidence that essentially there's no material  
16 difference between those two descriptions?

17 A. Yes, I feel that is so.

18 [14:22:01]

19 Q. Thank you very much. And we might leave the matter of  
20 individual assessments there and come back to it in later  
21 sessions.

22 MR. ADULHAK:

23 Mr. President, I'd like to also show one more document, with your  
24 permission, to Professor Campbell, and I should just point out,  
25 this is Document E62/2. It is a confidential document. However,

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1 the section which I propose to show is the very bottom of page 2.  
2 This was a request by the Ieng Thirith lawyers for listing a  
3 number of questions which they asked to be put to Professor  
4 Campbell or to be considered by him. And the very specific  
5 passage which I refer to does not contain any confidential  
6 information. It is Item 5 on page 2. It simply lists a number  
7 of matters in relation to the ability of an accused to appreciate  
8 the proceedings, whether or not such ability was present.  
9 I do have a copy if that will be of assistance. I'll just hand  
10 that up. It's essentially the bottom part of that page, and it  
11 is below the text that has been redacted.

12 MR. PRESIDENT:

13 Your request is granted.

14 So, please court officer is instructed to display the document  
15 that shows the part that is requested to be shown.

16 MR. ABDULHAK:

17 I'm very grateful, Mr. President.

18 [14:25:34]

19 So, if we may just scroll down to the bottom of this page. Thank  
20 you.

21 Q. Professor Campbell, this contains a number of questions  
22 which you were asked to consider by the Ieng Thirith defence  
23 team. First of all, have you read this document?

24 MR. CAMPBELL:

25 A. Yes, I have.

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1 Q. And again, without going into great detail on the  
2 assessments – in your assessments, did you take these questions  
3 into account in relation to one or both of the Accused?

4 A. Yes, I did.

5 Q. And I'll just note for the record, and because we have the  
6 English version of this document on the screen, this is paragraph  
7 65 of Document E62/2 and it specifically refers to the elements  
8 set out in the ICTY Strugar case. And I think, the court  
9 officer, we won't need that document anymore.

10 And just following on from that question, you testified earlier  
11 today that a cognitive assessment necessarily relates to a task  
12 which a person may be required to undertake. Is that -- am I  
13 correct in summarizing your evidence?

14 A. Yes, that is so. When one is assessing a person, one  
15 assesses them with respect to the particular task that they may  
16 be called upon.

17 Q. And considering this document and in light of your mission,  
18 as indicated in the Trial Chamber's Order, did you understand  
19 that a particular task for which you were assessing the cognitive  
20 functioning of the Accused, had to do with participation in a  
21 trial?

22 A. Yes, I did

23 .[14:27:45]

24 Q. Did you in any way feel that your experience may be lacking  
25 in this respect?

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1 A. I think the instructions there are reasonably specific, and  
2 I felt that I could meet those requirements, assess the patient  
3 -- the person appropriately.

4 Q. Thank you very much. And just a couple more questions.  
5 There's been great discussion of the Mini-Mental State Exam. In  
6 your experience, is it possible for an individual to achieve a  
7 score of 30 out of 30 and yet be cognitively impaired?

8 A. A score of 30 out of 30 is taken as being normal  
9 intellectual function. There are some aspects of the Mini-Mental  
10 State -- some aspects of intellectual function that the  
11 Mini-Mental State does not examine particularly closely or well.  
12 But otherwise, it is a good test of memory.

13 Q. And just to recap, is it correct to say that -- this test  
14 was one of a number of matters in which you relied on, in any  
15 event?

16 A. That is correct.

17 Q. And the very last question, Professor; you did this morning  
18 also refer briefly to the potential causes of dementia, and I  
19 think that you stated that among those causes were psycho-social  
20 conditions. Is that correct?

21 [14:29:25]

22 A. Whenever there's impaired cognitive function and -- there  
23 are a number of different factors that are likely to impinge on  
24 that, and psycho-social factors are clearly very important. I  
25 mean, there is evidence that people who are kept intellectually

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1 active do actually preserve function better.

2 Q. And just following on from that, would it be fair to say  
3 that cognitive impairment - or correct me if I'm wrong, and  
4 perhaps this is really where we need to rely on your expertise -  
5 can it be alleviated through addressing some of those  
6 psycho-social conditions?

7 A. Yes, it can. I mean, there can be both treatable causes of  
8 impaired function and untreatable causes, and very important to  
9 identify the treatable causes and deal with those, which is why I  
10 recommended a decrease in the psychotropic drugs, for example,  
11 that Ieng Thirith has been taking.

12 Q. And I apologize, I said that was my last question, but  
13 you've just invited me just to confirm essentially, then it is  
14 your evidence that your opinion as to -- would it be correct to  
15 say that your view as to the current state of affairs -- that it  
16 is an interim situation given that those reductions are still  
17 continuing?

18 A. Yes, that is correct. And also there are some agents that  
19 can be effective in Alzheimer's disease. They're effective in  
20 only a small majority. And as I suggested in my second report,  
21 if there is no improvement with the ceasing of the psychotropic  
22 drugs, then consideration should be given to trying those to see  
23 if they do have any benefit.

24 MR. ABDULHAK:

25 Thank you very much.

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1 And thank you, Your Honours.

2 [14:31:09]

3 THE PRESIDENT:

4 Thank you, Mr. Co-Prosecutor.

5 Next, the Chamber would like to give the floor to the Lead

6 Co-Lawyers for Civil Parties if they wish to put questions to

7 Professor Campbell in accordance to the guidelines provided by

8 the Chamber this morning. Thank you.

9 MS. SIMONNEAU-FORT:

10 Thank you, Mr. President. We have prepared some questions after

11 looking at the documents.

12 Sorry, sir. Yes, we have prepared some questions.

13 MR. PRESIDENT:

14 There is an -- audio problem. Can court officers fix the problem

15 and report to us once the problem is solved?

16 (Recording malfunction)

17 The problem is now fixed. Lead Co-Lawyers, you can now proceed.

18 MS. SIMONNEAU-FORT:

19 Thank you very much, Mr. President.

20 As I was saying, we have prepared some questions after we had

21 only had a chance to look at the documents on Friday. Now, in

22 fact, all of those questions have already been asked and like

23 everybody here, we do not wish to become repetitious or pose

24 redundant questions. We, therefore, do not have any questions to

25 put at this stage in the hearing.

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1 Thank you, President.

2 [14:34:14]

3 MR. PRESIDENT:

4 Thank you.

5 Now that we do not have any further questions to be put to the  
6 expert for our joint hearing, it seems that we come to an end to  
7 this joint hearing today. And as planned, we will have separate  
8 hearings concerning Ieng Thirith followed by an individualized  
9 hearing concerning Nuon Chea. Participants will be determined  
10 later as to who can participate in those hearings and in order to  
11 --.

12 (Judges deliberate)

13 MR. PRESIDENT:

14 I notice that Ms. Ellis is on her feet. So, you can now proceed.

15 MS. ELLIS:

16 Mr. President, I understood that the defence was to have a chance  
17 to ask a few questions finally before we close the public part of  
18 the session from what was said at the outset, and I wondered if  
19 we might be permitted to do that.

20 MR. PRESIDENT:

21 Yes, you are allowed to do that. But before that, I would like  
22 to remind that you need to confine yourself to different  
23 questions, rather than repeating the questions, and I'm sure you  
24 understand this issue.

25 [14:37:01]



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1 MS. ELLIS: Thank you very much.

2 QUESTIONING BY DEFENCE COUNSEL:

3 BY MS. ELLIS:

4 Q. Professor Campbell, you've been directed to the document  
5 that sets out the capacities that are considered when the matter  
6 of cognitive impairment is being assessed. And as we saw, those  
7 were in criminal proceedings, non-exhaustive, but involve:  
8 understanding the proceedings, instructing counsel, testifying of  
9 choice - if that's the case - understanding the consequences, and  
10 of course, before all that, understanding the charges.

11 Now, from what you've said, your experience in court work has  
12 been outside of the criminal justice system and to do with  
13 testamentary capacity, for example. But when you are assessing  
14 the cognitive impairment for those kinds of court cases, are you  
15 not considering the same kinds of capacities?

16 MR. CAMPBELL:

17 A. Yes, both persons' general capacity and also in  
18 relationship to the particular questions around their ability to  
19 instruct the person representing them.

20 Q. Although this happens to be your first experience of a  
21 report for a criminal trial, essentially, the assessment on  
22 cognitive impairment is the same whatever the actual situation?

23 A. Yes, clearly I need to get an understanding of the actual  
24 process and did my best to do that. By the way, the assessment,  
25 as you indicate, requires the same tools to be used.

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1 [14:39:27]

2 Q. You've already told us that in order to make your  
3 assessment of Ieng Thirith, you saw her on several occasions. On  
4 the first day you saw her, you saw her both in the morning and in  
5 the afternoon?

6 A. That is correct.

7 Q. And that, therefore, covered a period of several hours. Is  
8 that right?

9 A. Yes, that is so.

10 Q. You then made, back in May when you first met her, a return  
11 visit to see her the following morning?

12 A. Yes, I did.

13 Q. And you then told us that on your return last week, you had  
14 an opportunity to see her again?

15 A. Yes, I saw her in both the morning and in the afternoon  
16 last week.

17 Q. And can you just give us some idea of the period of time,  
18 therefore, in total you have had in order to carry out your  
19 assessment?

20 A. The time with Ieng Thirith would probably be around four  
21 hours in total.

22 [14:40:47]

23 Q. Thank you. Now, you've told us quite a bit about the two  
24 tests that you felt it appropriate to conduct in this case: the  
25 MMSE and the Montreal Cognitive Assessment. Just so that we're

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1 clear, in addition to those tests involving - as you've told us -  
2 the ability, for example, to deal with numbers and subtract  
3 simple numbers, the patient is also shown a series of pictures to  
4 identify objects. Is that right?

5 A. That is correct, yes.

6 Q. And just to be clear, those objects, for example, animals -  
7 they're all very familiar objects, aren't they?

8 A. They are.

9 Q. And the tests require the patient to try and recall the  
10 objects that they have seen once they've shown whether they can  
11 identify what they are?

12 A. Yes, the main memory test in the MMSE is to name three  
13 objects, get the person to repeat them and then to check again  
14 after some additional questions have been asked.

15 Q. And do you also state a sentence and see how well that  
16 sentence can be repeated by the person who's being tested?

17 A. When one is doing the full MMSE - yes, one does. But given  
18 the problems with translation, I didn't use that particular test.  
19 As I said, I selected questions from both the MMSE and the  
20 Montreal test.

21 [14:42:40]

22 Q. From the Montreal test, one of the aspects of that was  
23 dealing with the clock and the ability to tell the time?

24 A. Yes, to draw the clock, which is a test of constructional -  
25 spatial-constructional problems

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1 Q. Yes.

2 A. -- and also the time, in order to test the person's, again,  
3 constructional problems and conceptual thinking.

4 Q. And would you expect a child, of perhaps over seven or  
5 eight, to be able to perform that particular task?

6 A. Yes, most children would be able to do that.

7 Q. It's a fairly simple basic test, in other words?

8 A. It is.

9 Q. Thank you. In order to carry out these two tests, you had  
10 the benefit of an interpreter. And as I understand your evidence,  
11 that can, in some situations, slightly alter your ability to make  
12 judgements on how reliable the testing might be?

13 A. Yes, it does because one is not getting the direct answers  
14 oneself. And also, as indicated earlier, there may well be  
15 cultural issues in some of the questions.

16 [14:44:06]

17 Q. But would it be fair to say that were the tests, in  
18 essence, dealing with quite simple issues or questions, that  
19 should present less of a problem where there is an interpreter?

20 A. Yes, with the questions I asked, I would have expected the  
21 person to be able to handle those, given that the questions were  
22 provided through an interpreter.

23 Q. Because you - from what you've said - will have taken into  
24 account that there is an intermediary and, therefore, will want  
25 to ensure that what is posed can be easily translated and,

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1 therefore, there is less scope for there to be any unreliability  
2 in the response?

3 A. Yes, that is so. For example, the phrase that is repeated  
4 in the MMSE has particular significance that the person may pick  
5 up. Now, I'm not sure whether that is maintained if it's  
6 translated and, therefore, did not use that question.

7 Q. From what you've said, if the results of those two tests  
8 show cognitive impairment, to some extent, that is the icing on  
9 the cake because your main assessment comes from all those other  
10 areas, as you've described: taking the history, looking at the  
11 medical background, looking at any scans, looking at any medical  
12 records, looking at the social environment -- all of that and the  
13 behaviour - as observed by others over a period of time - is, to  
14 some extent, the critical aspect of assessments. Would that be  
15 fair?

16 A. Yes, that is so, especially in this situation where one  
17 does have the problem of translator and the cultural issues.  
18 These are used, really, just to confirm the initial assessment.

19 [14:46:25]

20 Q. And with all your many, many years' experience, one of the  
21 other features - would you agree - that you will always be alert  
22 to, in assessments of this kind, is whether the patient is in any  
23 way trying to avoid, consciously, answering questions or feigning  
24 inabilities. Is that something you will be familiar with and you  
25 will be alert to?

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1 A. Yes, it's not a situation that's likely to arise very  
2 commonly in -- general clinical practice, but one does have to be  
3 aware of other circumstances, which may influence the person's  
4 ability to answer. For example, if there's a member of the  
5 family present who may be observing, that may influence their  
6 ability and may influence their willingness to actually  
7 participate in the test.

8 Q. That was not the situation here, though?

9 A. That was not the situation here.

10 Q. When you'd compiled your report - just to be clear - you  
11 didn't show it, did you, to Ieng Thirith for her comments?

12 A. No, I did not.

13 Q. And it would not be usual, would it, when a report is  
14 prepared to assist the judges in their ultimate assessment of the  
15 issue, for you to show that report in advance of providing it to  
16 the Court, to the patient.

17 A. No, I would expect that that would be the court's decision  
18 and the person representing the person.

19 Often, when one is taking a history, one goes back over it with  
20 the person to ensure that it's correct, but it doesn't mean  
21 showing them the written summary.

22 Q. You've told us that dementia is, in your opinion, a  
23 physical illness. Would it be right to describe it as an illness  
24 in which the brain's structure becomes altered, and then there is  
25 a death of certain nerve cells?

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1 A. Yes, dementia is a chronic and progressive impairment of  
2 cognitive function, intellectual function, brain function which  
3 has a number of causes. The most common is Alzheimer's in which  
4 there is loss of nerves, nerve function. Commonly, there is a  
5 vascular component to it, a vascular dementia, and very often a  
6 mix. And there are other dementing illnesses - less frequent,  
7 less common.

8 [14.49.19]

9 Q. And you, as a physician - you're a geriatrician, but you  
10 are a physician, are you not - are very well equipped and do deal  
11 with the illness of dementia, as you've said, on a daily basis?

12 A. That is correct.

13 Q. The referral to a specialist, such as a neuropsychiatrist,  
14 is if there is a particular - I think the word is, perhaps,  
15 significant that you used - management problem in respect of the  
16 functioning or the behaviour of the patient?

17 A. Yes, that is so. For example, if the patient was wandering  
18 or particularly aggressive, for example, one may well call in a  
19 psychiatrist.

20 Q. And other disciplines have been mentioned. For example,  
21 the neurologists, they have very specific roles in some  
22 instances, but by no means always, in cases of dementia, do they?

23 A. Now, normally a neurologist would be involved if the person  
24 was very much younger. For example, if dementia first became  
25 manifest in someone in their forties or fifties, a neurologist

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1 might well be involved at that stage.

2 [14.50.42]

3 Q. So, then you're talking about early onset dementia, which  
4 is less common than as an individual ages. And radiologists are  
5 brought in sometimes to simply review the scans and - I think  
6 from what you said - you had the assistance, did you, of somebody  
7 in looking at the scans?

8 A. Yes, that is so. The radiologist will always report on  
9 scans and there were reports on the scans that Ieng Thirith had  
10 had. I looked at them myself also because, of course, as a  
11 clinician, I review them and also discussed them with another  
12 radiologist.

13 Q. Thank you. And then, there are neuropsychologists who do  
14 certain tests if they're felt to be necessary in the  
15 circumstances. Would that be right?

16 A. Yes. Early on in a dementia, whether this is an actually  
17 dementing illness, whether the person has significant cognitive  
18 impairment, or whether they are simply worried that they might,  
19 we might well do some basic testing at that - some  
20 neuropsychological testing at that stage as a base for further  
21 assessment later on.

22 Q. But it would be right to say, wouldn't it, that none of  
23 these specialists in their disciplines have the overall  
24 responsibility for the care and treatment of a patient suffering  
25 from dementia or cognitive impairment?



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1 [14.52.11]

2 A. No, often the care of such a patient is by a number of  
3 people involved; a physician, neuropsychologist may well be  
4 involved and then other staff providing support.

5 Q. And do you have the overall advantage of also being able to  
6 assess the physical condition of the individual?

7 A. Yes, that is so.

8 Q. When you came to provide your opinion, your assessment of  
9 Ieng Thirith - which as we've heard was that she was cognitively  
10 impaired and, as a result, compromised in exercising her fair  
11 trial rights - that, of course, was on the basis of all the  
12 examinations and assessments carried out?

13 A. Yes, it was.

14 [14.53.18]

15 Q. And it's already been referred to, but there was a letter  
16 that you wrote to the Trial Chamber on the 13th of May of this  
17 year in which you described the cognitive impairment as being  
18 significant.

19 A. Significant in the terms of the task that she was face  
20 with, yes.

21 Q. Yes, it was as you stated; it's E62/3/3.1. It's been  
22 referred to that you said you found a significant cognitive  
23 impairment. I simply raise that because the other two  
24 descriptive terms have been put as to "moderate" -  
25 "moderately-severe," which is in your report of the 23rd of June

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1 and Professor Carr having described it as "mild." You would not  
2 suggest, would you, that it wasn't a significant impairment that  
3 you assessed Ieng Thirith was suffering from?

4 A. At this stage, I feel she has a significant impairment.

5 Q. And it was for that reason that you recommended, as we've  
6 heard, that there should be a reduction in two of the drugs that  
7 she was taking in order to then assess whether that, in any way,  
8 improved the situation?

9 A. Yes, I suggested a reduction of the bromazepam and  
10 clonazepam and...

11 Q. Could I -- I was not going to go into details of what those  
12 drugs were, just the general principle.

13 A. Yes, a general reduction in the psychotropic drugs.

14 Q. And that general reduction, we understand from your  
15 follow-up, has not had any significant difference at all in her  
16 cognitive impairment. Hence, you've moved on to suggest something  
17 else?

18 [14.55.29]

19 That is correct.

20 Q. And of course, we'll be going into these details later.  
21 But the position, as it stands at the moment, is that your  
22 assessment is that Ieng Thirith cannot meaningfully participate  
23 in the trial process?

24 MR. PRESIDENT:

25 Ms. Ellis, you have touched upon the details which should be

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1 "discussing" during the closed sessions. We have reminded you  
2 several times concerning the general questions that you should  
3 "be" put to the expert. We are concerned that you may ask the  
4 same questions at a later stage. Otherwise, these questions will  
5 not be permitted to be put to the expert when the time comes.  
6 So once again, the Chamber reminds that you put -- the right  
7 questions concerning the general issues and emit or refrain  
8 yourself from asking specific questions, which may be asked at a  
9 later stage, to the expert concerning specific accused person,  
10 "which" we will begin with Ieng Thirith followed by Nuon Chea.  
11 And there, we will also limit the participants to the sessions.  
12 Once again, we hope you understand the issue at hand and that you  
13 should also consult with your colleagues, as well as your other  
14 counsels to avoid asking repetitive questions so that the  
15 proceeding can go smoothly.

16 [14.57.47]

17 MS. ELLIS:

18 Mr. President, I'm sorry if you consider the questions were  
19 inappropriate. It was re-examination, and I hope that every  
20 question asked was based on questions others had asked in order  
21 to clarify or expand on that. And the purpose for which I asked  
22 - what was, indeed, my final question as to the current fitness -  
23 was simply on the basis that Professor Campbell had been invited  
24 by the Court to give his views on Nuon Chea. And therefore, it  
25 seemed to us that it was fair and appropriate not to leave

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1 hanging in the air the conclusion of his assessment of our  
2 client. But I've asked the question. If you do not permit  
3 Professor Campbell to answer, so be it. That was my last  
4 question. Thank you very much.

5 MR. PRESIDENT:

6 Professor, you don't have to answer this last question. Is there  
7 any other questions?

8 [14.59.15]

9 QUESTIONING BY DEFENCE COUNSEL:

10 BY MR. PAUW:

11 Q. Mr. President, Professor Campbell, just very briefly, the  
12 prosecution mentioned your thesis and stated the relevance of  
13 that thesis. I've been doing some research on your publications  
14 online as well. And I'm sure that that's a very limited approach  
15 to medical publications, but would it be fair to say that you are  
16 an expert on the issue of fall prevention in an elderly  
17 population?

18 MR. CAMPBELL:

19 A. It's in that field the majority of my research has been  
20 done.

21 MR. PAUW:

22 No further questions, Your Honours.

23 MR. PRESIDENT:

24 Thank you. I'm observing that the joint hearing has now come to  
25 an end. What continues is the Chamber's determination as to how

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1 we are going to proceed with the hearings concerning specific  
2 accused. During those hearings we -- the next hearing will be  
3 the one that concerns the Accused, Ieng Thirith; and so, the  
4 participants will be the counsel for Ieng Thirith and the  
5 prosecutors, as well as the co-lawyers for civil parties. And  
6 then the hearing concerning Nuon Chea will follow after this  
7 hearing. And during these latter hearings...

8 [15.01.36]

9 JUDGE LAVERGNE:

10 Maybe it would be a good idea to specify.

11 (Judges deliberate)

12 MR. PRESIDENT:

13 After our consultations, there is a small amendment to the  
14 proceedings. After the break, we will resume with a separate  
15 hearing concerning Ieng Thirith pursuant to the -- pertaining to  
16 the expert report. Therefore, the presence of Nuon Chea's  
17 co-lawyers can be "observed" here as long as the session is in  
18 public. And after our consultation just now, we decided that  
19 co-lawyers for Nuon Chea can also be present if the hearing is  
20 conducted in public, so that they can observe. And this also  
21 applies to other parties and the public unless parties are  
22 informed otherwise that they cannot "be" participate in any  
23 particular portion of the hearing -- when it comes to our  
24 determination regarding the balance between the rights of the  
25 public to know information and the rights of the accused persons

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1 -- not to disclose their private information.

2 The Trial Chamber, as indicated this morning, intends to conduct  
3 this hearing in public at the most extent possible

4 [15.06.00]

5 Now it is appropriate for us to take a 20-minute break, and we  
6 will resume at 3:25. Thank you.

7 (Judges exit courtroom)

8 (Court recesses from 1506H to 1527H)

9 (Judges enter the courtroom)

10 MR. PRESIDENT:

11 Please be seated. The Court is now back in session.

12 In a moment, the Court will proceed to examine the reports  
13 prepared by -- Professor Campbell concerning the accused person,  
14 Ieng Thirith.

15 [15.27.38]

16 I will now hand over to Judge Cartwright to continue the  
17 questioning of the expert in relation to his report concerning  
18 the Accused, Ieng Thirith.

19 JUDGE CARTWRIGHT:

20 Yes. Thank you, President.

21 QUESTIONING BY THE BENCH:

22 BY JUDGE CARTWRIGHT:

23 Q. Now, we're going to focus specifically on the reports that  
24 you have prepared in relation to Ieng Thirith, and I will begin  
25 the questioning as previously, Professor Campbell.

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1 [15.28.18]

2 Now, in your first report completed in June of this year, you  
3 came to certain medical and cognitive conclusions. Could you  
4 summarize those conclusions, please, for the Court?

5 MR. CAMPBELL:

6 A. My conclusions were that: Ieng Thirith did have significant  
7 cognitive impairment, and there were a number of possible causes  
8 for that, "included" an underlying dementing illness, which may  
9 have been due to either Alzheimer's or vascular dementia, but  
10 most likely, a component of Alzheimer's disease; that her  
11 cognitive function would also possibly have been influenced by  
12 the medications that she was on and also by the stress that she  
13 had been under for a number of years and also her current social  
14 circumstances.

15 Q. Thank you.

16 [15.29.18]

17 Now, can we turn in more detail first, please, to any physical  
18 findings that you made in relation to Ieng Thirith before going  
19 on to the more extended analysis of her cognitive status? Did  
20 you come to any conclusions about her physical status?

21 A. She was generally frail, but otherwise, there were no  
22 specific physical problems that I felt would influence her  
23 ability to participate in the trial. She did have a number of  
24 chronic problems, but they were being managed appropriately.  
25 Her blood pressure, for example, was being managed appropriately.

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1 She had had some renal problems, but that has been quite stable  
2 over some time.

3 Q. Now, you specifically spoke of -- or reported on her  
4 musculoskeletal disease in your report. In the English, it's  
5 page 13. And in that, you noted the concerns that she had  
6 expressed, some of which have been repeated by her lawyers in  
7 Court today.

8 [15.30.38]

9 Could you expand a little on that, please?

10 A. Ieng Thirith does complain frequently of pain in her knees,  
11 her ankles, her legs and did so on my reassessment, also. I  
12 re-examined her joints again on this visit. I could find no  
13 signs of inflammation in her knees or her ankles. I had found a  
14 small effusion in the knee the first time I examined, but not on  
15 this occasion.

16 On review of the assessment of her musculoskeletal system  
17 previously, she had had an orthopaedic review and, again, no  
18 particular problem had been found, and that had included an x-ray  
19 of her knees.

20 Q. And in fact, since you examined her most recently, you have  
21 recommended some further measures with her medication for the  
22 pain that she is concerned with. Is that correct?

23 A. That is correct. She was on a very low dose of  
24 paracetamol, which is a simple analgesic without significant side  
25 effects. I felt that she may well be more comfortable if this



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1 was used in a slightly larger dose and more regularly.

2 [15.31.52]

3 There is some evidence from the literature quite recently  
4 indicating that if there are concerns about pain, then simple  
5 analgesics can decrease that pain and decrease the level of  
6 agitation.

7 Q. In the section on musculoskeletal disease, you spoke of  
8 Ieng Thirith being on vitamin D replacement.

9 [15.32.22]

10 Could you just explain what that measure is for and what your  
11 conclusions are concerning that?

12 A. When a person is in a situation as she is, their sunlight  
13 exposure may be significantly reduced -- importantly reduced. In  
14 that situation, they can develop a vitamin D deficiency, which  
15 can manifest itself as muscular aches and pains, bone pain; and  
16 so, it's important in that situation to ensure that the person is  
17 getting adequate vitamin D. The easiest way to do that is to use  
18 a tablet of vitamin D to replace, and that's used very commonly  
19 in practice now.

20 Q. And when you spoke a moment ago about people in her  
21 situation, can I infer from that you mean people who are  
22 confined, as Ieng Thirith is, in a detention facility or other  
23 like facility where there is less access to everyday outside  
24 activity?

25 A. Yes, that is so. For example, now in people in rest home

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1 care, we would use vitamin D, a tablet a month, almost as a  
2 routine.

3 Q. Arising from your review of her physical condition, was  
4 there anything that caused you any concern in relation to her  
5 attendance during hearings, the facilities that are provided for  
6 her – anything of that nature?

7 A. As I indicated, she is physically frail. I feel she will  
8 be able to attend most of the Court sessions, but she may wish to  
9 use the holding cells for periods to enable her to use the bed  
10 there.

11 [15.34.26]

12 Q. But no special chairs, anything of that nature that you  
13 thought would be appropriate for her?

14 A. No, I didn't feel any particular equipment or furniture was  
15 required.

16 Q. Well, it's obvious to everyone now that you have concerns  
17 about her cognitive ability; and I'd appreciate it, please, if  
18 you could help me go through your first report, and then we'll  
19 return to the second report at a later stage.

20 [15.35.08]

21 First of all, before you completed your report, amongst the many  
22 medical reports and assessments you considered, you reviewed the  
23 psychiatric report completed by Professor Ka and Dr. Brinded in  
24 2009. Is that correct?

25 A. That's correct.

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1 Q. In lay terms, could you repeat – I think we've heard most  
2 of it already, but could you state again, please – what the  
3 conclusions -- what conclusions were reached by those two experts  
4 now almost two years ago?

5 A. They felt that she had early memory changes, which they  
6 described as an early dementing process, but also described it as  
7 being consistent with age.

8 [15.35.58]

9 Now, that is not entirely consistent in that one would not expect  
10 a dementing process to be part of what one would expect with age.  
11 There are certain memory changes that occur with age, but they  
12 are not indicative of a dementing process.

13 Q. So, it's like the familiar comments you hear from older  
14 people: "I must be getting Alzheimer's because my memory is  
15 starting to fade."

16 A. That's correct.

17 Q. Right. Well, you saw also in your summary of the materials  
18 that in -- the beginning of 2006, Ieng Thirith suffered a  
19 fracture of the left neck of the femur, and that required  
20 surgical intervention.

21 [15.36.50]

22 First of all, where is the left neck of the femur, bearing in  
23 mind that all this is being translated into Khmer and into  
24 French?

25 A. The femur consists of the shaft, which is the main thigh

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1 bone, which then angles across and ends in a head – a rounded  
2 area which fits into the joint in the pelvis. And the neck of  
3 the femur is that small portion of bone between the head and the  
4 shaft, and it is a very common site of fracture for older people.

5 [15.37.40]

6 Q. Now, there was a connection drawn between that trauma and  
7 the diagnosis indicated by the two experts in 2009. Can you  
8 explain that connection to the Court, please?

9 A. She did have disturbed behaviour after that accident and  
10 the surgery. There were two possibilities raised: that this was  
11 a manifestation of a psychiatric illness; although, more likely  
12 is that she suffered a delirium. That is, whenever anyone has an  
13 acute illness – be it trauma, surgery, a febrile illness – they  
14 can become acutely confused with the delirium. That is, that  
15 becomes more common as one gets older and becomes even more  
16 common if there is an underlying cognitive impairment at the time  
17 of the stress.

18 [15:38:35]

19 Q. Are there -- in the report that Professor Ka and Dr.  
20 Brinded completed, they identified mild cognitive impairment,  
21 especially in the area of recent memory. They -- as you've  
22 already indicated, they associated that with her age, but also  
23 noted some indications from their review of a CT head scan. Did  
24 you review that head scan in particular, and do you differ in any  
25 way from the conclusions that they reached in 2009 from the same

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1 head scan?

2 A. I've reviewed all the head scans apart from the one that  
3 was done in Thailand, and my findings are consistent with the  
4 reports that there is a generalized atrophy. The difficulty with  
5 CT head scans is that there is not a good correlation between the  
6 extent of the atrophy and the extent of the cognitive impairment.  
7 One can see people with quite significant cognitive impairment,  
8 but little change in the CT scan and vice versa.

9 The main value of a CT scan, in this situation, is to exclude  
10 other causes that may -- be responsible for the cognitive  
11 impairment. For example, an underlying brain tumour or a  
12 collection of blood between the skull and the brain.

13 Q. And, of course, you reviewed -- examined Ieng Thirith  
14 almost two years after the completion of this expert report. Are  
15 your current findings consistent with the diagnosis that they  
16 made?

17 A. I felt from my findings that her condition had progressed  
18 since they saw her. They had a reasonable degree of cooperation  
19 from her; I found it difficult to maintain her focus on the  
20 questions that I was asking and to get a good account of her  
21 past, which would have indicated an intact memory for previous  
22 events.

23 [15:41:00]

24 Q. You went into some detail, in paragraph 32 of your report,  
25 in summarizing your findings after you'd conducted a history and

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1 an examination and reviewed the various scans and tests et  
2 cetera. Could you outline for the Court, please, your findings in  
3 that part of your report?

4 A. In my report there, I indicate that I feel the most likely  
5 underlying problem is an Alzheimer's-type dementia. There were  
6 not many changes consistent with a vascular dementia on the CT  
7 scan and no history of small strokes; although, she had been  
8 hypertensive.

9 I felt though it would very likely -- more factors contributing  
10 to the cognitive impairment than just Alzheimer 's disease, as  
11 I've indicated there.

12 Q. Well, those particular factors that you mention there have  
13 already been touched on, but they are: her personal stress, her  
14 exposure to trauma and her restricted environment and stimulation  
15 - meaning she lives a very simple life in the detention centre, I  
16 presume.

17 A. Yes, that is correct, with little additional stimulation to  
18 try to maintain -- help her maintain her function, intellectual  
19 function.

20 Q. Now, a feature of your examination was the recommendations  
21 that you made concerning adjustment of Ieng Thirith's medication.  
22 And you had in mind particular psychotropic drugs which could be  
23 reduced; and also, you recommended a period over which they could  
24 be reduced.

25 [15:43:08]

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1 Now, what were your reasons for making those recommendations,  
2 first, before we look at them in more detail?

3 A. Ieng Thirith was on three psychotropic mediations, two of  
4 one type - so-called benzodiazepines and the other was  
5 quetiapine. Now, psychotropic medications can affect cognitive  
6 function. She had been on those for a considerable time, and the  
7 justification for them was no longer evident. As far as I could  
8 gather, no previous attempt had been made to reduce those  
9 medications.

10 I felt that they may be adding to her problems, rather than  
11 assisting, and that it would be important to try a reduction of  
12 that, carefully, under supervision. It would need to be a  
13 gradual reduction, as I outlined, because of the length of time  
14 that she had been on them and because of the issue of withdrawal  
15 effects.

16 Q. So, there were two basic reasons for making this  
17 recommendation: first, therapeutic - that is, in her own  
18 interests to improve her treatment, perhaps I could say in  
19 summary; and secondly, it might improve her ability to understand  
20 what is going on around her, to talk to her lawyers and matters  
21 of that nature. Is that a correct summary?

22 A. That is correct. Were she a patient of mine, then I would  
23 be taking -- making similar moves, and as you indicate also, in  
24 the hope that this would improve her mental condition such that  
25 she was able to participate in her own defence.

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1 [15:44:57]

2 Q. Now, between your report in June and most recently when you  
3 return to Phnom Penh to reassess Ieng Thirith, did you engage in  
4 discussions with her doctor -- the doctors who treat her to  
5 discuss and resolve the program over which medications should be  
6 reduced?

7 A. Yes, we held an audio conference, which was successful, and  
8 agreed on a continuation of the plan. The doctors had already  
9 started to reduce her medications. So, that plan continued; so,  
10 as I indicated earlier, she has now been off the benzodiazepines  
11 for a week. And when I met with her doctors last week, we  
12 discussed the reduction of the quetiapine, and that has now been  
13 started.

14 Q. So, you have now reassessed her after she's concluded the  
15 benzodiazepines -- but there's still another regime to be reduced  
16 -- until it is reduced to the level you think appropriate. Is  
17 that right?

18 A. Yes, that is correct. The quetiapine is now being reduced  
19 about -- at a quarter of its dose a week, so that will take four  
20 weeks to complete.

21 I think the other issue which is important, which I indicate in  
22 my recent report, is that as there has been no improvement,  
23 really, with the decrease in the benzodiazepines, an underlying  
24 Alzheimer's disease becomes more likely. There are agents that  
25 can be used for this, and it is possible, although not likely,



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1 that she may benefit from that.

2 Q. When you talk about the possibility of an underlying  
3 Alzheimer's disease, is this a condition that is difficult to  
4 detect clinically by CT scans, or is it simply that it's too  
5 early to be able to confirm it, so far as Ieng Thirith is  
6 concerned?

7 [15:47:12]

8 A. It is difficult to make the diagnosis on imaging alone  
9 because as I said earlier, there is a poor correlation between  
10 the degree of atrophy and the degree of cognitive impairment.  
11 It is really a clinical diagnosis based primarily on the history  
12 and examination findings in which one excludes other possible  
13 causes of the cognitive impairment.

14 Q. Turning now then to the medication again, you returned last  
15 week and you reviewed some further reports and also had  
16 discussions with her doctors, as you have indicated. You mention  
17 in your latest report, at page 1, that you reviewed some  
18 laboratory tests, and you have annexed those tests to the back of  
19 your report. Can I just turn first to those, these are the blood  
20 tests.

21 [15:48:28]

22 In two places - the one called T3 libre and the second, T4 libre  
23 - they are slightly below what appears to be the normal range.  
24 Is that a matter of concern for you; is it significant?

25 A. Not at all. These are the two hormones produced by the

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1 thyroid gland, and the thyroid gland is under stimulation from  
2 the pituitary gland which produces TSH.

3 Whenever one looks at normal ranges, they are population norms;  
4 that is, if one took a whole group of people, 95 per cent would  
5 fall within this range. The body, through the pituitary gland,  
6 though, has set its own levels so that if one's own thyroid is  
7 producing insufficient thyroid hormone, the pituitary will  
8 increase the amount of TSH and stimulate the thyroid gland.

9 The fact that the TSH, there, is in the normal range indicates  
10 that the thyroid gland is functioning normally.

11 Q. Now, just a brief question about the CT head scan of the  
12 2nd of June 2011; was that one that you hadn't seen when you  
13 completed your first report, or were you just simply looking at  
14 it again on this occasion?

15 A. That was the -- date of that was June, and I don't think  
16 I'd seen that in my first assessment.

17 Q. And was there anything of significance that you -- that  
18 arose out of your review of that CT scan?

19 [15:50:17]

20 A. It was entirely consistent with the previous scans.

21 Q. So then, last week, you interviewed Ieng Thirith again in  
22 the presence of her doctors from Calmette who actually treat her  
23 and with an interpreter; and then you arranged a second interview  
24 directly by Professor Chak Thida, while you observed in the  
25 background. Can you explain why you conducted two interviews,

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1 please?

2 A. In my first interview, I conducted that through the  
3 interpreter, with Ieng Thirith responding to my questions. And  
4 she recognized, I think, that this was a test situation, and I  
5 felt that that may have affected her response.  
6 Reviewed that with her doctors after that morning interview and  
7 suggested that if I took a less prominent role and sat on the  
8 background -- we had fewer people present, so there was just  
9 Professor Chuck discussing with Ieng Thirith, and the interpreter  
10 sat next to me and conveyed the conversation to me. That would  
11 be a less obvious test situation, and we may get a difference in  
12 the response.

13 Q. Did you, in fact, perceive any difference in the responses  
14 between the two interviews?

15 A. I think she was a little more relaxed in the second  
16 interview. She was on the couch in that second interview and  
17 that was useful, but in terms of the impairment of memory, that  
18 was still evident.

19 Q. And you again asked those who supervise Ieng Thirith  
20 day-by-day if they'd seen any changes in her behaviour or memory.  
21 What was their response? Did you talk to more than one person or  
22 just one?

23 [15:52:24]

24 A. Just two people, I think it was, who are mostly involved  
25 with her care. The main purpose of that was firstly, to see if

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1 they'd witnessed any change in behaviour with the reduction of  
2 the medications, and there was no significant change as far as I  
3 could determine. But also to determine if she still got lost and  
4 still manifested the confusion that had been evident previously,  
5 and that is so.

6 Q. And that led you to your conclusion that after the  
7 stopping of the medication that's concluded thus far, there's  
8 been no improvement in her cognitive function. Is that correct?

9 A. That is correct. I felt she was a little more alert  
10 this time, but in terms of her underlying memory, there was no  
11 real improvement.

12 Q. When you say that you consider her memory as moderately  
13 impaired, the details of her past are vague and often inaccurate.  
14 Can you summarize what you mean in coming to that conclusion?

15 A. I asked her about various aspects of her past. I mean,  
16 clearly there are some areas in which it would be difficult for  
17 her to reply and her memory may be -- her replies might be  
18 influenced by other than memory. But for example, reviewing her  
19 time in France and her education there, she had trouble recalling  
20 any detail of that time, and only after prompting was she able to  
21 respond and indicate that she remembered.

22 [15:54:08]

23 Similarly, when we discussed her family, again, she had  
24 difficulty actually providing any details of the family, where  
25 they were, when they visited.

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1 Q. Now, I'm sure that many observers will be thinking: she  
2 might be fooling you. Do you think there's any possibility that  
3 this could be the case, Professor Campbell?

4 A. I have been concerned about that and watching very  
5 closely to see if I could detect anything that might indicate  
6 that. And in my assessments, I have not really detected any  
7 indication that she may be deliberately trying to deceive me.

8 Q. Now, there's one further medication that is yet to be  
9 reduced to the level that you and her treating doctors consider  
10 appropriate. Do you think that she requires a further assessment  
11 after that has been concluded? Do you think it's going to make a  
12 significant difference to her cognitive function?

13 A. I think it is unlikely that either the quetiapine  
14 reduction or the use of the agent specifically for Alzheimer's  
15 will make an improvement, an important clinical improvement. I  
16 do feel though, that that needs to be tried; and if there is any  
17 indication that there has been an improvement, then clearly, a  
18 re-assessment would be justified.

19 Q. Before we turn to the recommendations that you have  
20 made concerning a different type of medication, you said in your  
21 most recent report that your conclusions about Ieng Thirith's  
22 ability to participate in her defence are unchanged from your  
23 first report; and I think that they are primarily found at  
24 paragraph 41 of your first report.

25 Could you summarize those, please? I know we've covered

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1 them, but just to make sure we've covered everything.

2 [15:56:29]

3 A. Yes, my conclusions were that she would have difficulty  
4 recalling the events which are under question; that she would  
5 have difficulty instructing her defence and also have trouble  
6 concentrating during the process and responding during the court  
7 proceedings.

8 Q. Thank you.

9 Now, you did make some recommendations concerning new  
10 medication. Could you outline, first, your reasons for making  
11 those recommendations, and then tell us a little bit about what  
12 you might -- what changes you might expect to see if she responds  
13 to that medication?

14 A. There were two changes; one was to increase the dose of  
15 paracetamol to try and improve pain relief and see if that  
16 decreased the agitation. And one would expect to see a decrease  
17 in complaints of pain as a consequence of that, and the affect of  
18 that would be immediate.

19 The other is the use of a drug which is now being used in people  
20 with Alzheimer's after they -- have discussed with them and their  
21 family. It's not a drug that is used universally. For example,  
22 with patients I always discuss with them the possible merits and  
23 potential side effects to determine if they wish to try it or  
24 not.

25 [15.58.15]

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1 The drug only works in around a third of people. It does not  
2 affect the underlying progression of the disorder, but it can  
3 take the person back a time in terms of improving their memory,  
4 improving their cognition.

5 Q. Would that improvement gradually deteriorate over time  
6 itself?

7 A. Yes, that is correct. I mean, with Alzheimer's disease,  
8 there is a gradual deterioration. This drug may pick them up a  
9 wee bit, but the decline continues.

10 Q. Now, just some final general questions from me, Professor  
11 Campbell.

12 [15.59.02]

13 Is there any other aspect of Ieng Thirith's medical treatment  
14 that you consider has any significant impact on her cognitive  
15 ability, something you haven't mentioned thus far?

16 A. No, there is nothing else. I have reviewed the medications  
17 and her physical problems as they affect her cognition.

18 Q. When you were here last week talking to Ieng Thirith, did  
19 you discuss with her the hearing that is taking place today?

20 A. No, I did not.

21 Q. Can you, in summary, outline the level of care that Ieng  
22 Thirith currently requires in relation to her medical and  
23 personal care, please?

24 A. She is under regular medical supervision by the doctors of  
25 Calmette Hospital, and they have managed her physical problems.

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1 [16.00.15]

2 She is also under the supervision of the staff at the detention  
3 centre, who provide for her basic physical needs.

4 Q. And am I right in inferring that you consider she is having  
5 adequate medical attention and adequate personal care for her  
6 personal circumstances?

7 A. Yes, that is correct.

8 Q. Yes. Thank you, Professor Campbell.

9 JUDGE CARTWRIGHT:

10 President, I have no further questions.

11 MR. PRESIDENT:

12 Thank you, Judge Cartwright.

13 [16.00.55]

14 Judge Lavergne, you may now proceed.

15 JUDGE LAVERGNE:

16 Thank you, President.

17 QUESTION BY THE BENCH:

18 BY JUDGE LAVERGNE:

19 Q. Professor Campbell, I have -- a few quick questions in  
20 order to revisit the different diagnoses between the diagnosis  
21 that was realized by Professor Brinded and Professor Ka and the  
22 one that you completed yourself.

23 [16.01.28]

24 In the 1999 report, you said that she was suffering from slight  
25 degradation of cognitive ability. You spoke about a moderately



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1 severe state of dementia. Can you illustrate this a bit by  
2 telling us if -- telling us to which level of disorientation this  
3 corresponds to?

4 [16.02.08]

5 When you met with her, did -- was Ieng Thirith able to understand  
6 what was the aim of your diagnosis? According to you, when Ieng  
7 Thirith was here this morning, do you believe that she was able  
8 to understand what she was doing here, what was the reason for  
9 her presence here, and who were the different people sitting in  
10 this courtroom?

11 Maybe this is a bit too complicated because it speaks to other  
12 questions relating to her knowledge of the judicial process, but  
13 could you tell us, however -- give us more specific indications  
14 so that we may have a little idea about what this condition  
15 really is?

16 And according to you, what is the difference between -- Professor  
17 Brinded's observations and your own observations?

18 MR. CAMPBELL:

19 A. I've viewed the day's procedures without actually speaking  
20 to her about it.

21 [16.03.23]

22 I can give you a clear indication of how she viewed my seeing her  
23 and her understanding of that visit. On my first visit, I  
24 explained my situation, why I was there, very clearly on the  
25 first day. When I asked her again on the second day, she could

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1 not recall, really, what the purpose of my visit had been. She'd  
2 just -- that I'd come, and I wanted her to sign something.  
3 So that there was difficulty in actually -- she was having  
4 difficulty grasping the purpose of my visit.  
5 In terms of the difference between Professor Carr and Dr.  
6 Brinded's assessment and mine, there is a two-year gap. And one  
7 would expect, with an underlying dementing illness, for the  
8 degree of impairment to have progressed over that time course.  
9 And so, I think the changes that I saw were consistent with the  
10 assessment that had been done at that time.

11 Q. If I remember correctly what was mentioned in Professor  
12 Brinded's report, he was saying that Ieng Thirith eventually  
13 would use written notes to be able to complement or to remedy for  
14 a certain number of cognitive problems she is facing.

15 [16.05.06]

16 For example, do you believe that this kind of a statement is  
17 still relevant today -- this kind of observation? Do you believe  
18 it's still relevant today?

19 A. No, I found no evidence of that. When I saw Ieng Thirith  
20 on my second visit on the second day -- my first assessment,  
21 second day, she brought a number of papers along with her and  
22 leafed through those papers when I asked questions, although  
23 those papers were not particularly related to the questions I was  
24 asking. So I do not feel that she was using in a constructive  
25 way, any written material that she had.

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1 Q. Thank you, Professor Campbell. I have no further  
2 questions.

3 MR. PRESIDENT:

4 Thank you, Judge Lavergne. Thank you, Professor Campbell.

5 [16.06.15]

6 Since it is already five past 4:00, it is an appropriate time to  
7 adjourn this session. The Trial Chamber will take the  
8 adjournment right now, and the session will be resumed tomorrow  
9 starting from 9 o'clock.

10 Dame Ellis, you may now proceed.

11 MS. ELLIS:

12 Mr. President, having spoken to Ieng Thirith during the brief  
13 break we had this afternoon when she again was anxious to return  
14 to the detention centre, we anticipate there is likely to be a  
15 similar request on her behalf tomorrow morning.

16 [16.07.20]

17 In the circumstances, we really seek your guidance as to whether  
18 the application can be heard now for her to waive her right to be  
19 in the court or in the holding cell and to allow her to remain in  
20 the detention centre or whether you'd prefer that we make that  
21 application, if it's relevant, formally first thing tomorrow  
22 morning.

23 (Short pause)

24 MR. PRESIDENT:

25 Having advised the application by Ieng Thirith's defence team

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1 with regard to the schedule for tomorrow's session and having  
2 consulted among the Judges of the bench and also relying on the  
3 rule, sub-paragraph (5) of Rule 81, the Trial Chamber still  
4 maintains our position that the security personnel are instructed  
5 to bring Ieng Thirith back to the courtroom by 9 o'clock.

6 The defence counsel, however, can exercise their right to make  
7 such application again early in the morning when the court  
8 session commences after they have consulted with Ieng Thirith.  
9 [16.10.52]

10 So to summarize this position, the defence counsel is, indeed,  
11 allowed to make such application tomorrow morning when she is  
12 brought to the courtroom.

13 The security officers are now instructed to take the accused  
14 person back to the detention facility and return them to the  
15 courtroom by 9:00 a.m.

16 Regarding Ieng Sary, the situation remains the same as stated in  
17 the order by the court as he attending the court as an observer.

18 If he would like to participate in the proceeding as an observer,  
19 then he also will be returned to the courtroom as we did this  
20 morning.

21 The Court now is adjourned.

22 (Court adjourns at 1612H)

23

24

25