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

ព្រះរាជាណាចក្រកម្ពុជា
ជាតិ សាសនា ព្រះមហាក្សត្រ

Kingdom of Cambodia
Nation Religion King
Royaume du Cambodge
Nation Religion Roi

អង្គជំនុំជម្រះសាលាដំបូង
Trial Chamber
Chambre de première instance

ឯកសារដើម
ORIGINAL/ORIGINAL
ថ្ងៃ ខែ ឆ្នាំ (Date): 06-Sep-2011, 09:50
CMS/CFO: Kauv Keoratanak

TRANSCRIPT OF PRELIMINARY HEARING ON FITNESS TO STAND TRIAL PUBLIC

Case File N° 002/19-09-2007-ECCC/TC

30 August 2011, 0900H

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

Trial Chamber Greffiers/Legal Officers:
SE Kolvuthy
Matteo CRIPPA
DUCH Phary

For the Office of the Co-Prosecutors:
SENG Bunkheang
Tarik ABDULHAK
PAK Chanlino
Sarah ANDREWS

For Court Management Section:
UCH Arun

The Accused:
NUON Chea
IENG Thirith

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

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

I N D E X

WITNESS: Pr. JOHN P. CAMPBELL

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Questioning by Mr. Seng Bunkheang .... page 69

Questioning by Mr. Abdulhak .... page 76

Questioning by Mr. Lor Chunthy .... page 95

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Questioning by Ms. Simonneau-Fort .... page 109

Questioning by Ms. Ellis .... page 111

Questioning by Judge Cartwright .... page 124

Questioning by Judge Lavergne .... page 137

List of Speakers:

Language used unless specified otherwise in the transcript

Speaker	Language
MR. ABDULHAK	English
MR. CAMPBELL	English
JUDGE CARTWRIGHT	English
MS. ELLIS	English
JUDGE LAVERGNE	French
MR. LOR CHUNTHY	Khmer
MR. NUON CHEA	Khmer
MR. PESTMAN	English
MR. PHAT POUV SEANG	Khmer
THE PRESIDENT (Nil Nonn, Presiding)	Khmer
MR. SENG BUNKHEANG	Khmer
MS. SIMONNEAU-FORT	French
MR. SON ARUN	Khmer
MS. SUTZ	French

1 PROCEEDINGS

2 (Judges enter the courtroom)

3 [09.03.00]

4 MR. PRESIDENT:

5 Please be seated. The Court is now in session.

6 The session today is still on the issue concerning the reports of

7 Professor Campbell regarding the accused person, Ieng Thirith.

8 Yesterday we left off with the completion of the joint session

9 and the session that the Judges of the Bench put questions to the

10 expert. It is now the opportunity for the defence team for Ieng

11 Thirith to put questions to the expert.

12 [09:04:29]

13 MR. PHAT POUV SEANG:

14 Mr. President, Your Honours, I am Phat Pouv Seang, the counsel

15 representing Ieng Thirith.

16 I may seek your permission to allow my colleague to put questions

17 to the expert, please.

18 MS. ELLIS:

19 May it please you, Mr. President, Your Honours, may I indicate

20 first of all that we do not intend inviting the Court to go into

21 closed session at any stage. We have taken the view that this is

22 a matter of great public interest and therefore it should be

23 canvassed as best it can in public.

24 QUESTIONING BY DEFENCE COUNSEL:

25 BY MS. ELLIS:

1 Q. Professor Campbell, there is no doubt that Ieng Thirith
2 suffers from cognitive impairment, is there?
3 MR. CAMPBELL:
4 A. I have found impairment each time I have examined her and
5 that is consistent with the finding of other people who have
6 assessed her.
7 Q. And specifically, the expert report of Dr. Brinded and
8 Professor Ka came to the same conclusion.
9 A. Their findings, two years before I saw Ieng Thirith, are
10 consistent with my findings.
11 [09:06:20]
12 Q. And in order to exclude the possibility that there was a
13 physical explanation for the cognitive impairment the CT scans
14 were undertaken and they revealed no bleeds and no tumours?
15 MR. ABDULHAK:
16 Mr. President, I'm compelled to object to my friend's questioning
17 simply because I think the form of questioning does lead the
18 witness in a particular direction.
19 I think yesterday questions were by and large similar but we
20 didn't object simply because we felt the areas that were being
21 explored were general and it was appropriate to allow all the
22 parties to explore issues fully. I think today the Court will be
23 more assisted in ascertaining the truth and hearing from
24 Professor Campbell if counsel put open questions to him as
25 opposed to putting forward suggestions as to what was contained

1 in the reports, and if we can proceed on that basis that will be
2 the prosecution's submission.
3 MR. PRESIDENT:
4 Counsel Diana Ellis, you may now respond to the objection by the
5 prosecution.
6 [09:07:59]
7 MS. ELLIS:
8 It is our submission that we are entitled to pose questions to
9 Professor Campbell. The question that I put was a confirmation
10 of the methodology and the way in which he reached his
11 conclusion, that there was likely to be a diagnosis that it was
12 Alzheimer's that Ieng Thirith was suffering from. I am simply,
13 in a summary form, I hope for ease of understanding, dealing with
14 the matters that were canvassed in a number of ways yesterday.
15 And with great respect to the Office of the Prosecutor, I do not
16 understand the basis of their objection. This is an expert
17 witness, I am not leading him, he is perfectly capable of
18 answering whether I have understood correctly the process by
19 which he has concluded it is likely the disease is Alzheimer's.
20 MR. ABDULHAK:
21 If I may respond briefly, Your Honour.
22 And just to -- in response to our friend, the difference is
23 simply as follows; if you ask a witness "There is no doubt is
24 there" that a certain fact is true, that is a leading question;
25 no two ways about it.

1 We obviously want to hear from the expert and as counsel has
2 indicated he's already expressed opinions on a number of issues
3 and of course all of the questions being put to him, all of the
4 areas being examined are appropriate but he should be simply
5 asked an open-ended question as to his conclusion as opposed to
6 being suggested what his conclusion was.
7 (Judges deliberate)
8 [09:10:48]
9 MR. PRESIDENT:
10 Thank you, the Co-Prosecutor, for your observation.
11 The Chamber would like to remind and advise the counsel for Ieng
12 Thirith to refrain from putting leading questions.
13 You may now proceed.
14 MS. ELLIS:
15 Q. Professor Campbell, as a result of undertaking the scans
16 did you find any evidence that there was a physical cause for the
17 cognitive impairment?
18 MR. CAMPBELL:
19 A. The scan showed a generalized cerebral atrophy, that's a
20 shrinkage of the brain which would be consistent with Alzheimer's
21 or age-related. The correlation between the changes on the CT
22 scan and cognitive function are not good, would be consistent
23 with either.
24 . Q. Did you find any evidence of tumour? Did you find any
25 evidence of bleeds within the brain?

1 A. No.
2 Q. Did you undertake or were you aware that blood tests had
3 been undertaken in order to see whether there were any
4 deficiencies of vitamins or hormones?
5 [09:12:14]
6 A. I had reviewed all the blood tests on my first visit and
7 reviewed them again this time, there is no evidence of any
8 biochemical abnormality likely to cause cognitive impairment.
9 Q. And is the significance of these tests, the fact that
10 if any deficiencies are noted it is then possible to remedy them
11 by medication, in some appropriate fashion?
12 A. Yes, that is correct.
13 Q. You told us yesterday that you then advised a reduction
14 in the psychotropic medicine that Ieng Thirith was at the time
15 taking and that was in order to allow you to better assess
16 whether those drugs had any effect on her cognitive functioning;
17 is that right?
18 A. That is correct. It is probable that the cognitive
19 impairment is due to a number of different factors of which the
20 medications she was on may be one.
21 Q. But having reduced the medication to the point that she
22 now is no longer taking two of those three drugs you've seen no
23 difference at all in her cognitive functioning; is that right?
24 A. That is correct. On my assessment on this occasion she
25 was a little more alert than on the last occasion but that may

1 well be just a day-to-day fluctuation and I would not necessarily
2 attribute that to the change in medication.
3 [09:13:59]
4 Q. And can you explain, please, what it is that caused you
5 then to decide that it was more likely that she was suffering
6 from Alzheimer 's disease?
7 A. That has always been the most likely underlying
8 problem, it is consistent with the length of time of her
9 deterioration and the impairment that she now has. We have
10 removed one of the possible contributing factors and the
11 cognitive impairment remains.
12 Q. Is Alzheimer 's disease a type of dementia?
13 A. It is the most common cause of dementia.
14 Q. Is dementia a disease which affects both intelligence and
15 mental capacity?
16 A. It does.
17 Q. Does dementia typically lead to memory loss?
18 A. Memory loss is a key feature of dementia.
19 Q. Is another feature a reduction in attention span?
20 [09:15:25]
21 A. It is.
22 Q. Is another feature an inability to undertake everyday
23 normal tasks?
24 A. That is so.
25 Q. Does it lead to difficulties in communication?

1 A. It can affect speech but the more usual problem in
2 communication is disruption of the thought processes prior to
3 communication.
4 Q. So does it follow that if the thought process are
5 disrupted it then becomes difficult to formulate language in the
6 same way?
7 A. Yes, that is so.
8 Q. Does dementia also typically lead to confusion and
9 frustration?
10 A. It very frequently does so because the person is unable
11 to comprehend what is happening around them and misinterprets
12 what is happening.
13 Q. And is it often the case that there are personality and
14 behaviour changes in people suffering from dementia?
15 A. There are and often prior character traits may become
16 more evident in a person with dementia.
17 [09:16:56]
18 Q. And yesterday I think you suggested that in some cases
19 some of the people you see develop behavioural or psychological
20 problems; is that something again that is known to typically
21 occur in patients suffering from this disease?
22 A. Yes, behavioural problems do occur and also other
23 psychiatric illnesses, in addition, for example, depression.
24 Q. From what you told us yesterday it is a disease which
25 more typically affects those over 65.

1 A. The prevalence of the disorder increases quite steeply with
2 increasing age.
3 Q. Is it correct that there are several types of dementia, of
4 which Alzheimer's is one?
5 A. That is correct. And not uncommonly a person with
6 dementia has a mix of two different pathologies.
7 Q. Is there commonly also a vascular dementia that may be
8 mixed with the Alzheimer's?
9 A. Yes, that is correct.
10 Q. Does the vascular dementia arise as a result of blockages
11 to the blood vessels?
12 [09:18:36]
13 A. It can. And it's also associated with high blood
14 pressure and the changes in the small vessels in the brain
15 associated with high blood pressure.
16 Q. Whatever type of dementia, is it a common feature of
17 the disease that it brings about changes in the brain structure
18 causing the death of nerve cells?
19 A. That is correct, there is damage to the nerve cells in
20 Alzheimer's which affects their function and ultimately leads to
21 the death of the neuro or nerve cell.
22 Q. Professor Campbell, what I'd now like to ask you is
23 specifically about the symptoms. Would it be right to say that
24 when you're examining patients you are looking to identify a
25 range of symptoms commonly found in patients suffering from

1 dementia?

2 A. That is correct. Although often in people with

3 dementia the person may not be aware of the symptoms him or

4 herself and information from other people who may have observed

5 problems is very important.

6 Q. And just so that it is clear, that the reason why I

7 seek to ask you about the symptoms is in order to then consider

8 whether Ieng Thirith herself exhibits some or all of these

9 specific symptoms; do you understand?

10 You've mentioned already the significance in this illness of

11 the memory loss, does it start generally with a lack of recall of

12 more recent events and then become progressively worse so that

13 the long-term memory becomes affected too?

14 [09:21:02]

15 A. Yes, that is so.

16 Q. Is it the case that the loss of memory may lead to what is

17 called confabulation?

18 A. That occurs in certain types of dementia, less commonly in

19 Alzheimer's than others. The person may recall events that did

20 not in actual fact occur.

21 Q. Perhaps you could assist in case that term is unclear,

22 as to what is meant by confabulation.

23 A. Well, simply it means making up memories to fill the

24 gaps.

25 Q. Is another symptom that the mobility of the individual

1 may deteriorate?

2 A. Yes, that can occur later on in Alzheimer 's disease,

3 it occurs earlier in certain types of Alzheimer 's disease --

4 sorry, in certain other types of dementia. For example, Lewy

5 body dementia.

6 Q. Do sufferers frequently fail to recognize objects?

7 A. Yes, they may.

8 Q. And have a reduced ability to carry out everyday

9 actions?

10 A. Yes, that is so. Later on they may need guidance with

11 their daily activities.

12 Q. Does it lead frequently to disorientation in time and

13 place?

14 [09:23:01]

15 A. Yes, that is so.

16 Q. Does it have an affect on the judgement of the patient?

17 A. Yes, that is often an important problem early on in

18 dementia and again with certain types of dementia.

19 Q. Does it lead to difficulties in concentration and often

20 cause a loss of a train of thought?

21 A. Yes, that is so.

22 Q. And does it lead patients to frequently focus on pain

23 rather than on abstract concepts?

24 A. I'm not sure that dementia is such -- causes a problem

25 like that. I mean they may have pain symptoms which they are

1 unable to explain and that my cause agitation.

2 Q. And these symptoms that you've agreed are recognized in

3 dementia patients, do they generally get progressively more

4 severe over time?

5 [09:24:27]

6 A. Progression is a characteristic feature of a dementing

7 illness.

8 Q. You've said that you're more likely to get dementia as

9 you get older and you've mentioned high blood pressure as being

10 another indicator; would that be right?

11 A. It's more a risk factor, people with hypertension are

12 at greater risk.

13 Q. And what is the position if people have hypertension

14 over many years does the risk increase the longer you have the

15 condition?

16 A. Yes, Alzheimer's is associated with early high pressure

17 but paradoxically as the Alzheimer's progresses the blood

18 pressure often declines.

19 Q. Is an irregular heart beat another feature that may

20 make dementia more likely?

21 A. No it's not. The research in cardiac rhythm

22 disturbance, for example, atrial fibrillation which increased the

23 risk of stroke but irregular heart beat from other causes, not

24 necessarily, although the risk factors for heart disease are also

25 risk factors for Alzheimer 's disease.

1 Q. What would be the position with somebody who suffered
2 from tachycardia, is that merely an irregular heart beat?
3 A. No, I would not expect that to be associated with
4 dementia.
5 [09:26:15]
6 Q. I'm moving on now, Professor Campbell, and I'd like to
7 ask you about the general medical history, as you will know it,
8 of Ieng Thirith. Firstly dealing with what is known prior to her
9 detention on the 14th of November of 2007.
10 You've seen the report provided by Professor Ka and Professor
11 Brinded and in that -- you're nodding, I think probably for the
12 record it's necessary to say yes or no, please.
13 A. Yes, I have.
14 Q. And in that report there are references to a number of the
15 medical conditions that she has suffered from over the years.
16 It's a matter of record on the case file that the Bumrungrad
17 International Hospital of Bangkok provided records which commence
18 in December 2004. Have you seen any medical history prior to
19 that date?
20 A. No, I have not seen any medical history prior to that
21 date.
22 Q. Did you understand from the report of November 2009 of
23 Professor Ka and Dr. Brinded that Ieng Thirith had suffered from
24 a number of physical disorders, as noted from 2004 to 2007?
25 A. Yes and I reassessed her physical conditions.

1 Q. One of the conditions was anaemia; does that have any
2 relevance to the question of her cognitive impairment?
3 A. No, her blood film has indicated a very mild anaemia on
4 occasions but not one that would be associated with any cognitive
5 impairment.
6 [09:29:05]
7 Q. She has also been diagnosed as suffering from chronic
8 bilateral renal parenchymal disease. That is a disease of the
9 kidneys. Does that in any way have any affect on her cognitive
10 impairment?
11 A. No, her renal impairment is mild and I would not expect
12 it to be associated with any problems with cognition.
13 Q. Is there any known cause of that renal problem; is it
14 related in any way to hypertension?
15 A. It is most likely hypertension and age related. She
16 also has a history of urinary tract infections. I doubt that
17 they have contributed to the deterioration in renal function but
18 may cause an acute -- more acute deterioration in cognition at
19 the time.
20 Q. She's had a diagnosis of arthritis of the spine. Would
21 it be right to say that that does not directly impact on her
22 cognitive impairment?
23 A. That is correct.
24 Q. She has also been diagnosed as suffering from
25 cardiomegaly, is that an enlarged heart?

1 A. Yes. And that will be the result of her hypertension
2 but her cardiac function has been well preserved.
3 [09:30:55]
4 Q. And you say that the noted rhythm disturbances, the
5 tachycardia, described as a sinus tachycardia, that doesn't, in
6 your opinion, contribute in any significant way to her condition?
7 A. No, that is so. A sinus tachycardia is simply the
8 heart, through its normal conduction, beating more quickly and
9 will occur in any situation, such as when she is anxious or when
10 she is more active.
11 Q. But throughout the period from 2004 to 2007 there's
12 clear evidence on the records, isn't there, of a continuing
13 problem of hypertension?
14 A. She has had a long-standing treatment of her
15 hypertension, yes.
16 Q. Does high cholesterol have any impact on a demented
17 condition?
18 A. High cholesterol is associated with increased risk of a
19 vascular dementia and it's also associated with an increased risk
20 of Alzheimer 's disease.
21 Q. Did you have a note of anywhere of her cholesterol
22 level?
23 A. I've seen her cholesterol levels, I can't recall the
24 actual figures but they have never been particularly high, the
25 ones I've seen. Also in Alzheimer 's disease later on the

1 cholesterol levels can decrease.

2 [09:32:33]

3 Q. The only other general condition that I wish to refer

4 to is, again, something that was mentioned yesterday, she had a

5 hip replacement operation on the 7th of January 2006.

6 A. That was as a result of her fracture of the hip.

7 Q. And that fracture was, according to the records, as a

8 result of a fall.

9 A. Yes, she would have had a fall and it was also felt

10 that she osteoporosis, a thinning of the bone which increases her

11 risk of fracture.

12 Q. Prior to having the hip replacement operation on the

13 7th of January you told us yesterday that you were aware that she

14 had had a CT scan, that CT scan was performed on the 6th of

15 January 2006.

16 Would you agree that a CT scan is not one of those procedures

17 that is routinely undertaken in patients?

18 A. No, it's not. There need to be clear indicators.

19 Q. And from the report that you've seen you can confirm,

20 can you not, that the indicator that led to that CT scan was

21 confusion of Ieng Thirith?

22 [09:34:41]

23 A. Yes, my understanding is that she was confused at the

24 time of her hip fracture and that would have led to the CT scan

25 to ensure that there was no blood clot as a consequence of the

1 trauma.
2 Q. And what that CT scan in fact revealed was that there
3 was generalized brain atrophy.
4 A. Yes. I've not seen the actual report but the reviews
5 of the report -- and I've not seen the films themselves.
6 Q. Did you not see -- I beg your pardon. Did you not see
7 the report dated the 6th of January which described the findings
8 on that occasion?
9 A. Yes, I've seen copies of that report and it's mentioned
10 in the Brinded/Ka Sunbaunat report.
11 Q. Thank you.
12 It was after the operation on the hip that it was noted that
13 Ieng Thirith was in some way psychologically affected, that she
14 was dizzy, that she couldn't sleep, and her behaviour gave cause
15 for concern. That response, post-operationally, is more likely,
16 is it not, to occur in a vulnerable patient?
17 A. It is more likely to occur in a vulnerable patient,
18 although can occur in those people with no preceding cognitive
19 impairment.
20 [09:36:45]
21 Q. But while there is already a degree of impairment it
22 may be more likely that there will be post-operative delirium and
23 the other symptoms.
24 A. That's correct.
25 Q. I'm going to come back in a little more detail to the

1 scans but I just would like firstly then to deal in general terms
2 with the medical records and reports that you have seen prepared
3 on Ieng Thirith since she's been within the detention centre and
4 immediately prior to her arrival.
5 You saw -- I think you told us -- the report of the 13th of
6 November 2007 made by the Director of the Bumrungrad
7 International Hospital in which there was reference to her
8 suffering from psychic mental disorder, high blood pressure and
9 chronic kidney failure.
10 A. Yes.
11 Q. And did you note that that report also said that she must
12 take psychic medication regularly?
13 A. Yes, those medications have started at that time and have
14 been continued. They would be expected if there was underlying
15 psychiatric illness but if the problem had been delirium then
16 long-term use would not be recommended.
17 [09:38:55]
18 Q. You can confirm from the material you've seen, can't you,
19 that Ieng Thirith, once she was discharged from the hospital in
20 Bangkok from the 22nd of February through until mid-August of
21 2006 was an out-patient?
22 A. Yes, that is so.
23 Q. And it's also right that in order that she could be cared
24 for in respect of her other physical conditions she was a regular
25 attender at that hospital up until about October of 2007, and

1 that you've seen from the material provided to you, haven't you?
2 A. Yes.
3 Q. So that medication that she was prescribed, including
4 the drugs which are described as psychic medication were
5 prescribed over a lengthy period of time and right up until her
6 admission to the detention centre.
7 A. Yes, as far as I'm aware she has been on those drugs
8 since that time.
9 Q. And as you have agreed, it appears to have been the
10 view of the Bumrungrad Hospital that that medication should in
11 fact continue to be used regularly.
12 A. That was their recommendation at the time.
13 Q. And that date was the 13th of November 2007 wasn't it?
14 A. I would need to take your word on that without going
15 back to check.
16 [09:41:09]
17 Q. Well I have all the document numbers if there is any
18 need or any request for me to refer to the numbers.
19 From the records, again, that we understand you've seen as you've
20 told us, there was an admission to Calmette Hospital on the 22nd
21 of February 2008 when Ieng Thirith was coughing up blood in fact,
22 and at that time, it's right isn't it, that mental trouble was
23 also diagnosed?
24 A. It is indicated in her notes.
25 Q. Her notes also indicate that she was still, in this period,

1 suffering from anaemia, don't they?
2 A. Yes, that is so, that has been in her notes throughout.
3 Q. And then the Calmette Hospital doctors were reporting
4 regularly whilst Ieng Thirith was in the detention centre and
5 you've seen their reports, haven't you, and they commence on the
6 7th of March of 2009 through until mid-August of this year.
7 You've seen those reports also haven't you?
8 A. I've had all those reports, yes.
9 Q. And I'm not going to go through those reports in any detail
10 but would you please confirm that repeatedly she is, in terms of
11 her mental state, described as suffering from mental troubles,
12 nervous episodes and psychic disorder, hypertension and insomnia?
13 [9:43:27]
14 A. That is so.
15 Q. That is the theme that runs through those reports prepared
16 on a very frequent and regular basis isn't it?
17 A. It is.
18 Q. And that is in spite of the continued use of medication
19 designed to calm her and to control any psychological
20 disturbances?
21 A. I think that's a very important point; that those symptoms
22 continued despite the use of the medication. And again,
23 paradoxically sometimes these medications can add to that problem
24 rather than improving it.
25 Q. Could I come on to look at the medications that Ieng

1 Thirith has been taking and the information I take from the
2 document provided from the General Director of Calmette Hospital
3 on the 27th of July of this year.
4 Again, Professor Campbell, that is information that you have seen
5 isn't it?
6 A. That is so.
7 [09:45:04]
8 Q. She was in fact taking some 12 different types of
9 medication; is that right?
10 A. She's on a large number of medications.
11 Q. I hope you trust my arithmetic. She was taking medication
12 for gastric problems; is that right?
13 A. Yes, that is correct.
14 Q. A diuretic to deal with her kidney function?
15 A. And cardiac problems. M'hm.
16 Q. She was taking paracetamol, I think you've indicated
17 you've now suggested an increase in the dose.
18 A. Yes. I didn't feel she was on an effective dose.
19 Q. She was taking a drug for stress and anxiety.
20 A. She was taking the three drugs for stress and anxiety.
21 Q. Is Euphytose one of those?
22 A. Euphytose , I think is a natural remedy, not -- I've slight
23 difficulty with the names as I've used the proper names rather
24 than the commercial names.
25 Q. Whatever it's origin those that take it or given it, it

1 is for stress and anxiety isn't it?
2 [09:46:54]
3 A. Yes, that's so.
4 Q. She was taking Lipitor which is for high cholesterol is
5 it not?
6 A. Yes it is.
7 Q. She was also taking an iron deficiency drug for her
8 anaemia and a drug for her high blood pressure?
9 A. Yes, she's been on drugs for blood pressure.
10 Q. Drugs for her bone preservation?
11 A. She's been on calcium and Vitamin D.
12 Q. And also Zyloric for uric acid build-up; that's
13 actually with kidney function?
14 A. Yes, uric acid can be -- build-up, can be associated
15 with that.
16 Q. And then she was taking the clonazepam. Is that a drug
17 that is prescribed for anxiety and sleep difficulties?
18 A. It is a benzodiazepine drug which is sedating and used for
19 anxiety as well as some specific neurological disorders.
20 Q. The quetiapine which she was at that time being prescribed
21 is a drug, is it not, for bipolar disorder, depression and
22 schizophrenia?
23 [09.48.25]
24 A. Not so much depression. It's used for schizophrenia and
25 bipolar disorders and major behavioural disturbances. It is a

1 major psychotropic drug.
2 Q. That's what I was going to ask you. It is a -- quite a
3 powerful drug. Is it not?
4 A. Yes, it is.
5 Q. And from you've told us the drug reduction of the
6 benzodiazepines has now concluded and the quetiapine reduction is
7 starting. Is that right?
8 A. That is so and the plan was to reduce that over a 4-week
9 period.
10 Q. And am I right that when you proposed the reduction in the
11 quetiapine, you initially met with some resistance from the
12 doctors at Calmette Hospital who were treating Ieng Thirith
13 because they were very concerned that it was, in fact, an
14 important drug to keep her more stable. That's right isn't it?
15 A. That is correct. Would you like me to enlarge on the
16 reasons for the concern and the reasons for proceeding?
17 Q. If you feel it would be helpful, Professor Campbell. I
18 wouldn't want to prevent you enlarging on anything.
19 A. Thank you. I think when a person has been stable on a drug
20 for a long time, as she has on this drug, there is always a
21 concern about change and about rocking the boat if things are
22 reasonably stable.
23 [09.50.24]
24 I think the difficulties though are that if the drug has been
25 started for a particular short-term problem; for example, to

1 manage agitation at the time of delirium, then it is important to
2 review that use and to try the person off the drug. I think
3 often the effects of these drugs if they're on them for a long
4 time, they may not be evident and, therefore, I felt that a
5 cautious reduction under supervision was in her interests.
6 Q. You very helpfully explain the considerations that you had
7 in advising that reduction, but the concerns which have been
8 overcome, as it turns out, of the Calmette doctors was that they
9 were anxious not to destabilize her because they believed it
10 controlled her behaviour helpfully. That's right isn't it?
11 MR. ABDULHAK:
12 Again, Mr. President, if I may be heard, again, we're back to the
13 same format of questioning, I'm afraid. We didn't want to object
14 initially because we don't want to again interrupt, but certainly
15 propositions being put to the expert about the opinions of third
16 parties in the form of a conclusion and then him being asked to
17 confirm are clearly not appropriate.
18 [09.51.57]
19 Some of those conclusions may well be recorded in documents and
20 Professor Campbell can be asked about those documents. But if
21 questions can be put in an open fashion, I think that will assist
22 everyone.
23 MS. ELLIS:
24 Mr. President, I certainly did not understand that where there is
25 a document that makes very clear the position of another doctor

1 and that document is being considered by Professor Campbell that
2 it is inappropriate to put to him the content. I, again, do not
3 understand the nature of the objection being made by my learned
4 friend.
5 It saves an awful lot of time rather than producing a document
6 for Professor Campbell to look at. He has seen this. He's
7 entered into discussions with the other doctors. He is perfectly
8 capable of saying that he doesn't agree that that was the concern
9 and he has confirmed what he knows to be the case. So the
10 objection I don't understand and the form of my questioning being
11 challenged is inappropriate. I don't understand either.
12 (Deliberation between judges)
13 JUDGE CARTWRIGHT:
14 Thank you, President.
15 Ms. Ellis, the President has asked me to indicate that your
16 questioning is getting dangerously close again to putting words
17 into the mouth of the expert. It would be preferable if you
18 would put the portion of the document to which you are referring.
19 Make sure he's read it, of course, and ask him his views on those
20 comments if that's possible for you at this point.
21 Thank you.
22 MS. ELLIS:
23 I have the document in front of me and I will do it in that way
24 if the Court directs me.
25 [09.55.06]

1 Q. Professor Campbell, have you seen the document of the 29th
2 of June of this year from the General Director of Calmette
3 Hospital? It is a document that informs the Court administration
4 of the views of the doctors at Calmette Hospital as to the
5 reduction of clonazepam and quetiapine?
6 MR. CAMPBELL:
7 A. Yes, I have seen that document which was prior to our
8 teleconference.
9 Q. Thank you. And was it -- do you want to have another look
10 at the document to remind yourself of the contents or are you
11 content for me to read it to remind you of the specific paragraph
12 I'm asking about?
13 JUDGE CARTWRIGHT:
14 Ms. Ellis, would you be able to quote the reference number for
15 the record, please?
16 MS. ELLIS:
17 The document I have has no reference number on it, but I will
18 provide it to the Trial Chamber when we have our short break, if
19 I might do that.
20 MS ELLIS:
21 Q. What is stated in the document signed by Dr. Chheang Ra,
22 the relevant passage is "quetiapine should not be reduced and
23 stopped permanently as her state of health has improved and been
24 stable so far due to her having been taking this medicine from
25 before 2007."

1 [09.57.22]

2 MR. CAMPBELL:

3 A. Yes, I'm aware of that paragraph and I think it is very

4 difficult to attribute the stability of her condition or any

5 improvement, if there was improvement, to the drugs given that

6 there had been no change in the drugs during that time.

7 Q. Could I now, please, move on with you to consider the CT

8 scans conducted on Ieng Thirith and I'm only asking you about the

9 brain scans?

10 The first scan that is known about is that scan of the 6th of

11 January 2006. From what you've said, you have not had an

12 opportunity to see the original scan, but only the report as set

13 out in the expert report of Professor Ka and Dr. Brinded. Is

14 that right?

15 A. That is right.

16 [09.59.53]

17 MS. ELLIS:

18 If the Court just gives me a moment.

19 (Short pause)

20 MS. ELLIS:

21 Q. You saw, I believe you told us yesterday, a set of

22 questions that we had prepared at the request of the Court for

23 you to consider in the preparation of your report. Do you

24 remember that?

25 A. Yes, I have and I've reviewed those.

1 Q. I want to ask you then if you can tell us whether there is
2 any significance to certain factors shown up on the scan report,
3 "multiple, hyper-dense foci in the peri-ventricular deep and
4 sub-cortical white matter of both frontal lobes." Is that
5 significant in any way?
6 A. What those changes are consistent with is the sort of brain
7 changes one sees in a person with long-standing hypertension.
8 The difficulty though is that those have been not really a
9 significant feature of the subsequent scans and those changes
10 would be permanent. That's why it is difficult to comment
11 without seeing the actual scan itself.
12 Q. Is there any significance to the reference to the frontal
13 lobes?
14 A. It's the frontal lobes that are characteristically affected
15 in this condition.
16 Q. If the frontal lobes are affected does that have any effect
17 on the cognitive functioning of the patient?
18 [10.01.52]
19 A. Frontal lobe change is very important. The frontal lobes
20 are critical in ones judgement, initiation of activity, planning
21 and also self-restraint.
22 Q. And you say that any changes in that part of the brain are
23 permanent so that the drug that you're suggesting Ieng Thirith
24 should be prescribed will have no effect on that?
25 A. The drug I'm suggesting, its effect has been primarily on

1 Alzheimer's disease not in vascular dementia and the changes that
2 are suggested here are consistent with vascular changes. As I've
3 said, they have not been so evident in subsequent scans.
4 Q. And why did you say that was?
5 A. It is difficult to explain without seeing the changes,
6 themselves, on the original scan.
7 Q. Another feature noted -- could I just indicate that this
8 document is on the case file. The ERN number if it's wanted is
9 00157503. The ventricular system and the CFS spaces were
10 slightly and moderately dilated. Does that tell you anything in
11 respect of the functioning cognitively of Ieng Thirith?
12 A. As I said before, this is the real difficulty with CT scans
13 such as this. The changes would be consistent with Alzheimer's
14 disease, but also can be seen in older people with well-preserved
15 cognitive function.
16 [10.03.57]
17 Q. The conclusion of the doctor that prepared that report, I
18 quote, was "there's generalized brain atrophy with multiple
19 hyper-dense foci in the basis pontis and bilateral frontal white
20 matter suggested of small-vessel disease and/or other
21 non-specific age-related white matter change."
22 A. Yes, I've seen that report.
23 Q. Generalized atrophy, is that brain shrinkage?
24 A. It is.
25 Q. Does the brain, if it shrunk, ever swell up again?

1 A. No, it doesn't.
2 Q. Quite clearly from what you've said, it's very difficult
3 for you to comment without seeing the original scan, but would it
4 be your opinion -- and tell me if it's not -- that the findings
5 are consistent with early dementia?
6 A. Those reported findings would be consistent with early
7 dementia.
8 Q. Moving on then to the next of the scans that are recorded
9 in the documents, there was a scan on the 13th of November 2007
10 and that was, it is said, done without injection. Did you see a
11 report of that scan and did you see the original scan?
12 [10.06.15]
13 A. Yes, I've seen the scans and the reports.
14 Q. Did that ---
15 MR. PRESIDENT:
16 Ms. Ellis, could you please hold on a moment. Counsel Son Arun
17 is on his feet.
18 You may proceed.
19 MR. SON ARUN:
20 Forgive me for interrupting the Court proceeding, but my client,
21 Nuon Chea, has severe headache that he cannot remain sitting in
22 this courtroom. May he be excused and return to the detention
23 facility, if you may?
24 MR. PRESIDENT:
25 Upon having (inaudible) of the request and since Nuon Chea

1 indicated that he has have concern and that he be excused from
2 the proceedings and, of course, this hearing is for Ieng Thirith;
3 not for Nuon Chea, however, the application that Nuon Chea be
4 returned to the detention facility is not possible because there
5 will be a follow-up session that Nuon Chea have to be present.
6 At this moment, Nuon Chea is excused, indeed, but he can only be
7 returned to the holding cell; not the detention facility and he
8 will be on stand-by to participate in the session dedicated for
9 individualized session.
10 Security personnel are now instructed to take Nuon Chea to the
11 holding cell.
12 Counsel Diana Ellis, you may now proceed.
13 MS. ELLIS:
14 Q. The scan of the 13th of November 2007 is described as being
15 done without an injection. Could you explain what is the
16 difference when a scan is undertaken where there has been an
17 injection and where there hasn't?
18 [10.09.18]
19 MR. CAMPBELL:
20 A. With a CT scan done with an injection of contrast media,
21 this is useful for showing up a situation where; for example, the
22 person may have an underlying tumour. It is used with care
23 because it can cause problems in people with renal impairment.
24 Q. What did you note when you reviewed that scan of the 13th
25 of November 2007?

1 A. That scan, again, showed generalized cerebral atrophy;
2 brain shrinkage.
3 Q. The next occasion on which a CT scan was performed was on
4 the 13th of October of 2009. Did you, in fact, see that scan? I
5 don't think it's referred to in your report where you set out the
6 different scans that you have had an opportunity to consider.
7 In your expert report, you refer to at paragraph 6(c) on page 3
8 that you saw the medical reports that we've been going through on
9 hospital admissions, appointments and investigations and you
10 refer -- I beg your pardon, you in fact refer to the 13th of
11 October 2007 which would appear to be an error and that was
12 November 2007. So would you agree you didn't see one in October
13 2007; it was November 2007?
14 A. Yes, that is correct. And I've checked that again on this
15 occasion.
16 Q. Thank you. And then the next scan that you refer to of the
17 head is the 22nd of October 2009?
18 [10.11.51]
19 A. Yes, that is so. That was the most recent scan prior to my
20 seeing her on the first occasion and on this occasion, I've
21 reviewed her latest scan.
22 Q. So it follows from what you're saying that although we have
23 been provided with a document E110/4/2.3.9 which is a scan
24 undertaken on the 13th of October 2009 that was something you did
25 not see yourself or did not know had been (inaudible). Is that

1 right?

2 A. Could we just clarify that? There was, you say, a scan on

3 the 13th of October 2009?

4 Q. Yes, that's the information that we've been provided with

5 and the number of the document I've provided to the Court.

6 A. Did you have another scan of the 22nd of October because

7 that's the date I've noted here?

8 Q. Yes, yes.

9 A. I suspect that there was only one scan and that the dates

10 are wrong there.

11 Q. I was going to ask you whether there would be any reason

12 why two scans would be undertaken within such a short space of

13 time.

14 A. No, there would have been no reason. I suspect that it's

15 the same scan.

16 [10.13.16]

17 Q. Is it ever advisable to undertake a CT scan unless it's

18 thought to be necessary in the diagnosis of a condition?

19 A. No, not at all.

20 Q. And why is that?

21 A. Because it's unlikely to show up anything of significance,

22 it is expensive and there is radiation exposure.

23 Q. When you looked at the scan of the 22nd of October 2009,

24 did you have an opportunity to compare it with the scan taken two

25 years earlier in 2007?

1 A. Yes, I reviewed those scans.

2 Q. In reviewing them, what was your conclusion as to what they

3 showed?

4 A. All the scans that I have seen have shown a generalized

5 cerebral atrophy.

6 Q. Have they also shown the temporal lobes -- the frontal,

7 temporal lobes to look atrophied?

8 A. That is part of the generalized cerebral atrophy.

9 [10.14.42]

10 Q. And the significance of the atrophy of the frontal lobes is

11 the lobes are important, as you've told us, in controlling

12 behaviour, emotion. Damaged lobes can cause people to

13 confabulate; can they?

14 A. They can cause those changes, but it's important, as I've

15 said earlier, to note that there is not a good correlation

16 between the signs and the degree of atrophy on the CT scans.

17 Q. Is that because it's possible to have a degree of

18 generalized brain atrophy and yet not exhibit any external

19 symptoms?

20 A. Yes, that is so.

21 Q. And is that why you attach the significance that you do to

22 the behaviour, the examination and the observations of others?

23 A. Yes, the CT scans need to be viewed as part of the overall

24 picture. They do not in themselves provide a diagnosis.

25 Q. How easy is it to make comparisons between scans perhaps

1 performed on different machines?
2 A. Yes, that can be difficult although if there is definite
3 progression that should be evident.
4 Q. Did you note or were you in a position to note whether
5 there had been any progression that was visible from the scans
6 between 2007 and 2009?
7 [10.16.43]
8 A. I think through to -- as I've said, the scans I've seen
9 over that time through to the last scan in June, I would not say
10 that there had been significant change in the degree of cerebral
11 atrophy. I do not feel I could comment accurately on that.
12 Q. Are you, therefore, saying that some changes have occurred,
13 but you wouldn't put any particular weight on them?
14 A. Yes, that is so.
15 Q. Thank you. Now, I would like to move on to paragraph 25 of
16 your expert report of the 23rd of June of this year.
17 That is page 9 of the report, paragraph 25, E62/3/6. I simply
18 want to go through with you some of the aspects of your testing
19 that haven't already been referred to in court. You've told us
20 some of the tests that you undertook. I really just want to deal
21 in a little more detail with some of the others.
22 Firstly, I look at your report in the form of a letter to the
23 Court the 13th of May 2011 where at paragraph 5 on page 2 you say
24 that you noted severe (inaudible) on formal mental testing. One
25 of the tests involved asking Ieng Thirith to recall objects.

1 Were these objects that she was shown or were they pictures?
2 [10.19.47]
3 A. In this particular test, the MMSE, one names three objects,
4 asks the person to repeat them so that one can be sure that they
5 have heard and understood and then later on in the examination
6 after some other tests have been done asks the person to recall
7 those three objects.
8 Q. So that you having stated three objects, she was able to
9 recall two immediately, but could remember none on the delayed
10 recall. That was the position; wasn't it? Weren't there over
11 the ---
12 A. Yes.
13 Q. Sorry?
14 A. Yes, that is so.
15 Q. I'm not going to go over the numbers. You described that
16 yesterday.
17 You then did the 3-step folding test. She completed the first
18 two steps, but not the third. Just so we can be clear, what is
19 the nature of that test? What is she being asked to do exactly?
20 A. She's been asked to sequence a series of events -- a series
21 of actions and so one asks the person to take a piece of paper in
22 the right hand, to fold it in half and then to put it on the
23 floor and she was able to take it in her right hand, fold it in
24 half, but by that stage had forgotten the third command -- the
25 third request.

1 [10.21.26]
2 Q. You then say she was able to name a pen and a watch, but
3 not able to name the animals shown in the pictures in the
4 Montreal assessment. Again, are you showing her pictures?
5 A. With the pen and the watch, they're actual objects and this
6 is testing for two things; naming ability, language, but also
7 visual recognition which can be impaired. With the animals in
8 the (inaudible) they are clearly pictures.
9 Q. You didn't parade them in. And then you tested her. She
10 was able to repeat a sentence, but when writing a sentence she
11 lost the sense of what she was writing before completion?
12 A. Yes, that is so. She started to write the sentence and
13 then lost her train of thought during that and was unable to
14 complete it.
15 Q. And are we talking about a sentence which is very lengthy,
16 a large number of words, or a very simple -- simply constructed
17 sentence?
18 A. One asks the person just to write a sentence; it can be any
19 sentence that they wish. So they make the sentence up.
20 Q. So she is unable to actually write? You say that the
21 sentence she, herself, has created first of all?
22 A. Yes, she had trouble completing that task; completing that
23 sentence.
24 [12.23.15]
25 Q. And then you said that she was unable to reproduce the

1 intersecting pentagons and attempted to add-on to the original
2 diagram.
3 A. This is really a test to construction or function and what
4 she demonstrated -- she demonstrated in a number of tests the
5 tendency to perseverate; that is, to continue on with an action
6 even though it's been completed. Interestingly, on repeating the
7 intersecting pentagons, on this occasion, she was able to
8 complete that.
9 Q. You say she was able to read the instruction, "close your
10 eyes" which was written in Khmer, but she could not grasp she was
11 being asked to carry out that instruction?
12 A. Yes, one asks the person to carry out what is being written
13 here and one writes in this situation in Khmer, "Close your eyes"
14 and although she could read that, she didn't continue to complete
15 the instruction.
16 Q. And you've already described the difficulty she had with
17 the alternating trail making test and in respect of the clock
18 face so I won't go through those further.
19 And it was that that led you to consider there was severe
20 impairment. Would you agree these are very basic tests?
21 A. Yes, as I've indicated, I thought they indicated a moderate
22 impairment.
23 [10.24.54]
24 Q. Can I move on now, please, to the behaviour of Ieng
25 Thirith? You have seen, haven't you, the letter written by the

1 Director of the detention centre on the 16th of March of 2009 in
2 which he provides the table showing that on 24 occasions between
3 the 7th of November 2008 and the 11th of March of 2009 the
4 behaviour of Ieng Thirith had given cause for concern?
5 A. I don't think I have seen that table.
6 Q. It is set out in a document B37/2.
7 MS. ELLIS:
8 Does it assist the Court to have the ERN number?
9 JUDGE CARTWRIGHT:
10 Apparently, it doesn't assist to have the ERN number. I think
11 we're looking for the document under the B37 ---
12 MS. ELLIS:
13 It's B37/2.
14 JUDGE CARTWRIGHT:
15 Thank you. Perhaps it could be put up on the screen. Would that
16 assist Ms. Ellis?
17 [10.26.39]
18 MS. ELLIS:
19 Definitely, it would assist. Thank you very much.
20 MR. PRESIDENT:
21 Court official is now instructed to project the document on to
22 the projector.
23 (Short pause)
24 JUDGE CARTWRIGHT:
25 I think it's preferable not to -- on reflection, having read the

1 document, myself, for the first time as well, it's preferable not
2 to put this on the screen, Ms. Ellis, because of the very
3 specific comments made in it. But perhaps if Professor Campbell
4 can simply look at it and you can put appropriate questions,
5 please.
6 [10.29.20]
7 MS. ELLIS:
8 Yes. Could we then, please, take it off the screen? Thank you.
9 MS. ELLIS:
10 Q. Professor Campbell, you -- it's quite quick to look through
11 it. You've now seen it. That indicates, doesn't it, in terms of
12 the dates, that between the 7th of November 2008 and the 11th of
13 March 2009 that is on 24 occasions between those dates there was
14 behaviour by Ieng Thirith which was insulting and gave concern to
15 the Director who then wrote to the Co-Investigating Judges.
16 MR. CAMPBELL:
17 A. That is indicated in the document.
18 Q. Thank you. Did you then see that the Director wrote again
19 on the 27th of July of 2009 making further complaints of her
20 irregular, inappropriate behaviour between the 15th of March of
21 2009 and the 5th of July of 2009 inciting 26 incidents and that
22 is B37/5?
23 A. No, I've not seen that document either.
24 MS. ELLIS:
25 Mr. President, could I just again pass the document to Professor

1 Campbell without the need to put it on the screen so he can
2 confirm the content of it? It is a document that I think we only
3 have in French, but as I understand Professor Campbell won't be
4 challenged in a way that makes it impossible for him not to
5 assist.
6 MR. PRESIDENT:
7 Counsel Diana Ellis, how many more questions would you wish to
8 put to the expert?
9 [10.33.02]
10 MS. ELLIS:
11 I have a number of questions on the report that he prepared and
12 the content of Professor Ka and Dr. Brinded. May I inquire ---
13 MR. PRESIDENT:
14 Thank you for this indication. Since it is an appropriate time
15 for adjournment, the Court will take the adjournment for 20
16 minutes. We will resume at ten to eleven.
17 (Court recesses from 1033H to 1057)
18 (Judges enter courtroom)
19 THE PRESIDENT: Please be seated. The Court is now back in
20 session.
21 We now hand over to Ms. Diana Ellis to proceed with her remaining
22 questions.
23 MS. ELLIS:
24 Thank you, Mr. President.
25 Q. Professor Campbell, have you had an opportunity to look at

1 that document from the director of the detention centre dated the
2 27th of July of 2009?
3 MR. CAMPBELL:
4 A. I have. It stretches my school boy French but I think I
5 have got the general understanding.
6 [10:58:10]
7 Q. And do you agree again, essentially, it is indicating a
8 further 26 occasions between the 15th of March of 2009 and the
9 5th of July of that year when there were -- seemed to be
10 behaviour which was considered inappropriate and insulting and
11 irregular, really encapsulates the concerns?
12 A. Yes, that is how it's been viewed.
13 Q. I'm going to ask you to look at another letter because it
14 is also from the director, and if you haven't had access to the
15 previous two you probably haven't seen this. And for the
16 assistance of the Court it is B44. If I might hand it up to
17 Professor Campbell please.
18 THE PRESIDENT: The court officer is now instructed to hand over
19 the document to the expert.
20 MS. ELLIS:
21 Q. Again, Professor Campbell, this is a letter, is it not,
22 sent by the director of the detention centre? It's dated the
23 19th of May of 2010.
24 MR. CAMPBELL:
25 A. Yes, it is.

1 Q. And it is a letter that is directed by way of a report to
2 the Co-Investigating Judges, as indicated in the title?
3 A. That is correct.
4 [11:01:01]
5 Q. And of significance for our purposes I simply would ask you
6 to confirm this; that it sets out that Ieng Thirith was placed in
7 the detention centre on the 14th of November of 2007?
8 A. That is correct.
9 Q. That for the next year she was observed and did not cause
10 any problems?
11 A. Correct.
12 Q. And it then indicates that as from the month of October
13 2008 she became unruly?
14 A. Correct.
15 Q. By 2009 it was creating a bad atmosphere in the unit and
16 she was raising her voice a lot in 2010?
17 A. Correct.
18 Q. And without going into the details of the behaviour, would
19 you agree that it appears that once she started to misbehave in
20 late 2008 she was becoming progressively worse?
21 A. I think there are two important issues. I think firstly
22 the progression, as you have indicated. I think the other issue
23 is that in the earlier reports the antagonism was much more
24 focused and directed. In this report it indicates a wider
25 pattern of abuse and disinhibition.

1 [11:02:56]

2 Q. And does the director also describe an incident where she

3 used inappropriate material in the course of trying to take care

4 of herself? Again without going into details, it's the last

5 sentence of the first paragraph.

6 A. Yes, it does.

7 Q. Would that perhaps indicate that she was again losing the

8 ability to really act appropriately and care for herself

9 appropriately?

10 A. Yes, that is consistent with that.

11 Q. Thank you. Again concerning behaviour, you've touched on

12 the fact that you had the benefit of considering DVDs of the 24th

13 of February of 2009 and also in February 2010. You've already

14 mentioned that, and that you also read the transcript of one of

15 those hearings.

16 Would it be right to say that -- and you referred to this in your

17 report -- that they show her to have some memory impairment then?

18 A. Yes, the memory impairment was with respect to her husband

19 and her husband's name.

20 Q. And also she failed to recall the number of children that

21 she had?

22 A. Yes, that is correct, and on other occasions as well.

23 Q. And did you also notice that in speaking she appeared to

24 move without obvious reason from one topic to another?

25 [11:0515]

1 A. Yes, it appeared that her thoughts did not logically
2 progress and that she did go off on tangents.
3 Q. In your expert report at paragraph 10 on page 6 -- I'm
4 sorry, that's not the reference I wanted to give you so please
5 ignore that. You've also spoken, I think, to medical staff and
6 they have noticed fluctuations in her memory and more marked in
7 recent memory?
8 A. Yes, the problems have been with both recent and past
9 memory but recent memory.
10 Q. And that's at paragraph 11 of your report, not paragraph
11 10.
12 And from their observations of her, they find that she -- and I
13 quote from your report -- "sometimes talks to herself usually
14 about the past and her youth"?
15 A. Yes, that is correct.
16 Q. Would you describe that as normal behaviour?
17 A. No, not in this context.
18 Q. And she currently speaks of matters not relevant to the
19 clinical assessment. Is that in any way indicative of an
20 inability to focus on the matter in issue?
21 [11:07:18]
22 A. Yes, that does reflect a problem with focus and with
23 concentration.
24 Q. And at paragraph 13, again dealing with the observations of
25 those working with her, did they inform you that she now usually

1 needs staff to provide direction?

2 A. Yes, I understood from them that she often requires

3 direction and can become lost within the detention centre and on

4 occasions does not recognize her own room.

5 Q. So that one of the symptoms we looked at earlier of

6 disorientation in place appears to be exhibited there, does it?

7 A. Yes, that's how I interpreted it.

8 Q. And that is disorientation within a very enclosed

9 environment where she has been for nearly four years?

10 A. Yes, it's not a complex environment.

11 Q. Did you find that she on occasion was mistaking her

12 grandchildren for her own children? Again I've taken this from

13 paragraph 13.

14 A. Yes, getting a proper account from her of what family she

15 had and where they were and how many grandchildren she had.

16 Q. You also decided, didn't you, that you would speak with her

17 husband, Ieng Sary, in order to get his impression of any changes

18 that he might have observed. Is that right?

19 A. I did.

20 [11:09:42]

21 Q. And is it right that you recorded that he had said there

22 had been great changes and she keeps forgetting things?

23 A. Yes, those are direct quotes from my discussion with him,

24 obviously having gone through the translator first.

25 Q. And he told you that she forgets her eldest sister and

1 parents have died, even though he keeps telling her that they
2 have?
3 A. Yes, that is so.
4 Q. Is this a recognized symptom that arises in people as they
5 become demented; that they often fail to recall the death of
6 close family members?
7 A. Yes, that does occur in moderately severe dementia and they
8 can mistake family members. They can fail to recognize
9 long-standing family members, such as their husband, for example.
10 Q. And her husband was also to tell you that she doesn't
11 recall that she was ever a minister or details of the date of the
12 -- significant dates for the regime?
13 A. Yes, that is what Ieng Sary told me.
14 [11:11:16]
15 Q. And he told you the change was gradual, did he?
16 A. He felt there had been a progression, a deterioration,
17 since her admission to the detention centre.
18 Q. And he said that she can forget where she's sleeping?
19 A. That is so.
20 Q. He also said that she in the past had rarely got angry but
21 now got angry out of, he thought, frustration?
22 A. Yes, that is so.
23 Q. That she can lose control of her speech and talks to
24 herself?
25 A. Yes.

1 Q. Now, it might be said that of course he is not a
2 disinterested party. On the other hand, would it be fair to say
3 that those observations made by him in fact you had heard
4 independently in many instances, as we've just been through
5 earlier, from other carers or people who had close contact with
6 her?
7 A. Yes, I felt that the observations he made were consistent
8 with the other observations that I had heard from other people.
9 [11:12:42]
10 Q. I asked you yesterday whether the family history had any
11 relevance to the issue of what condition Ieng Thirith might in
12 fact be suffering from. It's well documented that her sister
13 suffered from serious mental health problems. Schizophrenia's
14 been mentioned. Do you consider that that factor may give Ieng
15 Thirith a genetic disposition to dementia?
16 A. Not to dementia, no.
17 Q. Hanging in the air is, to something else. What would that
18 be?
19 A. I'm not an expert on the inheritance of schizophrenia so I
20 couldn't comment on that.
21 Q. It's also documented that her mother suffered mental
22 illness. Might that have any relevance?
23 A. No, I don't think that is an important factor. As I said
24 yesterday, the inherited factors in dementia are of more
25 importance in young people -- younger people -- rather than

1 people of Ieng Thirith's age.

2 Q. Now, I'd like to come on to look at the two expert reports

3 that the Court has requested over the past few years. You've

4 seen and read and considered the report of the 22nd of November

5 2009 of Professor Ka and Dr. Brinded. Is that right?

6 A. I have.

7 Q. And Dr. Brinded is apparently an English speaking doctor, a

8 forensic psychiatrist from New Zealand?

9 [11:14:58]

10 A. That's correct.

11 Q. If we turn to paragraph 6 of that report please -- page 6 I

12 think it is. It's page 6. There are not paragraph numbers. And

13 the report is B37/9/8 for the record.

14 Professor Campbell, what I want to do is, so everyone is clear,

15 is look at the impression the two doctors gained of Ieng Thirith

16 in October/November 2009 and see where there might be differences

17 when you come to examine her nearly two years later.

18 In the report -- and do you have it in front of you? Thank you.

19 And I'm looking at the paragraph which commences -- the second

20 paragraph down -- "In summary". I'm not going to read it I'm

21 going to make points from it.

22 They say they spoke at length about her arrest and detention with

23 her. They say they spoke about the charges. They say they spoke

24 at considerable length and they spoke in considerable detail.

25 They say she spoke of significant events. They say she spoke of

1 her life as a student in Paris, and she spoke of the death of
2 students. They say that she used English and French as well as
3 the Khmer language. And they say at paragraph 7 that her speech
4 flow was normal and that she was orientated in time and place.
5 Do you agree that that is all contained in that particular
6 section of the report?
7 [11:18:00]
8 A. Yes, I agree.
9 Q. Thank you. They describe that she was aided at one stage
10 by the use of a written document. Do you agree that it does not
11 anywhere state that she was the author of that document?
12 A. No, it does not state that.
13 Q. They were able to ascertain from her that she understood
14 the role of her lawyers and the charges that she faced. Is that
15 right?
16 A. Yes, they indicate that.
17 Q. They went on to say that she had an impaired short-term
18 memory and complained that she couldn't remember dates and had
19 difficulty in answering lengthy questions, and at times she
20 confused the chronological sequence of events, and when she was
21 asked stressful questions she returned to key events. Is that in
22 that report?
23 (No interpretation)
24 MS. ELLIS:
25 Q. Would the fact that she had difficulty answering lengthy

1 questions in November 2009 be an indicator that there are
2 problems to do with her cognitive functioning perhaps at an
3 earlier stage?
4 MR. CAMPBELL:
5 A. Yes, that was a conclusion that they drew from the
6 interviews.
7 Q. And again, is there difficulty in sequencing events in
8 chronological order an indication of a cognitive impairment?
9 [11:20:33]
10 A. It can be. It depends very much on the complexity of the
11 sequencing and how important they were to the person. I mean, we
12 all have troubles at times but it depends very much on the
13 circumstances.
14 Q. At page 7 they state that it was obvious from her behaviour
15 at times that she had experienced a degree of psychological
16 trauma due to her life events, and that is something I think
17 you've agreed with, as you've told us?
18 A. Yes, that is so. I think this is a very complex situation
19 with a number of factors contributing to the problems.
20 Q. We've already dealt with their conclusions, which were that
21 she was suffering from mild cognitive impairment. That is on
22 page 9 of the report. They also identified and refer to a mild
23 paranoid thinking. Can mild paranoid thinking again be an
24 indicator of dementia?
25 A. Yes, it can be. For example, if a person losses something

1 they can feel it's been stolen, and there have been instances of
2 that.
3 Q. And it's clear from the final passage in the report that
4 they understood there would need to be a reassessment at a stage
5 closer to the trial proceedings?
6 A. That's their conclusion.
7 [11:22:53]
8 Q. Now we come onto your examination conducted, as you've told
9 us, over a significant period of time, and you reported on the
10 23rd of June of this year. The picture that you found was very
11 different from that painted by the report of Dr. Brinded and
12 Professor Ka, wasn't it?
13 A. Yes, there were undoubted differences.
14 Q. When you wrote to the Court on the 13th of May, on the
15 second page, the first point you make is that she had very poor
16 concentration with an inability to maintain focus or sustain a
17 conversation and topic.
18 A. Yes, and that had been quite different from the earlier
19 report.
20 Q. You can correct me if I'm wrong, but it appears, going
21 through your report, that you didn't have any what might be
22 called normal conversation with her over more than a minute or
23 two?
24 A. Yes, that is so. It was obviously difficult going through
25 the interpreter, but I also spoke with the interpreter to see if

1 the lack of flow in the conversation and the sentencing was due
2 to the interpretation or if that was because of problems that
3 Ieng Thirith was having, and he felt that it was with the
4 problems that she was having expressing herself.
5 Q. And in your report at paragraph 15 you say that Ieng
6 Thirith had difficulty understanding the purpose of the
7 consultation. Is that right?
8 A. Yes, and I returned to that the next day and she could not
9 recall the purpose of my visit.
10 [11:25:22]
11 Q. She told you that she was fearful -- and I quote -- about
12 problems with her head and it was difficult for her to see her
13 students but she couldn't say why?
14 A. That's right. And in the report of two years previously,
15 it's evident from the comments made there, that she kept
16 referring back to her students.
17 Q. Was it your impression that she thought that she was still
18 in some way actively engaged with her students?
19 A. Well, she spoke of her students as though they were a very
20 present issue, and yes, that she was still engaged with them.
21 Q. She complained, you say, in the same paragraph, of leg
22 pains frequently, and also mentioned her students, but she
23 couldn't again say when the pain had started?
24 A. No, I've not on any of the occasions been able to get an
25 accurate history of the leg pains.

1 Q. Might it be the case that the constant reference to the leg
2 pains is due to an inability to more accurately describe the
3 difficulties and discomforts that she experiences?
4 A. I think when she has any difficulty understanding the
5 questions or the conversations then that is her way of diverting
6 away from her inability to respond appropriately.
7 [11:27:22]
8 Q. We know from what you've told us that she had observations
9 by doctors at Calmette to see whether there were any arthritic
10 changes, any problems in her knees, in her movement, that might
11 have given rise to the degree of pain that she has constantly
12 expressed and nothing of significance was found. That's right,
13 isn't it?
14 A. That is so, and I also did not find any problems really on
15 examination of knees and ankles.
16 Q. The arthritis that is identified is in fact the arthritis
17 of the spine?
18 A. She does have wear and tear changes in her spine, that's
19 true. And with knee arthritis, large joint arthritis, again,
20 there's often not a particularly good correlation between, for
21 example, x-ray changes and the degree of discomfort, so that I
22 would not dismiss her pain as being due to arthritis involving
23 her joints.
24 Q. But do you think her constant reference to pain might also
25 be due to some aspect of her lack of full cognitive functioning?

1 A. Yes, I think that is a factor.
2 Q. At paragraph 16 of your report you say that she showed
3 little emotion. I use the word "emotion". You use the word
4 "affect". Is it the same?
5 A. Yes, it is.
6 Q. Thank you. Emotion is the more familiar word generally,
7 That she became agitated at her inability to answer questions.
8 Did that suggest to you that she would like to or wanted to
9 answer questions but just could not?
10 [11:29:28]
11 A. Yes, I think she was frustrated by her inability to
12 understand what was happening.
13 Q. To take up questions that have been posed by the Court, you
14 didn't get the impression that this was a woman who was quite
15 cunningly trying to pretend that she had a lack of understanding.
16 You rather believed that she simply could not deal with the
17 matters she was faced with. Is that right?
18 A. Yes, I was very conscious of that issue and I did not feel
19 that she was deliberately trying to mislead.
20 Q. You describe a difficulty in concentrating and in
21 maintaining focus and that any conversation went off on tangents
22 and didn't remain on the issue that was being discussed?
23 A. Yes.
24 Q. And bearing in mind that two years earlier there had been a
25 reference to her language skills in French and English. She's

1 known and documented to have spoke both those languages fluently,
2 as well as Khmer. You note that she spoke mainly in Khmer with
3 you, only occasional French and English. Is that right?
4 A. That's correct.
5 Q. And I won't ask you about French because you indicate a
6 little challenge there, but in respect of English, would you
7 agree that she could no longer be described as a fluent English
8 speaker?
9 [11:31:23]
10 A. I would have difficulty commenting on that. She was not
11 fluent in English in my discussions with her but then she was
12 working mainly in Khmer not in English.
13 Q. But every question was asked in English?
14 A. It was.
15 Q. Again a loss of language skills is a feature as people
16 begin to become cognitively impaired, is it not?
17 A. Yes, it is.
18 Q. You've already mentioned the matters set out at paragraph
19 17. She didn't -- wasn't able to name the building where she was
20 located or indeed the purpose of that building. In other words,
21 she didn't know that she was being effectively detained in a
22 prison?
23 A. Yes, she certainly was unable to answer the questions about
24 where she was and the purpose of the building and why she was
25 there.

1 [11:32:34]
2 Q. It's a common question to ask somebody who may be demented
3 if they know the date, isn't it?
4 A. It is.
5 Q. She gave you the wrong date, didn't she?
6 A. Yes.
7 Q. Indeed, she gave you a date of the 10th of March?
8 A. Which is her birthday, as far as I understand.
9 Q. Thank you. That was the question I was going to ask if you
10 knew. She gave you the same date of the 10th of March for both
11 her wedding and the date of the interview, didn't she?
12 A. She did.
13 Q. But am I right that when you asked her her birthday she
14 didn't know, in fact, the date of her birthday?
15 A. No, that's right.
16 Q. And she didn't know how old she was?
17 A. No, she didn't know her age.
18 [11:33:37]
19 Q. Paragraph 18: She thought that her parents were also in
20 the building and were telling her what to do?
21 A. That is so. In subsequent discussions I've been made to
22 understand that that may be a Khmer belief that those who are
23 dead are still with the person and may be supporting them. So I
24 have difficulty actually interpreting those particular comments.
25 Q. But of course you had already, as we know from your

1 evidence today, and as you set out in paragraph 14, heard from
2 her husband that he said that she forgets that her parents and
3 elder sister have died even though he keeps telling her they
4 have. Would that not suggest that it is an explanation other
5 than the fact that as Khmer she believes her parents are still
6 with her?
7 A. That is correct. But given the cultural issues, I am a
8 little hesitant.
9 Q. You wouldn't want to base a diagnosis on it?
10 (No interpretation)
11 MS. ELLIS:
12 Q. She told you that she was married in Cambodia when in fact
13 it's well known, as you learnt, I think, that she was married in
14 France. Is that right?
15 MR. CAMPBELL:
16 A. That's correct.
17 [11:35:17]
18 Q. And she also said that she had no children that she's given
19 birth to naturally she had adopted children?
20 A. Yes, that was the response I was getting from her.
21 Q. Something which you understand to be incorrect?
22 A. That is so.
23 Q. And unlike two years ago, she had little memory of where
24 she was educated, where she went to school, or any details of
25 that nature, save for the fact that she had been a teacher?

1 A. Yes.
2 Q. And then you say at paragraph 21 of your report that when
3 you asked her if she held a position in government she started
4 looking through her papers and the material in fact was totally
5 irrelevant that she was looking at?
6 A. Yes, she'd brought a number of papers to that interview but
7 they weren't related to the questions, as far as I could
8 determine.
9 Q. Does it follow that when she went through the irrelevant
10 material she was not able to come up with any answer as to what
11 role she had been allocated in government?
12 A. No. I mean, my interpretation was that this was a
13 sensitive area and she was not able to come up with details at
14 that time. She was more agitated in discussing that.
15 [11:37:02]
16 Q. She, at paragraph 22 you say, had no recollection of the
17 first hearing, no memory of the charges and said to you there
18 were no accusations against her?
19 A. That's what she said to me, yes.
20 Q. And again that presents a very different picture of her
21 understanding when she spoke to the two doctors back in October
22 2009. Would you agree?
23 A. Yes, I agree.
24 Q. She had an inability to remember the names or occupations
25 of those doctors from Calmette who were present. Is that right?

1 A. That's correct.

2 Q. And were they doctors that you would have expected her to

3 have a familiarity with due to their treatment of her over a

4 significant period?

5 A. Those were doctors who had regular contact with her.

6 Q. And from what you've said, neither could she recall why you

7 had seen her the previous day when you went back for a second

8 visit less than 24 hours later?

9 A. That's correct.

10 [11.38.38]

11 Q. Did you, in fact, want her to sign any documents?

12 A. No, no.

13 Q. So that question came out of nothing that you had said or

14 done; "Do you want me to sign anything?"

15 A. No. I assumed it had come out because I was seeing her in

16 an official capacity and she interpreted it in that way.

17 Q. Now, you would agree, wouldn't you, that there is a

18 significant change in the abilities and the capacities and

19 performance of Ieng Thirith between the period of October 2009

20 and May 2011?

21 A. Yes, certainly my findings were different from those found

22 18 months to 2 years previously.

23 Q. Would that be something that would be consistent with a

24 person who suffers from dementia, Alzheimer 's disease, that

25 being a progressive disease?

1 A. It would be consistent with that but also needs to be taken
2 in conjunction with the circumstances that she was in over that
3 18-month to 2-year period where those circumstances, or lack of
4 outside stimulation, the pressures that she was under,
5 incarceration, will also have added to the cognitive function,
6 her mood, as well.
7 [11.40.29]
8 Q. Is the position this then?
9 That she was mildly cognitively impaired in October 2009 but for
10 a number of reasons, including the fact that Alzheimer's is a
11 disease that progresses, it is not surprising if she has become
12 moderately, severely cognitively impaired nearly two years later?
13 A. That's right. I fear her impairment is greater now than it
14 was two years ago and is a moderate impairment.
15 Q. You set out at paragraph 28 in your same report that your
16 assessment is that it is a "global cognitive impairment".
17 What did you mean by the use of the word "global"?
18 A. A dementing(sic) illness is a global impairment and it
19 affects most brain functions. Disorders in a certain part of the
20 brain can cause focal problems, for example, construction with
21 language, but in this situation it has a more diffuse effect on
22 the brain as a whole.
23 Q. And you identified, particularly, evident was the
24 impairment in the domains of memory, speech, construction and
25 frontal lobe function, which was consistent with a dementing(sic)

1 disorder?
2 A. That's correct.
3 [11.42.37]
4 Q. And at paragraph 34, you said:
5 "The moderately severe dementia does impair her ability to
6 comprehend questions, follow instructions, recall events,
7 concentrate, and maintain a line of thought."
8 A. Yes, that is what I found in my examination of her.
9 Q. And following the reduction that you've already described
10 that took place in the medication when you did your follow-up
11 assessment on the 25th of August -- and I think, again, there's
12 just a date correction that is needed. It's the 25th of August,
13 page 2 of your follow-up report, paragraph 5(e), not the morning
14 of the 25th of May?
15 A. Yes, my apologies, that's correct.
16 Q. So that you had seen Ieng Thirith on the 24th of August, as
17 you've told us, and on the morning of the 25th of August you go
18 back again for the reasons you've indicated with Professor Chak
19 Thida to interview her and on that occasion you've described, for
20 the reasons that we needn't repeat, why you took a back seat.
21 Your conclusion at paragraph 6 is that there was no improvement
22 in her cognitive function in spite of the stopping of the
23 clonazepam and the bromazepam, the benzodiazepines, and that
24 those who had continued to have supervisory responsibility for
25 her hadn't, I think, noticed any improvements in her behaviour or

1 memory either; would that be right?
2 [11.45.05]
3 A. That is right.
4 Q. She still remained moderately impaired with past details
5 being vague and often inaccurate, poor concentration, and all
6 those matters that you have fully canvassed, remained; they were
7 canvassed fully in your main report of 23rd June?
8 A. Correct.
9 Q. You understand that you are here to assess and consider
10 her fitness to stand trial, and you've told us that you are
11 familiar with the non-exhaustive list of capacities as set out in
12 the case of Strugar?
13 A. Yes, as detailed in my order.
14 Q. Would you agree that in her present state she is not in a
15 position to understand the nature of the charges of Genocide,
16 Crimes against Humanity and War Crimes and concepts,
17 meaningfully, of guilt and innocence?
18 A. And that she would have difficulty understanding.
19 Q. Would you agree that from your assessment it could not be
20 said that she would be able to follow the trial proceedings and
21 rationally understand what was taking place in the courtroom?
22 A. That was my conclusion from my interviews with her.
23 Q. Would you agree that she is not in a position to read or
24 have read to her witness statements describing events of 35 years
25 and understand the content of those statements?

1 [11.47.37]
2 A. I think her impairment is such that she would have great
3 difficulty.
4 Q. And she would have great difficulty due to her impairment
5 in providing an account of what, in fact, she says she did do --
6 or did in 1975 to '79?
7 A. That is so.
8 Q. In a court where a witness comes and gives evidence against
9 an accused, the accused, of course, has the right to challenge
10 that evidence by putting the counter position, the facts as they
11 say they are.
12 The reality is this is something she simply could not do, could
13 she?
14 A. It would require her to follow and understand what has --
15 what was being said and then to remember the events in order to
16 make comment, and I think she would have real difficulty with
17 that.
18 Q. Would you agree that her difficulties, for all the reasons
19 mentioned, would be insurmountable when it comes to providing
20 instructions to her lawyers in order to assist in the preparation
21 of her case?
22 [11.49.05]
23 A. As she is at present, I would.
24 Q. The reality is that it would not be possible for her to
25 testify in her own defence and answer questions in

1 cross-examinations in any meaningful way, would it?
2 A. As I've said, as she is now. And as I've suggested there
3 may be means of improving the situation, although I think the
4 likelihood of improvement is low.
5 Q. I'll come on to the suggestions for improvement, but if we
6 could just complete the ---
7 THE PRESIDENT:
8 Counsel, at least could you please hold on such -- so we can try
9 -- you may proceed.
10 JUDGE CARTWRIGHT:
11 Ms. Ellis, you've been going very carefully through Professor
12 Campbell's report and putting statements from the report to him,
13 but when it comes to asking his conclusions which relate to the
14 decision the Court must make, would you please put more open
15 questions to him so that it's his opinion not yours that we hear.
16 And I think, once again, you're straying into that -- I know it's
17 tempting -- but please don't do it. Thank you.
18 [11.50.38]
19 MS. ELLIS:
20 Q. Could she testify in her own defence and stand up to
21 cross-examination?
22 MR. CAMPBELL:
23 A. As Ieng Thirith is at present, I think she would have great
24 difficulty doing that.
25 Q. In her current state, do you consider that she understands

1 the nature of the proceedings and the consequences of the
2 proceedings as they may be?
3 A. When I asked her about that she was unable to discuss the
4 matters, and I felt that was from her lack of understanding.
5 Q. As you were coming on to say a few moments ago, having
6 discovered that the reduction in the benzodiazepines has not
7 shown any marked improvement, your suggestion is that a different
8 type of medication should be tried. Is that right?
9 A. Yes, I think the quetiapine should be reduced as far as
10 it's safe, and then if there is no significant improvement -- and
11 I think it isn't likely that there will be -- then a trial of the
12 donepezil, which I mentioned, should be attempted.
13 Q. Could I ask for clarification from you as to what might be
14 the result of that drug acting effectively?
15 A. The hope would be that it did, in course, lead to some
16 improvement in memory. It does in some people have a significant
17 benefit but, as I've indicated, in the majority it does not.
18 [11.52.45]
19 Q. You say "in some people" it has a benefit. Is it a figure
20 of more or less than 30 percent who benefit?
21 A. It's around a third of people who benefit.
22 Q. So about 30 percent?
23 A. About 30 percent.
24 Q. Did I understand correctly from what you said yesterday
25 that the benefits, if there are any, are, in fact, short-term?

1 A. The drug has a symptomatic effect on those who benefit from
2 it. It does not alter the progression of the underlying problem.
3 Q. The drug has a number of side-effects you said yesterday.
4 Are those side-effects such that they may make it impossible for
5 the patient to continue with the drug use?
6 A. Yes, sometimes people discontinue the medication because of
7 the side-effects.
8 Q. Were Ieng Thirith to cope with any side-effects and to show
9 some improvement as a result of taking the proposed medication,
10 over what period of time would there be observable benefits
11 before deterioration sets in?
12 [11.54.45]
13 A. In those who benefit, the normal course is to use a
14 5-milligram dose for a month to see if there's improvement. If
15 there is no improvement to increase to a 10-milligram dose, with
16 a total trial period of around 3 months.
17 Q. I understood you to say that it doesn't affect the
18 underlying illness, the Alzheimer's, therefore, does that in
19 time, again, make the patient cognitively impaired to a
20 significant degree?
21 A. Yes. The disorder progresses and often with patients one
22 reaches a stage where you feel the medication, having been of
23 initial benefit, is no longer of benefit, and then discontinue
24 it.
25 Q. It's the timescale that I'm interested in. Some medication

1 works very well for six months and that's helpful but,
2 thereafter, the original problem re-emerges.
3 Can you give us a timescale in terms of the proposed drug in this
4 case?
5 A. That's very difficult because it is very much an individual
6 response that one sees, and sometimes people can be maintained
7 for a longer period on the medication; a year or two or more.
8 Q. I asked you this yesterday and I don't think we had an
9 answer.
10 [11.56.22]
11 You responded to the Court by saying that you had found Nuon Chea
12 fit, in your assessment -- it's a matter for the Court -- but in
13 your assessment, to stand trial.
14 At the present time, what is your assessment in that respect of
15 Ieng Thirith?
16 A. My assessment at this stage is that she would have
17 difficulty instructing her counsel and participating fully in the
18 trial.
19 Q. There's only one final, short matter I'd like to ask you
20 about.
21 You have mentioned that should she be -- become less cognitively
22 challenged and should the Court decide, in due course, that she
23 could meaningfully participate in the trial, she could use the
24 facilities within the holding cell.
25 Now, the facility central to that is that there is means by a

1 screen for her to see and listen to the events that are taking
2 place in the courtroom.
3 Have you any evidence from any of your discussions with those
4 that care for her or from any of your observations of her that
5 she is capable of following what goes on on a screen, which is a
6 less immediate medium by which to participate?
7 A. Well, not at the present stage, but if she were to improve
8 sufficiently to be able to participate in her trial, I would have
9 expected her to improve to the extent that she would be able to
10 understand the proceedings as conveyed to the holding cells.
11 Q. So it wouldn't be an option under the present impediment
12 that she suffers, but if there's an improvement then that
13 improvement would be reflected in her abilities concerning the
14 holding cell, and observing from there?
15 [11.58.03]
16 Is it more difficult for elderly people to follow what goes on on
17 the television or on the radio as they become more cognitively
18 impaired than in direct conversation?
19 A. It may, and it may be misinterpreted, but to the -- if
20 there was someone with her, then I don't think that would be a
21 problem.
22 Q. But that would perhaps be something to consider fully at a
23 later stage. Would you agree?
24 A. Yes, I agree.
25 MS. ELLIS:

1 Mr. President, Your Honours, I have no other questions, thank
2 you.
3 MR. PRESIDENT:
4 Thank you, counsel, for -- and Professor Campbell; in particular,
5 Professor Campbell for your efforts and assistance to --
6 responding to questions for the whole morning already.
7 And it is now an appropriate time to take the adjournment for
8 lunch.
9 The Court will take the adjournment and resume the session by
10 one-thirty.
11 Security personnel are now instructed to take Ieng Thirith to the
12 holding cell and return her to the courtroom by that time.
13 (Court recesses from 1200H to 1331H)
14 (Charged person exits courtroom)
15 (Judges exit courtroom)
16 MR. PRESIDENT:
17 Please be seated. The Court is now back in session.
18 [13.31.34]
19 This morning, the Court proceedings were left off with the
20 questioning by the defence team of Ieng Thirith to the expert,
21 Mr. John Campbell. Now the Chamber would like to hand over to
22 the Co-Prosecutors to be able to put questions to the expert.
23 MR. SENG BUNKHEANG:
24 Thank you, Mr. President.
25 QUESTIONING BY THE CO-PROSECUTORS:

1 BY MR. SENG BUNKHEANG:

2 Q. Good afternoon, Professor Campbell. You have already

3 reviewed the reports by Professor Brinded and Professor Ka

4 Sunbaunat, and you have already been familiar with the

5 methodology in assessing the accused person.

6 [13.32.45]

7 But we would like to hear from you, what is your position

8 concerning the methodology applied by the two professors?

9 MR. CAMPBELL:

10 A. Their methodology was very similar to mine.

11 Q. Would you wish to make any further recommendations or

12 elaboration on the methodology that has already been applied by

13 the two professors?

14 A. They interviewed Ieng Thirith and they reviewed the records

15 that she had and then assessed her competence according to their

16 direction, or direction that they'd received.

17 Q. Turning to the treatment Ieng Thirith received at

18 Bumrungrad Hospital in Bangkok, it appears that following her hip

19 operation in January 2006 she suffered hallucinations, dizziness

20 and sleeplessness. She was treated for these symptoms and the

21 medical reports from February, May and August 2006 contain the

22 diagnosis, psychosis in remission. Dr. Brinded and Professor Ka

23 Sunbaunat concluded in their report that Ieng Thirith had

24 suffered post-operative delirium, which did not appear to have

25 long-term effects.

1 [13.35.23]
2 Do you agree with this finding, or do you not?
3 A. I agree that that was the most likely diagnosis and the
4 cause of the problem after her hip fracture.
5 Q. Is post-operative delirium a temporary condition or is
6 dementia which you have diagnosed in any way the result of or
7 related to it?
8 [13.36.08]
9 A. Delirium is normally a self-limiting process, a response to
10 a particular stress, physical stress. If it is prolonged, it can
11 be associated with long-term cognitive impairment, although it's
12 more likely that the cognitive impairment preceded the episode of
13 delirium.
14 Q. Is it temporary condition?
15 A. Delirium itself is a temporary condition, yes.
16 Q. Would it be fair to conclude that you found a dramatic
17 change since the situation as assessed by Brinded and Dr. Ka
18 Sunbaunat in 2009?
19 [13.37.22]
20 A. There had certainly been changes, as I document, over that
21 two-year period.
22 Q. Would it have been appropriate to canvass with both of
23 those experts what may have led to such a significant change?
24 A. That is why I asked for a review by Professor Ka Sunbaunat.
25 Q. You state at paragraph 40 of your report, Document E62/3/6,

1 that Ieng Thirith suffers from a moderately severe dementing
2 illness, most probably Alzheimer's disease. At paragraph 32, you
3 stated that the history, examination, CT head scans and blood
4 tests suggested this is primarily a dementia due to Alzheimer's
5 disease.
6 [13.39.12]
7 However, your report does not indicate what specific factors led
8 you to conclude this was Alzheimer's disease. Could you tell the
9 Court what those specific factors were?
10 (Short pause)
11 MS. ELLIS:
12 Mr. President, Your Honours. if I could assist, what I've been
13 told is that she has been saying she wants to go home, but no
14 doubt there will be information forthcoming in a minute, if you
15 would like to receive it.
16 (Short pause)
17 [13.42.05]
18 MR. PRESIDENT:
19 The security personnel are now instructed to take Ieng Thirith to
20 the holding cell and ask Mr. Phat Pouv Seang to return to the
21 courtroom.
22 (Short pause)
23 [13.42.40]
24 MR. PRESIDENT:
25 The Court is now back in session. Co-Prosecutor, you may now

1 proceed with your questioning.
2 MR. SENG BUNKHEANG:
3 Thank you, Mr. President. I would like to repeat the question so
4 that Professor Campbell can catch it.
5 MR. SENG BUNKHEANG:
6 Q. You state at paragraph 40 of your report, E62/3/6, that
7 Ieng Thirith suffers from a moderately severe dementing illness,
8 most probably Alzheimer's disease. At paragraph 32, you stated
9 that the history, examination, series of head scans and blood
10 tests suggest that this is primarily a dementia due to
11 Alzheimer's disease.
12 [13.43.55]
13 However, your report does not indicate what specific factors led
14 you to conclude this was Alzheimer's disease. Could you tell the
15 Court what those specific factors were?
16 MR. CAMPBELL:
17 A. Alzheimer's disease is a clinical diagnosis. There are no
18 laboratory or radiological tests which demonstrate unequivocally
19 that the person does have Alzheimer's disease. It's a two-stage
20 clinical diagnosis.
21 The first stage is to ensure that the history and the physical
22 findings are consistent with Alzheimer's, that is, there has been
23 a progressive, global impairment of brain function over a time
24 period of at least a year or two years or three years, or longer.
25 The second stage is to ensure that there are no other conditions

1 which may be mimicking Alzheimer's, such as a biochemical
2 abnormality, an abnormality of endocrine function or some other
3 problem within the central nervous system that may be causing
4 these problems.
5 [13.45.19]
6 So that my process was to examine the history as far as I could
7 from the medical records and, from those acquainted with her, to
8 complete a physical examination, including some testing of
9 cognitive function, and to review the radiology and the
10 laboratory tests to ensure that there was no other condition.
11 Now, as I've indicated, I felt there may be some other conditions
12 which may be contributing and that they needed to be addressed
13 before coming to a final conclusion.
14 Q. You state at paragraph 7 of the same report that the CT
15 head scan of June 2001 shows cerebral atrophy consistent with age
16 of Alzheimer's, and at paragraph 8 that it is probable that
17 Alzheimer's disease is one of the conditions contributing to the
18 accused's cognitive impairment.
19 [13.46.45]
20 Can you elaborate on those conclusions? For example, how does
21 Alzheimer's lead to cerebral atrophy and how is this sufficient,
22 then, atrophy as a result of age and is it possible to
23 distinguish?
24 A. No. As I said, it's a clinical diagnosis and there is
25 overlap between age-related change and change related to

1 Alzheimer's disease, so one would not make a definite diagnosis
2 of Alzheimer's disease purely on the radiology.
3 Q. Is it possible to distinguish this disease, please?
4 A. Possible to distinguish this disease through radiology or
5 through laboratory tests, do you mean?
6 [13.48.04]
7 Q. Of course, through your assessment.
8 A. No, as I say, it's a clinical diagnosis by determining a
9 history and findings consistent with it and no other cause for
10 the impairment. And as I've indicated, it may not be the sole
11 cause of cognitive impairment.
12 Q. Is it correct to say that Alzheimer's disease is a
13 progressive condition with several different stages, for example,
14 1 to 7?
15 A. It's a progressive disorder, and the terms "mild, moderate
16 and severe" have been used here, but there is no clear
17 distinguishing features that make one mild and another moderate.
18 Q. Early on, the defence counsel indicated with relation to
19 the statement of the accused person that play an important part
20 in your assessment.
21 [13.50.03]
22 Did you know that Ieng Thirith was informed of the purpose of
23 this assessment and that Ieng Sary give some statement in
24 particular in your report, and do you think that he is faithful
25 in providing his statement concerning the health concern of Ieng

1 Thirith?

2 A. Can I just clarify that question?

3 Do I feel that Ieng Sary was faithful in his reporting of his

4 wife's condition?

5 Q. I would like to rephrase this.

6 [13.50.55]

7 You received a statement from Ieng Sary concerning his statement

8 -- concerning Ieng Thirith because he made some statement

9 concerning the health issue of Ieng Thirith. My question is,

10 indeed, whether you believe that such a statement is made

11 genuinely.

12 A. Yes. I interviewed Ieng Sary myself, so I was aware of his

13 demeanour throughout the discussion. And as I said in my report,

14 although I recognize that he is not a disinterested party, I felt

15 that what he told me was consistent with what I'd heard already

16 and I felt that he was being accurate in his statements.

17 Q. I thank you very much. I would like to hand over to my

18 colleague to put further questions.

19 MR. PRESIDENT:

20 International Co-Prosecutor, you may now proceed.

21 QUESTIONING BY THE CO-PROSECUTORS

22 BY MR. ABDULHAK:

23 Q. Good afternoon, Professor Campbell.

24 [13.52.07]

25 It's been a long day, and I'm sure you're quite tired, so we'll

1 only ask a few more questions simply by way of clarifying some of
2 the evidence you gave this morning and perhaps to focus a little
3 bit more on what lies ahead.
4 If we may just have on the screen the report by Dr. Brinded and
5 Professor Ka. That's Document B37/9/8. And if we could go to
6 page 5 of that document.
7 MS. ELLIS:
8 Mr. President, could I interrupt?
9 [13.53.04]
10 As I understand it, the reports are essentially confidential
11 documents. This is a public hearing, and the parties are clearly
12 making reference to passages within those documents to assist in
13 the approach to questioning. By putting a document on the
14 screen, it, of course, introduces other material which is not in
15 the public domain.
16 And therefore, I wonder as all those who need that document do
17 have it, including Professor Campbell, it wouldn't be more
18 appropriate to simply refer him to the passage rather than to
19 make available confidential material. The whole document is not
20 on the case file publicly.
21 [13.53.55]
22 Thank you.
23 MR. ABDULHAK:
24 If I may respond, Mr. President, very briefly.
25 I'm a little bit baffled. We spent the entire morning going

1 through Professor Campbell's reports and those of Dr. Ka and
2 Professor -- apologies, Dr. Brinded and Professor Ka in great
3 detail. In fact, extensive passages were read to Professor
4 Campbell. And the passages I seek to refer to are those passages
5 that have been discussed.
6 [13.54.28]
7 There's no additional confidential information that would likely
8 be shared, and I think it would assist everyone to be looking at
9 the same document, but I -- we're in your hands, as it were. I'm
10 happy to proceed in whichever way the Chamber deems appropriate.
11 MS. ELLIS:
12 Mr. President, I, of course, don't object to any passage which is
13 going to be made public in this Court. I'm simply anxious to
14 ensure that there is no other material save the material that is
15 being put to the witness that is publicly shown in the courtroom.
16 [13.55.01]
17 So I think the International Co-Prosecutor has dealt with that.
18 Thank you.
19 MR. ABDULHAK:
20 I thank counsel. And we will be brief, again.
21 Q. My colleague has already discussed with you or put some
22 questions to you in relation to the concept of post-operative
23 delirium, and I think you indicated that you felt that that was a
24 temporary condition.
25 MR. CAMPBELL:

1 A. That is correct.
2 Q. And I was interested to hear that you felt also that any
3 cognitive impairment may have, in fact, pre-dated that particular
4 episode.
5 A. We have no records pre-dating, so I can't really comment.
6 But as we discussed this morning, it does pre-dispose to
7 delirium, any pre-existing cognitive impairment.
8 Q. So it's a possibility, but certainly we can't be sure.
9 Thank you.
10 [12.56.05]
11 And I just wanted to -- in fact, we may be able to deal with this
12 without showing you this particular page at present and just
13 proceed more quickly. I'll just read this one line, really.
14 It's in the author's notes that there is no record of further
15 psychiatric symptomatology since her post-operative recovery.
16 They obviously wrote this report in late October or early
17 November 2009, and they're reflecting on an episode which had
18 taken place in, I guess, early 2006.
19 [13.56.40]
20 They found no further psychiatric symptomatology. Are you aware
21 of any other record that would shed different light on that
22 position?
23 A. No. What they're referring to there is that at the time of
24 her illness, the hip fracture, she had hallucinations and other
25 problems which may have been a manifestation of an underlying

1 psychiatric disorder or may have been delirium. And I took from
2 that sentence that they felt as there had been no other ongoing
3 hallucinations or indications of psychiatric illness, this was
4 most likely a delirium.
5 Q. I understand. Thank you.
6 [13.57.22]
7 Now, you've testified, I think, today that -- and correct me if
8 I'm wrong -- that there were no significant changes in the CT
9 head scans that were -- that are available from 2007, 2009 and
10 2011.
11 Would that be accurate?
12 A. Yes, that would be accurate. Yes.
13 Q. But you also said that it's not necessarily a case that a
14 CT scan or an atrophy visible in a CT scan would necessarily be
15 proportionate to a level of cognitive impairment. Would that be
16 accurate?
17 A. That's correct, yes.
18 Q. I'd like to show you a document which I don't think you've
19 seen, and I'm sort of anticipating that there might be an
20 objection. But this is Document C18. It is essentially the
21 record of Ieng Thirith's first appearance before the
22 investigating Judges.
23 [13.58.34]
24 And the passage that I would like to show is simply a brief
25 statement that was made by Ieng Thirith on that occasion, and I

1 have a copy if the Chamber would like to consider it prior to
2 making a decision.
3 JUDGE CARTWRIGHT:
4 Can I just ask which part you're intending to refer to, please?
5 [13.59.40]
6 MR. ABDULHAK:
7 Yes, Your Honour. I'm looking at page 3 of the English-language
8 version. It is the -- starting with the second paragraph and
9 then the following three passages simply containing a general
10 statement by the then charged person about the allegations made
11 against her.
12 (Short pause)
13 MR. PRESIDENT:
14 You may now proceed.
15 MS. SIMONNEAU-FORT:
16 Yes, Mr. President. Simply -- I have simply an observation. We
17 are delighted that these proceedings are known to the public
18 because I believe it's important that everybody understands
19 what's happening, and I believe that publicity should not be
20 defined in relation to what is good for Ms. Ieng Thirith or which
21 is not good for Ms. Ieng Thirith.
22 [14.01.41]
23 This morning, we were very much aware of the substance of the
24 documents, and I think that publicity should not be done in
25 relation to what is good or what not good for Ms. Ieng Thirith,

1 and I would like the Chamber to take this into consideration.

2 (Short pause)

3 MR. PRESIDENT:

4 To assist the Chamber and, of course, for the -- and in the

5 interests of justice and publicity, the Court officer is now

6 instructed to project the portion requested by the Co-Prosecutor

7 on the screen, please.

8 MR. ABDULHAK:

9 Thank you, Mr. President. So we're looking at -- for page 3 of

10 this document in the English language. It's Document C18.

11 MS. ELLIS:

12 Mr. President, in the light of what's been said, can it be made

13 quite clear that the defence has not objected to this passage

14 being put before the Court in public?

15 [14.03.34]

16 MR. ABDULHAK:

17 And I was just informed by my colleague that apparently this was

18 one of the documents that may have been provided to you, so you

19 may well be familiar with it.

20 [14.03.55]

21 Thank you very much.

22 MR. ABDULHAK:

23 Q. If I just read out to you two sentences, perhaps, or three

24 out of this passage. Obviously, this was an initial hearing

25 before the co-investigating Judges and this hearing took place on

1 the 14th of November, 2007. And obviously, the then charged
2 person was responding to allegations that the prosecutors had put
3 forward. And the second brief passage says:
4 "Everything the co-prosecutors said is 100 percent wrong. I'm
5 accused of having killed many people. I would like to be told
6 where, when and how."
7 [14.04.41]
8 Then in the following passage, she states:
9 "I would like the witnesses to come and speak for themselves."
10 And then she goes on to explain or state her role as she saw it
11 during the period covered by the indictment.
12 [14.04.58]
13 To your mind, were these statements of someone who was at a
14 cognitive level, able to function and understand the nature of
15 the proceedings?
16 MR. CAMPBELL:
17 A. I think it's very difficult to make a judgment based on
18 that small section. When I had commented on this, I had had the
19 whole transcript of her appearance at that time and felt at that
20 stage there was evidence of impairment in the whole of her
21 discussion at that trial.
22 [14.05.28]
23 There are elements there, clearly, where she is remembering
24 aspects of her past.
25 Q. But you would agree with me that certainly at that stage,

1 at least this passage doesn't indicate any inability to recall
2 key aspects of her role as she saw it or the allegations as they
3 were put to her.
4 A. Those particular paragraphs, yes, assuming that what she is
5 describing there is accurate. I'm not sure who Ms. Chea Leang
6 was and whether she was there at that time or whether this was
7 referring back to a previous time or whether or not it was
8 related to her comments then.
9 Q. I'll just clarify for you that point. Chea Leang is the
10 Co-Prosecutor. She's the National Co-Prosecutor, and she was
11 present at that hearing. Thank you.
12 [14.06.24]
13 If we may now turn to the Brinded and Ka report, which was the
14 document that we had prepared to show earlier. This is B37/9/8.
15 And if we're able to go to page 7 of that document in English.
16 [14.07.14]
17 And if I just may read out again the -- just a part of that first
18 passage. This is, again, Dr. Brinded and Professor Ka
19 summarizing their discussions with the accused, and they felt she
20 understood the roles of the Judges and the process of the Court.
21 [14.07.34]
22 "She did, however, express doubt the co-investigating Judges were
23 free from bias and indicated that she believed that one of her
24 co-accused had strongly influenced the Judges to her detriment."
25 And of course, you've considered that statement, have you not?

1 A. Yes, I have.

2 Q. To your mind, does that indicate a level of ability to

3 appreciate the proceedings?

4 A. At that stage, it does. It also raises the issue of the

5 co-accused and her relationship with that, which has been a

6 long-term issue which came up in the discussion this morning.

7 Q. Now, obviously the records of this Court are extensive and

8 you haven't, certainly, been provided all of the relevant files,

9 but I'll just point that in this passage, obviously, Ieng Thirith

10 expresses certain concerns as the impartiality of the

11 co-investigating Judges.

12 [14.08.36]

13 Within approximately a month and a half, applications were filed

14 by Ieng Thirith -- by the defence for Ieng Thirith on her behalf

15 challenging the proceedings on a number of grounds, including an

16 allegation that the Judges were not free from bias.

17 In light of that fact, does that lead you to any conclusions in

18 terms of her ability to appreciate the course of the proceedings?

19 Of course, at that time, I should say.

20 A. I find that very difficult to comment on because I do not

21 know the processes and the degree to which the initiation of that

22 challenge was hers. It's really difficult to comment on how much

23 of a part she played in that process.

24 Q. Understood. But perhaps, at the very least, it could be

25 said that she was aware of such concerns.

1 MS. ELLIS:
2 Can I interrupt because it's quite clear Professor Campbell can't
3 possibly comment on pleadings drafted by the defence of Ieng
4 Thirith. He won't have seen them, wasn't a party to decisions on
5 how they were drafted. It would be totally wrong, in our
6 submission, for Professor Campbell to be asked to speculate.
7 MR. ABDULHAK:
8 Very briefly in response, Mr. President. We're certainly not
9 inviting Professor Campbell to comment on pleadings, but rather,
10 to reflect on whether or not, in light of this statement, Ieng
11 Thirith may have been able to appreciate such applications, which
12 we feel is fully within Professor Campbell's expertise.
13 MR. PRESIDENT:
14 But the professor has responded that he could not comment on this
15 issue because he was not present during that time.
16 [14.01.35]
17 Does the Prosecutor have any other questions, and try to be
18 careful not to touch upon the issues that goes beyond the
19 professor's expertise or the issues that may not allow the
20 professor to understand since he has only come to work on this
21 issue recently.
22 MR. ABDULHAK:
23 Thank you, Mr. President. I shall move on.
24 Q. Just a brief clarification in relation to an issue that you
25 dealt with this morning, Professor.

1 [14.11.22]
2 You were asked about the -- certain incidents which took place or
3 that were reported from within the detention facility in which
4 the accused was alleged to have engaged in inappropriate
5 behaviour. Now, Dr. Brinded and Professor Ka concluded that they
6 did not believe that such emotional outbursts were a consequence
7 of a mental disorder.
8 Would you care to comment on that?
9 MR. CAMPBELL:
10 A. Yes. As I commented this morning, the outbursts at the
11 time Dr. Brinded and Professor Ka saw Ieng Thirith had been
12 directed mainly at one of the co-defendants, was my
13 understanding. What was shown this morning showed a broadening
14 of that and concern about other people as well, and suspicion of
15 them and "mis-control" in her outbursts, indicating a degree --
16 increasing degree of disinhibition.
17 Q. So it would be fair to draw a link, if you like, between
18 what you've diagnosed as dementia or Alzheimer's disease and some
19 of these incidents.
20 A. Yes, they could certainly be associated.
21 Q. Thank you.
22 [14.12.50]
23 And if I may, just one more question on the past, so to speak,
24 and then we might focus a little bit and very briefly on the
25 future.

1 One of the reports that hasn't been dealt with, I think, so far
2 is the February 2011 examination of the accused by psychiatrist
3 Dr. Chak Thida. And if we could just show that document very
4 briefly, it is Document E17/1/2.4. Again, this would not contain
5 any additional information to what's been discussed thus far.
6 It's just general observations on the accused's cognitive
7 functioning.
8 [14.13.52]
9 And if we look at Item 2 very briefly, Dr. Thida and, in fact,
10 together with Professor Nhem Sophoeun, indicate that the accused
11 seemed interested in their questions and that the conversation
12 went smoothly, but she again discussed her physical difficulties.
13 And finally, that she responded correctly to the doctors'
14 questions.
15 [14.14.22]
16 And then under 4, Speech, they indicate that there was normal
17 range, normal responsive, meaningful and coherent. And under 5,
18 they indicate that there were no hallucinations.
19 Obviously, we're dealing with a complex set of factors that may
20 be contributing to the cognitive impairment you found. What I
21 was interested in was that you've spoken to Dr. Thida.
22 [14.14.54]
23 Were you able to canvass this report with her?
24 A. I was able to discuss with her the changes that she
25 observed, and as I've indicated, she participated in the

1 interview on the second occasion.

2 I mean, I think there is considerable variation in the way that

3 Ieng Thirith presents and relates to the people who are

4 interviewing her, and we may be seeing that here, a fluctuation

5 in her condition.

6 Q. So would it be correct to say that there may well be

7 occasions on which she is able to perhaps engage more

8 meaningfully, such as, perhaps, as this document seems to

9 indicate?

10 A. I think there are occasions when she will engage better and

11 with certain people better than on others. I would be doubtful

12 that she would engage to the extent that she was able to conduct

13 a coherent, reasoned argument.

14 Q. Thank you.

15 [14.15.56]

16 And I'll just ask you one general question and then perhaps we'll

17 focus on the future prospects a little bit. And it's a very --

18 just a technical point.

19 This morning, you were asked if prevalence of dementia increased

20 with age, and I think the age -- specific age that was put to you

21 was 65 years of age. I think, and correct me if I'm wrong, that

22 you may have indicated 85 yesterday, but please do say the

23 correct number.

24 A. If we look at the prevalence, and this is in societies

25 other than in Cambodia, but one assumes that there is similar

1 prevalence, it is around 6 to 7 percent for people 65 years and
2 over, increasing to 80 percent for those people 80 years -- 20
3 percent for those people 80 years and over.
4 Q. Thank you.
5 [14.16.44]
6 Now, coming back to the sort of way you left off this morning
7 with the defence, it is fair to say that you said that you felt
8 cognitive impairment was at the moderate level?
9 And I ask this -- I should -- in the interests of clarity, I ask
10 this because I think your report states moderately severe. And I
11 know you've said terminology is not entirely determinative, so I
12 just wanted to clear that up.
13 A. Yes, I would define this as moderate in the sense that it
14 is interfering with her daily function and her ability to manage
15 within her surroundings.
16 Q. Thank you very much.
17 [14.17.32]
18 And of course, you also indicated that the process of reduction
19 of medications that you recommended is an ongoing one?
20 A. Yes, that is correct.
21 Q. And I think you also indicated that the one drug that -- or
22 medication that remains to be discontinued is quetiapine.
23 A. That is so.
24 Q. Is it correct -- you may have already answered this
25 question earlier, so I apologize if I'm repetitive.

1 [14.08.01]
2 Is it correct that it treats schizophrenia and bi-polar disorder?
3 A. Yes, it is a major tranquilizer used for the major
4 psychoses. It has been used in people with behavioural
5 disturbance with dementia, but there are significant drawbacks in
6 using it in that way.
7 Q. And what would some of the side effects for the use of this
8 drug, particularly looking at cognitive functioning?
9 A. A slowing of the processes, cognitive function, in effect,
10 on reasoning ability and it can affect also the person's
11 mobility, gait as well.
12 Q. And in light of that, you recommended that this drug be
13 withdrawn in consultation with the Calmette medical team, and
14 that's now taking place.
15 A. Yes, that is so.
16 [14.18.57]
17 Q. Now, would it be fair to say that there is a possibility
18 this is one of the currently contributing factors to the sort of
19 cognitive diagnosis that you made?
20 A. It's a possible contributing factor. I would not expect
21 the reduction to have an important effect, but I think it is
22 important to explore that possibility.
23 Q. Thank you.
24 [14.19.28]
25 You also recommended that another medication be prescribed, and

1 that was discussed this morning. And can I just confirm that
2 that is for a period of three months?
3 A. Yes. If there are no adverse effects from the medication,
4 then a three-month trial is what is usually tried.
5 Q. And it is possible, but perhaps, to be fair, not highly
6 likely that some cognitive improvement may well take place?
7 A. That is so. It is possible, but unlikely.
8 Q. You commented in your follow-up report at the very end, and
9 consistently with what I think you just said, that these
10 medication changes may not produce -- that it was not probable
11 that they would produce a significant improvement. But you also
12 indicated that it is possible that they will enable her to
13 participate better in her defence.
14 [14.20.39]
15 Are you able to expand on this a little bit further?
16 A. What I'm really saying is there is that until we've
17 explored all possibilities and tried all measures to try and
18 improve function, we cannot be definite that she will not be able
19 to participate in her defence.
20 [14.20.57]
21 As I said, I think it's unlikely, but for her sake, this should
22 be tried.
23 Q. And of course, you're aware that the Chamber has now
24 appointed four psychiatrists and requested them to conduct an
25 assessment of Ieng Thirith as well.

1 A. Yes, I'm aware of that. And clearly, one of the issues
2 with respect to the medications is the timing of that assessment.
3 Q. And do you consider that it would be appropriate for you to
4 conduct a reassessment following the trial period that you've
5 recommended?
6 A. Should that be the wish of the Court, then -- the Chamber,
7 then yes, I would be prepared to.
8 Q. In your opinion, that would -- that may be of assistance in
9 terms of you've just indicated that some change may well take
10 place.
11 A. Yes. Certainly if there was felt to be a change, then that
12 would be worth re-evaluating.
13 Q. And as I draw to a close, then in light of the
14 recommendations you've made and the continuing treatment, would
15 it be fair to say that the current conclusions are interim?
16 A. I think they are in that there is change and there is also
17 the evaluation by the other experts as well. So in terms of my
18 own conclusions, they, I feel, could not be finalized until all
19 possible measures have been tried.
20 Q. Thank you.
21 [14.22.26]
22 And lastly, you've indicated that the current conditional
23 cognitive impairment that Ieng Thirith suffers from is the result
24 of a number of causes, including -- I think you may have defined
25 them as psychosocial conditions.

1 Are there measures which may be implemented during her detention
2 which may alleviate some of these symptoms, in addition to the
3 medication?
4 A. I think given her circumstance, it would be very difficult
5 to initiate any other moves to try and improve the situation, and
6 I think it is unlikely that any moves would -- psychosocial moves
7 would improve the situation and the increase in stimulation or
8 activity.
9 [14.23.13]
10 I think it's very unlikely that would have any benefit.
11 MR. ABDULHAK:
12 Thank you very much.
13 I have no further questions. Thank you, Your Honours.
14 MR. PRESIDENT:
15 Thank you, Mr. Co-Prosecutor.
16 Next, the Chamber would like to hand over to the lead co-lawyers
17 for civil parties, if they have any questions to put to Professor
18 Campbell.
19 [14.23.28]
20 MR. PICH ANG:
21 Good afternoon, Chamber. Good afternoon to the Monks and the
22 public. For me, I do not have any questions to put to Professor
23 Campbell.
24 [14.24.37]
25 I also note the presence of Ms. Ieng Thirith and I also noted

1 that she was talking friendly with her counsel this afternoon.
2 MR. PRESIDENT:
3 Please go ahead, Mr. Chunthy.
4 MR. LOR CHUNTHY:
5 Thank you, Mr. President. First of all, my respects to the
6 Chamber, and good afternoon, Professor Campbell. And my respects
7 to the Monks and the public.
8 [14.25.17]
9 My name is Lor Chunthy, civil party lawyer. First, again, I
10 would like to thank Professor Campbell for coming to give his
11 testimony in assistance to the Trial Chamber to understand the
12 health conditions of the accused, Ieng Thirith.
13 [14.25.53]
14 QUESTIONING BY THE CO-LAWYERS:
15 BY MR. LOR CHUNTHY:
16 Q. I would like to ask, Professor, that before you come to
17 this country, do you understand what happened between 1975 and
18 1979, as this is the context that you are going to work on, given
19 your assessment?
20 MR. CAMPBELL:
21 A. Yes, I did read the history of that time.
22 Q. Thank you, Professor.
23 [14.26.52]
24 What I want to know next is, there was an incident in the Court
25 session before the Pre-trials Chamber where the accused person,

1 Ms. Ieng Thirith, objected to statement concerning her past
2 activities.
3 MR. PRESIDENT:
4 I don't think the professor can hear you. The court officer is
5 to make sure that Professor Campbell can have audio access.
6 MR. LOR CHUNTHY:
7 Q. I recall these event because during the hearing -- the bail
8 hearing before the Pre-trials Chamber, which occurred from -- on
9 the 24th of February, 2009, and another hearing on the 15th of
10 February, 2010, during which the accused, Ieng Thirith, reacted
11 to what was being discussed during that time. So I would like to
12 know whether you are aware of these incidents.
13 [14.28.56]
14 And the documents are C20/5 and C20/9.
15 MR. CAMPBELL:
16 A. The documents I have relate to the pre-trial hearing. Are
17 those the ones being referred to?
18 Q. Right. That's the transcript of the Pre-trials Chamber
19 hearings.
20 A. Yes, I've seen those.
21 Q. What do you think about her reactions concerning her
22 memory? Could you say that those reactions reflect some memory
23 in the past and now this memory is not present?
24 A. I thought that there was evidence in that hearing of both
25 memory impairment -- she had trouble remembering her husband's

1 name, for example -- and also a degree of disinhibition in her
2 responses.
3 Q. Thank you, Professor. One more question.
4 [14.30.28]
5 Given the situation that you have considered regarding Points 33
6 in relation to depression, I would like to know what basis did
7 you use in order to -- or what standard did you use in order to
8 assess and conclude whether the person has this kind of problem?
9 A. As far as depression is concerned, there had been no
10 previous assessments by psychiatrists that indicated that they
11 did not feel she was depressed. That does not mean that her mood
12 might not be low. Her circumstances are very likely to cause a
13 low mood. But there had never been any suggestion, either
14 previously or when I saw her, that that very low mood -- that low
15 mood was out of proportion to what one would expect in someone in
16 her circumstances.
17 [14.31.45]
18 She is being reviewed by four psychiatrists, and I would expect
19 them to explore that possibility also.
20 Q. Thank you.
21 You reported that there is a dementing(sic) concentration. I
22 would like to know what is the diagnosis or the symptoms
23 regarding the problems that you are assessing.
24 A. With respect to concentration, are you meaning?
25 Q. My question is that with regard to what you already

1 assessed concerning Mrs. Ieng Thirith, you have found that she
2 has developed hallucinations or cognitive impairment, but I would
3 like to know exactly what kind of symptoms or the diagnosis of
4 this kind of disease.
5 A. The hallucinations only occurred at the time of what was
6 most likely her delirium at the time of her hip fracture. The
7 problems with memory, as I've indicated, I feel that there is an
8 underlying dementing process with additional factors contributing
9 to it.
10 Q. Thank you.
11 [14.33.50]
12 So this means that because of that bone fracture, that leads to
13 these ailments. Is that correct?
14 A. The trauma of the fracture itself and the surgery required
15 to correct that is a very common cause of delirium in older
16 people, and would have been the cause in this situation.
17 Q. Now, with regard to the age of person, is it common that,
18 at her age, this kind of disease could develop on her or is it
19 not really natural; it's abnormal?
20 A. It is abnormal, but it is a common condition affecting
21 older people.
22 Q. Thank you. I have another question.
23 [14.35.16]
24 When you met her on several occasions, have you noted that she
25 developed -- or she's aware of your presence because I observed

1 that at one point there was a doctor who gave the -- who
2 interviewed her while you remained seated at the background,
3 observing.
4 I just would like to know whether such tactic is more common to
5 make sure she feels more comfortable interacting with the person
6 who puts the test to her.
7 A. Yes, that's why I used that method of examination on that
8 occasion, because I'd been concerned in the morning that, it
9 being an obviously test situation, she may not have -- she would
10 have been more anxious and may not have performed as well as she
11 might.
12 Q. Thank you. That leads to my final question.
13 [14.36.36]
14 In general terms, I would like, Professor, to clarify or
15 elaborate with respect to the context, Cambodian context or
16 cultural context may contribute to your findings and your report
17 as well.
18 A. Yes, that's a very important question, and I had been aware
19 of the cultural differences, that I'm working in a culture in
20 which I do not normally work, and that is why I had asked for
21 Professor Ka to re-interview after I had seen Ieng Thirith on the
22 first occasion. And that's why I was pleased to have one of the
23 psychiatrists with whom she was familiar conducting the
24 interview, final interview, on this visit and also having the
25 opportunity to discuss afterwards with that psychiatrist any

1 cultural issues about which I may not have been aware..
2 I apologize, that leads to the very final question. It is about
3 the CT head scan. You indicated that you have reviewed the
4 result of the scans previously and also the current scanning
5 result. What would be the changes in those outcomes of the scan
6 and could you please elaborate on this?
7 A, There may be very little change in the scan with time or,
8 alternatively, there may be an increasing degree of shrinkage of
9 the brain, cerebral atrophy, with time. It's also possible that
10 other conditions can become evident, can develop in people with
11 Alzheimer's, but there has been no evidence of that in the CT
12 scans that I have reviewed, including the latest of the 2nd of
13 June.
14 Q. Is it fair to say that it is difficult to conclude from the
15 result of the scan concerning the changes in the cognitive
16 function of Ieng Thirith?
17 [14.39.22]
18 A. Yes, one cannot look at a scan and say that it's going to
19 be associated with this degree of cognitive impairment.
20 MR. LOR CHUNTHY:
21 I am very grateful, Professor Campbell. I would like to hand
22 over to my colleague.
23 MR. PRESIDENT:
24 Thank you, Mr. Lor Chunthy.
25 Now, Ms. Elisabeth, you may proceed.

1 MS. SIMONNEAU-FORT:
2 I would like to give the floor, if I may, Mr. President, to my
3 colleague for the final questions. Thank you very much, Mr.
4 President.
5 QUESTIONING BY THE CO-LAWYERS:
6 BY MS. SUTZ:
7 Q. Good afternoon, Professor Campbell. Good afternoon to
8 everybody. I think quite a few questions have been asked. It's
9 been a long day for all of us, and so what I would like to do now
10 is just come back to a couple of answers that were given, which I
11 would be happy to see clarified somewhat.
12 [14.40.35]
13 There was a reference to the Strugar case today and yesterday.
14 And this morning, my colleague Diana Ellis asked if Ieng Thirith
15 was fit to understand the accusations against her, to understand
16 the legal procedures, to instruct her lawyers, to make statements
17 and to understand the consequences of a statement of guilt.
18 These emerge from the Strugar jurisprudence and you gave a
19 positive answer to all of those criteria. It was your
20 consideration, therefore, that Ieng Thirith was fit to stand
21 trial.
22 The Strugar case has come up several times yesterday as well in
23 referring to Nuon Chea by his defence, asking if you were up to
24 date on that jurisprudence, and at that time you said no. The
25 Co-Prosecutors referred to a document that was given to you by

1 Ieng Thirith's defence, which also referred to those criteria,
2 and in that instance you responded in the affirmative. So, if
3 possible, can we have a clarification about where you stand on
4 understanding of those criteria at the time when you drafted the
5 report?
6 [14.42.33]
7 Going through the report, you do not in fact refer to those
8 criteria at any point, nor despite the fact that the Chamber has
9 quoted that jurisprudence in the order appointing you. There is
10 no echo of such criteria, and so I would very much like to know
11 if, not today but when you drafted your report, you took those
12 criteria into consideration and how your report does in fact
13 address those criteria? Thank you.
14 MR. CAMPBELL:
15 A. Those criteria are outlined in the order assigning expert,
16 which I referred to in my document, set out on page - in
17 paragraphs five and six and the footnote refers to the Strugar
18 case. I think you may have misinterpreted my comments to the
19 defence ---
20 Q. Excuse me, there is reference to the jurisprudence and
21 there is a quote, but the criteria are not set out specifically
22 in the order. Thank you.
23 MR. PRESIDENT:
24 Counsel for the civil party, could you please repeat your
25 question because we seem to have not heard what was being

1 translated.

2 MS. SUTZ:

3 Thank you, President. I was asking if Professor Campbell,

4 bearing in mind the debates we had yesterday, if there was not a

5 little confusion because when he answered Nuon Chea's defence,

6 Professor Campbell's answer was in the negative. I'm happy to

7 stand corrected if I am wrong, but I believe that he replied in

8 the negative to Nuon Chea's defence yesterday when he was asked

9 if he was aware of this jurisprudence.

10 And when the same question was asked by the Co-Prosecutor,

11 Professor Campbell answered in the affirmative. So my question,

12 really, is just to ask for a clarification of Professor

13 Campbell's knowledge of such criteria. And if he is aware of

14 them, if he could go into how these criteria, in fact, back up

15 his reports since they aren't actually mentioned in it. Thank

16 you.

17 [14.45.29]

18 MR. CAMPBELL:

19 I think the defence for Nuon Chea had raised issues about other

20 jurisprudence, not Strugar, and I replied to that. The Strugar

21 criteria have been set out in the different documents I've

22 received, and they were the basis on which I drew my conclusions.

23 MS. SUTZ:

24 Can my learned colleague from Nuon Chea's defence perhaps

25 enlighten us on this subject?

1 MR. PRESIDENT:
2 Actually, the defence team for Nuon Chea is here as an observer,
3 so technically they are not part of the proceedings and
4 consequently are not allowed to do so with a statement.
5 MS. ELLIS:
6 In fairness, it was said by Professor Campbell, as we heard it,
7 that he had not seen the Strugar capacities. That, by the sound
8 of it, was a misunderstanding, but certainly our note recorded
9 that. I think it was corrected in the course of the day. I hope
10 that clarifies it.
11 [14.47.14]
12 MS. SIMONNEAU-FORT:
13 Q. Perhaps I could add to this issue. When expert testimony
14 is called for to judge the fitness of somebody to be tried, then
15 you go on the basis of what my colleague explained. And we are
16 not fully aware, from this debate, whether you are deeply aware
17 of these criteria or if you simply read the footnote in the
18 order. These fitness issues are very precise. There is no
19 reference to them in your report and there is no point in which
20 the report indicates that you tried to respond to the issues
21 raised in these criteria. But these are essential to judge the
22 aptness of somebody to stand trial. So could you please tell us
23 why, in your report, you absolutely never referred to these
24 fitness questions? That would give us a precise answer. Thank
25 you.

1 (Judges deliberate)

2 [14.48.43]

3 MR. PRESIDENT:

4 According to the order assigning expert Professor Campbell to

5 assess the fitness to stand trial of the accused persons, the

6 Chamber has not instructed the expert to rely on the criteria

7 with reference to the Strugar case as the basis for his

8 assessment. It is therefore the assertion concerning the

9 criteria with reference to Strugar jurisprudence is not relevant

10 to the order assigning the expert.

11 May the counsel be therefore advised to put questions that have

12 not been asked by the Co-Prosecutors and that the questions shall

13 be straightforward to the report-related issues by Professor

14 Campbell with reference to Ieng Thirith.

15 I would like to hand it over to Judge Lavergne to give further

16 clarification.

17 JUDGE LAVERGNE:

18 Thank you very much, Mr. President.

19 Perhaps one or two things have become lost in the discussion and

20 the first, I believe, was covered in your statement, and that is

21 the fact that the criteria that are set out in the Strugar

22 decision are juridical criteria. There are questions that

23 therefore fall to the competence of the Chamber. That is the

24 basis that the Chamber will base its decision upon, but they do

25 not - it is not part of the expert's mission to respond under

1 those questions. What our expert is asked to do is to provide
2 the Chamber with technical, medical information in sufficient
3 quality and quantity so that a decision can be taken by the
4 Chamber. I hope that is clear now.
5 [14.52.01]
6 MS. SIMONNEAU-FORT:
7 Thank you for that clarification. That is quite clear. The
8 order assigning Professor Campbell was asking him to decide upon
9 fitness or otherwise to stand trial. Now, the questions in
10 Strugar jurisprudence are not those that Professor Campbell has
11 to answer to, but what the Chamber must base its decision upon.
12 The Chamber must expand upon these in due course, but it is also
13 necessary for the expert to be aware of those criteria so as to
14 be able to duly inform the Chamber.
15 We understand that the order in assigning the expert did not set
16 out these questions in detail and we understood that. We have
17 our answer, too. The expert did not examine the fitness of Mrs.
18 Ieng Thirith by referring to the questions that the Chamber is
19 going to have to respond to subsequently.
20 In other words, he did not have the elements of the subsequent
21 decision that the Chamber will take in making his diagnosis. He
22 took a decision about a fitness to stand trial without working on
23 the basis that the Chamber will subsequently work upon. I just
24 wanted to be clear about that. Thank you.
25 JUDGE LAVERGNE:

1 We seem to have some understanding difficulties here. The
2 Strugar jurisprudence was covered in that footnote so that the
3 expert can understand what the final purpose of his report is.
4 The expert has to know what questions the Chamber is going to be
5 taking up so as to do his job. He doesn't have to respond to
6 them; he has to simply bear them in mind so that the Chamber is
7 able to do so subsequently.
8 [14.54.31]
9 MS. SIMONNEAU-FORT:
10 I am sorry for insisting, but the footnote does not set out the
11 precise questions that the Chamber has to respond to, and I'm not
12 certain that our expert was taking up those questions in any
13 great detail. I do not believe that he was taking into
14 consideration questions such as ability to understand procedure,
15 ability to understand accusations and so forth when he did his
16 study. We will draw the necessary conclusions. I do not believe
17 that the expert had those issues before his eyes when he was
18 working. I think that is the simple conclusion. Thank you.
19 MS. ELLIS:
20 Mr. President, as I understood an earlier answer from Professor
21 Campbell, he had been provided with the document drafted by our
22 defence team back on the 21st of March of this year. And at page
23 2 of that document, we specifically ask if Professor Campbell can
24 make a preliminary assessment of the elements of mental fitness
25 to stand trial in accordance with the approach in Strugar, and we

1 then set out the capacities, non-exhaustive, which he should bear
2 in mind.
3 I understood Professor Campbell to inform the Court he had seem
4 that document. If that is right, the lead co-lawyers have
5 misunderstood the extent of the information provided to Professor
6 Campbell at the time.
7 MR. CAMPBELL:
8 Could I just comment that I was fully aware of the document from
9 the defence and the criteria set out in that document prior to
10 seeing Ieng Thirith.
11 [14.56.28]
12 MS. SIMONNEAU-FORT:
13 Therefore, I believe that the question is particularly
14 significant that we asked. Why in the report is there absolutely
15 no reference to these questions so that we can understand to what
16 extent we -- you reach the conclusion that Mrs. Ieng Thirith is
17 not fit to stand trial. If there's no reference to the criteria,
18 it's rather hard for us to understand your conclusion. Thank
19 you.
20 MR. CAMPBELL:
21 Because I was not asked to assess against those criteria
22 specifically in the instruction I had from the Chamber.
23 MS. SUTZ:
24 Thank you, Mr. President. I have a final question, if I may, a
25 request for further clarification.

1 Q. Professor Campbell, you have said repeatedly yesterday and
2 today that Ieng Thirith, as you see it, was not trying to fool
3 you or to falsify any of the results of the tests. Is this a
4 personal conclusion you have reached, as any of us may, or is it
5 based on scientific premise? Thank you.
6 [14.57.56]
7 MR. CAMPBELL:
8 A. It's based on my experience as a clinician and
9 administering those tests a great number of times.
10 Q. Could it therefore be envisaged that although we know Ieng
11 Thirith has certain cognitive troubles, she may be able to
12 exaggerate them?
13 A. I think that's a difficult question to ask. I think to
14 answer, I think in certain circumstances her performance on tests
15 lacked that, may be compromised by, for example, her anxiety. I
16 did not feel from my assessment of her that she would have the
17 capacity to deliberately falsify the tests in a way that would
18 mislead me.
19 MS. SUTZ:
20 Thank you, President. I have no further questions.
21 QUESTIONING BY THE CO-LAWYERS:
22 BY MS. SIMONNEAU-FORT:
23 A final question, please.
24 Q. Professor Campbell, you know that four experts have been
25 designated and the Chamber therefore would like to carry out a

1 further study. That has been said publicly. But these future
2 experts, in your view, will tell us if the situation has got
3 worse, in the future, or might they be appointed to express a
4 view that differs from your own?
5 [14.59.47]
6 MR. CAMPBELL:
7 A. I would feel that they've been appointed to give
8 independent views, their own clinical opinions. I mean, they
9 will clearly base their opinion in part on what has gone before,
10 both my report and the reports from other people who have seen
11 Ieng Thirith. As I've said, it's a clinical diagnosis, and to
12 have the additional clinicians, I think, will be important in
13 making absolutely sure, one way or the other, as to whether Ieng
14 Thirith is medically capable of standing trial, fitness to stand
15 trial.
16 Q. This expertise, therefore, is necessary, I understand?
17 A. The experts have already been appointed, I gather, so it is
18 the opinion of the Chamber that they are necessary.
19 MS. SIMONNEAU-FORT:
20 Thank you, we have no further questions.
21 [15.00.54]
22 MR. PRESIDENT:
23 Thank you.
24 We note counsel for Ieng Thirith is on her feet. You may
25 proceed, finally. We will hand it over to you, but please be

1 brief and try not to repeat what has already been covered.
2 MS. ELLIS:
3 Thank you very much.
4 QUESTIONING BY DEFENCE COUNSEL:
5 BY MS. ELLIS:
6 Q. Professor Campbell, could I just go back to 2006, the 6th
7 of January? You've confirmed that you saw the report of the scan
8 that showed generalized brain atrophy. It was on the 10th of
9 January of that year that the episode of psychosis was diagnosed.
10 That's right, isn't it?
11 [15.02.24]
12 MR. CAMPBELL:
13 A. As we've discussed, I think that was a delirium rather than
14 a psychotic illness.
15 Q. It's a delirium, which lead -- which, from what you said,
16 then passed and there's no indication that it has ever
17 reoccurred?
18 A. There's been no indication through any of the reports of
19 any psychotic illness following that episode of delirium.
20 [15.02.55]
21 Q. In response to a question by the Co-Prosecutors, there was
22 a diagnosis of psychosis in remission that's contained in the
23 record from Bangkok. Does it therefore follow that she must, in
24 the view of one of the doctors there, have been seen as psychotic
25 at some point?

1 A. I think the most likely consequence -- the most likely
2 sequence of events is that she had hallucinations and they were
3 thought to be part of a psychotic illness rather than part of a
4 delirium. Hallucinations can occur with both delirium and
5 psychotic illnesses. I think in retrospect, this was a delirium
6 rather that a psychotic illness.
7 Q. Thank you.
8 She nevertheless attended a psychiatric clinic as an outpatient
9 for the next six months. Would it be fair to say that you have
10 seen no records that give a clear understanding of her
11 psychological state for much of the period between 2006 and
12 November 2007?
13 A. That's correct.
14 Q. What we have on the material is a paucity of description as
15 to why it was she was medicated for psychological illness and,
16 indeed in November 2007, described as having a psychological
17 illness.
18 [15.04.56]
19 A. I think the likely sequence of events is that the drug
20 quetiapine was started at that stage, the delirium settled,
21 probably irrespective of the medication. With her settling, it
22 may well -- the settling may have been attributed to the drug and
23 the drug therefore continued long term, rather than being tried
24 off it.
25 Q. Now, you've been asked about Alzheimer's and the diagnosis

1 of that disease. Is it the case that but for a very few cases,
2 the diagnosis is made as a result of an investigation on post
3 mortem? The brain has to be examined to have a complete
4 understanding that the patient has in fact suffered from
5 Alzheimer's?
6 A. To be 100 per cent sure at this stage, yes.
7 Q. And therefore, the probable diagnosis comes from the whole
8 range of factors you've described?
9 A. Yes. Most diagnosis is based on probabilities and we are
10 looking at the most probable situation.
11 [15.06.12]
12 Q. Thank you.
13 You've been asked quite a bit about the first expert report from
14 Professor Ka and Dr. Brinded and, as you've said, you've asked
15 for Professor Ka to be involved in reviewing Ieng Thirith before
16 you finalized your report of the 23rd of June of this year.
17 Are you aware of any disagreement between yourself and Professor
18 Ka in the area of Ieng Thirith's cognitive impairment at this
19 stage?
20 A. No, his findings were consistent with mine. His extreme
21 end of mild may well be my moderate, I think.
22 Q. But in terms of discussing the case with him, were you both
23 of a similar view?
24 A. I have not discussed the case with him; I've just had his
25 report.

1 Q. Thank you.

2 You then indicated why it was you sought the assistance on the

3 25th of August of Dr. Chak Thida, he being a Cambodian and,

4 therefore, perhaps assisting in the reliability of the testing.

5 He had provided the report that's being referred to and that

6 we've seen on the screen, indicating that Ieng Thirith in

7 February, the 17th of February of this year, appeared to respond

8 correctly to questions, have a normal speech range and responses

9 and was meaningful and coherent.

10 He did note, did he not, concern about her concentration and

11 attention?

12 A. Yes, she did.

13 [15.08.09]

14 Q. And were you in a position where you were able to see any

15 tests that had been conducted in February of this year by Dr.

16 Chak?

17 A. No, I did not.

18 Q. Did you ask for any tests?

19 A. No, I did not ask for any formal tests.

20 Q. And no formal tests were produced, the results, and shown

21 to you, from him?

22 A. No, that's correct

23 [15.08.36]

24 Q. But in any event, whatever his view in February 2011, was

25 he in agreement or disagreement with you as a result of the

1 process that was undertaken on the 25th of August of this year?
2 A. No, she was in agreement with that process and was very
3 willing to carry out that interview, and was aware of the
4 concerns about Ieng Thirith's memory that became evident during
5 that interview.
6 Q. Thank you.
7 You've indicated that you were familiar with the transcript that
8 has been displayed on the screen, of words spoken by Ieng Thirith
9 on the 14th of November 2007. And you have indicated that that,
10 even at that stage, does give rise to some concern about her
11 cognitive impairment.
12 A. Yes, both her words and her demeanour at that time.
13 Q. And having seen the transcript at that time, can you
14 confirm please -- and I won't put it on the screen because it's
15 clearly a document that's in the hands of all interested parties
16 -- it was said by her international co-lawyer -- her national
17 co-lawyer, Mr. Phat Pouv Seang, that she suffered from permanent
18 illnesses, needed to take medication four times a day, her
19 mobility was reduced, she needed lavatories for disabled people
20 and he expressed concern at the complications that might arise
21 from her detention and said that she was certified by a doctor as
22 suffering from a mental illness.
23 [15.10.42]
24 I simply put that on the record to complete what took place at
25 the time of the comments that she made, and you can confirm you

1 read that, if you read that document?

2 A. I cannot recall those actual words. I read mainly her

3 testimony, and that may have been prior to her testimony.

4 Q. Well, perhaps in view of the fact that it is a document

5 that is available to everyone, and I, of course, would be correct

6 ---

7 MR. PRESIDENT:

8 Counsel, could you please hold on a moment because we need to

9 make sure that a new DVD has replaced the full capacity one

10 already, at the moment.

11 (DVD change)

12 Counsel for Ieng Thirith may now proceed, but the Chamber would

13 like to also remind counsel that your questions are merely

14 additional questions that have already -- and that are not really

15 reply to the parties. Could you therefore be advised to just

16 make your questions in terms of the reply rather than additional

17 questions to the expert?

18 MS. ELLIS:

19 Thank you, Mr. President. Could I give the Court the reference

20 which is E17/1/2.4 which sets out what was said at the -- on the

21 occasion?

22 [15.13.14]

23 Q. And could I just then move on and ask, Professor Campbell,

24 please, you've mentioned mild, moderate, severe impairment. You

25 also used the word significant in one of your reports. How

1 should the Court understand the difference between a mild
2 impairment and moderate and moderately severe or severe?
3 MR. CAMPBELL:
4 A. When I use the word moderate it means that the cognitive
5 impairment is such that it is going to interfere with the
6 person's daily life, their ability to manage their affairs.
7 Significant, again, means that it is significant in their life.
8 It is affecting what they're able to do, how they interact with
9 people, how they're able to conduct their business.
10 Q. You have been asked by the lead co-lawyers about the
11 capacities as set out in Strugar. If we look at your expert
12 report of the 23rd of June, paragraph 41 where you say:
13 "She is unable to recall accurately many details of her past, is
14 unable to maintain concentration and a coherent conversation for
15 more than a few minutes and is often unable to respond
16 appropriately to questions. These impairments would compromise
17 her ability to participate fully in her trial and exercise her
18 fair trial rights."
19 [15.15.09]
20 When you drafted that paragraph, did you have in mind the
21 capacities that are referred to in Strugar?
22 A. Yes, I was aware of those capacities and had those in mind.
23 Q. Thank you.
24 And finally this; is it your position that as of today, your
25 conclusion is that Ieng Thirith is cognitively impaired to an

1 extent that she couldn't meaningfully participate in her trial
2 and exercise her fair trial rights? But before confirming that
3 decision, or changing it, you feel that every avenue should
4 properly be explored to see whether there can be some marginal
5 improvement?
6 A. That is how I feel; every option should be explored. I
7 have indicated in my supplementary report that my conclusions are
8 the same as they were in my initial report. And as has been
9 indicated, the final decision is of course that of the Chamber.
10 MS. ELLIS:
11 Of course. Thank you very much, Professor Campbell.
12 [15.16.47]
13 MR. PRESIDENT:
14 Thank you, counsel, and thank you, Professor Campbell.
15 It is an appropriate time to take a 15-minute adjournment. We
16 will resume at 3.30.
17 The Chamber would like to also inform the parties of the
18 proceedings and the public that the individualized session
19 concerning the report on the fitness to stand trial of Ieng
20 Thirith comes to an end.
21 The following session will be the session dedicated for Nuon
22 Chea.
23 And Ieng Thirith's defence team can attend the following
24 proceedings as observers should they wish to do so.
25 [15.18.06]

1 The security personnel are instructed to bring Nuon Chea to the
2 courtroom when the next session commences, and that Ieng Thirith
3 is ordered to be brought back to the detention facility.
4 (Court recess from 1519H to 1533H)
5 MR. PRESIDENT:
6 Please be seated. The Court is now back in session. The
7 following session will be the individualized session for Nuon
8 Chea regarding the expert report.
9 [15.33.36]
10 The Chamber would like to hand over to Judge Cartwright to put
11 questions to the expert concerning his report of Nuon Chea.
12 JUDGE CARTWRIGHT:
13 Yes. Thank you, President.
14 MR. PESTMAN:
15 Excuse me. Sorry for interrupting.
16 [15.34.02]
17 Your Honours, I would like to ask you to continue the examination
18 of this expert witness in closed session. I feel that we would
19 more freely be -- first of all, my client would wish to continue
20 in closed session because he does not want to discuss his private
21 medical matters in public. We feel that his interests, his right
22 to privacy outweighs the right of the public to be informed and
23 to follow those proceedings.
24 [15.34.43]
25 I think it's in the interests of justice that the curtains are

1 closed. And what I was trying to say is that I feel that we will
2 be more freely -- we will be able to allow -- we will be able to
3 present our documents more freely than we would be if we continue
4 in open session. And we would feel forced to -- not to ask
5 certain questions, refrain from certain -- asking certain
6 questions or presenting certain documents if we continue in open
7 session, especially when those documents contain sensitive,
8 potentially embarrassing medical information about our client.
9 [15.35.30]
10 So we would like to ask you to continue in closed session.
11 MR. PRESIDENT:
12 (No English translation)
13 MR. ABDULHAK:
14 Thank you, Mr. President, if we may respond very briefly.
15 [15.35.46]
16 I think up until this point and to the great benefit, certainly,
17 of the public, proceedings have proceeded in public. The
18 Co-Prosecutors certainly support as much of the proceedings
19 remaining in public as possible, and in that light, we would just
20 note that significant aspects of the assessment of Nuon Chea were
21 discussed yesterday.
22 [15.36.06]
23 And certainly it is -- Your Honours will commence the examination
24 and Your Honours may be in a position to determine which
25 questions could continue to be appropriately dealt with in public

1 session in light of those proceedings yesterday and then perhaps,
2 of course, consider where private medical information is at
3 issue, going into a closed session as requested.
4 MR. PRESIDENT:
5 Lead Co-Lawyers, you may now proceed.
6 MS. SIMMONEAU-FORT:
7 Mr. President, on the subject of closed or open sessions, I
8 believe that the openness of debates is important for justice.
9 [15.37.15]
10 Yesterday, there was much talk of the public side of the debate,
11 and you revealed a certain number of elements in the dossier as
12 well. And you referred to the fitness to stand trial and the
13 ability to attend hearings over a given period. Those are the
14 two issues that have been raised.
15 You told us about the answers given by the experts, and we spent
16 a day and a half talking about those answers. And you have
17 explained to us that there will be further expert studies.
18 [15.37.57]
19 So the questions we're talking about over these three days are
20 extremely important, with highly important consequences, and they
21 are being talked about in the media and the press. The stakes
22 are high. They are being publicly discussed, and it's very
23 important that the debate should, therefore, continue to be
24 public.
25 [15.38.21]

1 The more debates are public, the more the public, the victims,
2 the civil parties and the public in general will understand what
3 is going on, what is happening, and what the real stakes are.
4 If, for example, we need to appoint new experts, this means
5 further delays. If somebody's not fit to stand trial, that means
6 that the person will no longer belong to the trial at all, be
7 part of it.
8 These are major stakes. And with everything that has been said
9 so far, I do not believe that we can call for a closed session
10 which will deprive the public of a basic understanding of the
11 reasons why decisions are taken in the future by the Chamber.
12 [15.39.12]
13 You have ordered an expert's opinion. The questions in it are
14 public. The answers given are also public. And the consequences
15 of it and the decision that you will be obliged to make at the
16 end of your conclusions are also public. The expert has been
17 with us to answer questions, and the contents of his report are
18 only real when they are connected to public issues and public
19 questions.
20 The whole content of the report can be the subject of a public
21 debate today, and it's very important that we hold that public
22 debate. If we do not, then I am afraid that what we say here and
23 the conclusions that you may draw could be seen as being
24 arbitrary.
25 [15.40.07]

1 It's very important for the public that the question of the
2 health of the accused should be publicly debated. We are
3 interested in the health of the accused, but the public is also
4 interested in the health of the civil parties, and quite rightly
5 so. And it is very important that everybody should understand
6 the reasons behind the decisions that you will take, having heard
7 the opinions of experts, which you will take on the basis of
8 things that are being discussed before you today.
9 [15.40.40]
10 It seems, therefore, that public debate is necessary and it
11 should, therefore, continue as we have held it since the start of
12 this hearing. I don't really believe that we are going to talk
13 about issues that are particularly intimate or that are external
14 to the public issues that we are all debating.
15 Thank you.
16 (Short pause)
17 [15.43.26]
18 MR. PRESIDENT:
19 After having been seized of the application by Nuon Chea's
20 defence team to call a closed session with regard to the hearing
21 on the report prepared by the expert and that the accused person
22 also indicates that such a proceeding shall be called -- or shall
23 be made in a closed session, and having also considered the
24 response by the prosecutor and the co-lawyers, the Chamber
25 finally decides to reject the application by the defence counsel

1 because we have already noted that much debate has been already
2 been made during the few previous sessions, which was much made
3 in public.
4 [15.45.03]
5 The Chamber, indeed, wishes to make it clear that we would like
6 to call a closed session when it is needed and that, like in this
7 morning's session, all related confidential documents were
8 allowed to only be handed over to the expert, but not projected
9 on the screen.
10 I, therefore, now hand over the floor to Judge Cartwright to
11 proceed with the questioning to the expert.
12 JUDGE CARTWRIGHT:
13 Thank you, President.
14 QUESTIONING BY THE BENCH:
15 BY JUDGE CARTWRIGHT:
16 Q. Professor Campbell, I am conscious that this has been a
17 very long and tiring day for you, but equally, I am aware that
18 your time with us is limited, and for that reason, I am going to
19 begin the questioning from the bench and hope to get it through
20 before we adjourn for the day. And just so that the counsel, the
21 parties and the public are aware, my understanding is that
22 Professor Campbell must leave Phnom Penh tomorrow some time after
23 4 o'clock, so we have only tomorrow left and what's left of
24 today.
25 [15.46.20]

1 So we'll keep it as brief as we can, and I do -- I am very
2 grateful to you for the brevity of your answers.
3 Professor Campbell, we are, of course, aware that you have
4 examined Nuon Chea and you have prepared two reports for the
5 Court in relation to him, the first dated the 13th of June of
6 this year, and the second after your re-assessment last week
7 dated the 26th of November. I'll deal with the first one, and
8 then we'll move to the second one.
9 [15.47.00]
10 In your June report, you isolated some physical health issues in
11 relation to Nuon Chea, four areas: cardiovascular disease;
12 cerebrovascular disease; musculoskeletal problems, and what you
13 call other systems.
14 Could you summarize your findings in relation to each of these?
15 And of course, I simply remind the parties and the public that
16 we've been through the -- most of the elements of your
17 examinations of Nuon Chea and your review of the documentation
18 when we looked at this issue yesterday.
19 Thank you.
20 MR. PESTMAN:
21 Excuse me. I would like to again ask the Court, Your Honours, to
22 move into a closed session. We're going to discuss -- this
23 expert witness is invited to discuss his findings, findings
24 contained in the report which has been labeled strictly
25 confidential. I don't understand why on the one hand the report

1 is labeled strictly confidential and we are continuing now in
2 open session.
3 I don't -- I understand, and I think the report is labelled
4 strictly confidential for good reasons. I don't understand why
5 we should continue in open session when we are going to discuss
6 the findings of this expert in detail.
7 What we discussed yesterday was all general questions about
8 methodology, as you know.
9 [15:48:41]
10 JUDGE CARTWRIGHT:
11 Yes, thank you. The President has invited me to respond.
12 The documents were labelled strictly confidential to limit their
13 distribution to the public generally so that only those most
14 concerned with these issues would have access to the full
15 document.
16 Your application to go into closed session has been considered
17 and rejected.
18 And if I may summarize what Judge Lavergne was reminding me
19 concerning the procedures in the civil law system, once the
20 Chamber has referred to documents marked confidential or strictly
21 confidential on the case file they are put before the Chamber and
22 therefore are available for public discussion in the course of
23 this hearing.
24 JUDGE CARTWRIGHT:
25 Q. Shall I return, Professor Campbell? You're ready to

1 summarize the physical findings under those categories please?
2 MR. CAMPBELL:
3 A. I think it may be clearer for the Court if I summarize each
4 of the systems in relationship to the symptoms that may affect
5 fitness to stand trial.
6 So we start with the cardiovascular system. I won't reiterate
7 Nuon Chea's history. The potential problems in someone with
8 cardiovascular disease are firstly that the person has angina
9 brought on by the stress of the sitting. Nuon Chea has not
10 suffered from angina recently and so this is not an ongoing
11 problem.
12 The person may suffer from shortness of breath, but again, I do
13 not feel that he has had shortness of breath related to his
14 cardiovascular disease at all, and I do not feel the stress of
15 the court sittings will induce problems with heart failure and
16 shortness of breath.
17 [15:51:24]
18 The third cardinal symptom is one of exhaustion or tiredness
19 which can come on with cardiovascular disease, and it is possible
20 that the cardiovascular disease will contribute to his tiredness
21 with the proceedings.
22 As far as the cerebrovascular disease is concerned, it may effect
23 language but there has been no evidence of that in my discussions
24 with Nuon Chea or in the history. It does affect his mobility
25 and processes have been put in place to ensure that he is able to

1 get freely to and from the Court.
2 Cerebrovascular disease and multiple strokes, as we've discussed
3 earlier, can cause cognitive impairment, but in my discussions
4 with him and review of all the medical files there has been no
5 evidence of significant cognitive impairment.
6 As far as muscular skeletal system is concerned, this may affect
7 a person's ability to sit for prolonged periods and to
8 concentrate during that time. In my discussion on the first
9 interview with Nuon Chea he indicated that he could sit for two
10 to three hours or so without that being distressing.
11 When one brings all those systems together one needs to consider
12 them in total then they may have an effect on the person's
13 ability to concentrate over a prolonged period or to sit for a
14 long period. And as I've indicated in my second report, he
15 indicates that he finds an hour and a half to be at the limit of
16 his ability to concentrate and participate. That seems to be the
17 usual length of the sitting each session of the Court and
18 therefore could be accommodated in the normal Court times.
19 Q. Professor Campbell, you did mention other systems. Is
20 there anything that you want to mention in relation to those?
21 [15:53:14]
22 A. No, there have been ongoing problems with a mild degree of
23 chronic renal impairment but that has been stable. There are no
24 significant problems there. He has had a previous history of a
25 gastrointestinal haemorrhage but that is well in the past and not

1 a problem now.

2 Q. Thank you. Now, there have been quite a significant number

3 of medical reports concerning Nuon Chea that you have had access

4 to, particularly in relation to the four areas of his physical

5 health that you have just summarized. Is there any aspect of any

6 of those other reports on his physical health that you would wish

7 to comment on?

8 A. These have been very comprehensive reports, and I think one

9 of the overriding issues that comes through in those reports is

10 that his physical condition has been stable, recently stable,

11 over that time, both with his cardiovascular disease,

12 cerebrovascular disease, and also his mobility.

13 Q. Now, turning to the issue of his cognitive function, is it,

14 in general, correct that the reports summarize examinations and

15 tests that have been conducted and recommend regular assessment

16 given Nuon Chea's age?

17 A. Yes, that is so. That's particularly the reports from

18 Professor Lafont and Ponk Son (phonetic).

19 Q. And in fact those reassessments have been done on a

20 reasonably regular basis, have they not?

21 [15:54:55]

22 A. They have been done six monthly and those reviews have

23 consisted not only of the clinical assessment but also necessary

24 for a number of investigations including echocardiography and

25 electrocardiograms.

1 Q. And can you comment in relation to your observations and
2 the information you gleaned from those reports on Nuon Chea's
3 long-term memory?
4 A. The comments, particularly from Professor Lafont's report
5 indicate that they have not determined or found any cognitive
6 impairment or problem with language or structural problems, and
7 that has been a consistent finding throughout all those reports.
8 Q. And in addition to Professor Lafont there was a
9 neurological examination and report produced by Dr. Chan Samleng
10 on the 9th of June last year, 2010, and he made comment on Nuon
11 Chea's neurological status. Are you able to recall that report?
12 A. I am. And in relation to his neurological state his
13 findings neurologically have been consistent over time. He has
14 only very subtle residual effects from his 1995 stroke.
15 Q. Now, in 2009 Nuon Chea was offered the opportunity for
16 examination by Professor Ka Sunbaunat and Dr. Brinded and for a
17 variety of reasons declined to participate in that examination.
18 Do you recall seeing the report on his status, albeit without the
19 opportunity of examining him personally?
20 A. Yes, I have read that report and I read it again very
21 recently. Their decision or comments were based on the written
22 records that they had at that time.
23 [15:57:07]
24 Q. And does that method of assessment, while everyone would
25 have to acknowledge that it's not as good as a direct assessment,

1 is that a known medical means of assessing in general the status
2 of a person's health?
3 A. As you indicated, it is not ideal but I felt that the
4 conclusions they drew from the written material were entirely
5 reasonable.
6 Q. Now, you have in fact assessed Nuon Chea for his cognitive
7 as well as for his physical abilities. Is there any aspect of
8 the reports that you have considered or your own assessment and
9 examination that might lead you to conclude that he has impaired
10 cognitive function?
11 A. No, there is nothing in the reports that I have read or in
12 my discussions with him or examination that would lead me to feel
13 so.
14 Q. Now, over the last two days you've heard repeated
15 references to Nuon Chea's inability to concentrate for more than
16 an hour and a half, and you have just commented on that yourself.
17 And yesterday, I believe, you were asked if there was any
18 specialist expertise that could measure this ability to
19 concentrate objectively as opposed to being told by the person
20 what he believes his ability is. Can you comment on that?
21 A. I don't believe that there is a reliable measure in this
22 sort of situation that could be used to assess concentration.
23 Q. When you say "in this sort of situation" are you referring
24 to the conditions in which Nuon Chea finds himself, namely in
25 detention and facing rather very serious criminal charges?

1 [15:59:20]
2 A. Yes, partly that and also the purpose of the assessment.
3 As I indicated, someone with cognitive impairment or who failed
4 to concentrate may have a falling off of the test done over time.
5 But in that situation it is one's interpretation that this is an
6 impairment of concentration is based on the understanding that
7 the person is trying with that test as much as is possible, as
8 hard as they can.
9 Q. A few minutes ago you said that ability to concentrate for
10 an hour and a half coincided with the approximate limit of each
11 court session, that is from morning 'till morning tea time and so
12 on. Are you suggesting that with a break, a regular break, such
13 as the morning adjournment, the luncheon adjournment, the
14 afternoon adjournment, that Nuon Chea would be able to
15 participate in court?
16 A. Yes, I am suggesting that, especially with the use of the
17 holding cells as well.
18 Q. Now, we'll turn to your reassessment, which was conducted
19 last week, and which you call a follow-up geriatric report. And
20 I'll go through that in a little more detail because it has not
21 been made so widely available, given the brief time that we've
22 had it available to us.
23 So, first of all, you have a portion where you evaluate Nuon
24 Chea's current situation. Before we move to that, there was some
25 additional documents, medical documents that you reviewed in

1 paragraphs 4 and 5, and you've attached those to your report. Is
2 that correct?
3 A. That is correct.
4 [16:01:24]
5 Q. In those reports where we stay with those for a moment, I
6 notice the practice of the reporting physician or laboratory that
7 highlights test results that are outside the normal range. Could
8 you just go through the biochemical report please where
9 phosphorous, for example, is outside lower than the normal range
10 and just go through each of the marked test results and give us
11 your views as to whether these are significantly outside the
12 range and would have an impact for Nuon Chea.
13 A. The phosphorous is a little low but I would not expect that
14 to have any clinical consequences at all.
15 His glucose again is below normal but that may -- almost
16 certainly would have been a fasting specimen and I do not feel
17 that that is significant. So there's been no suggestion of any
18 impairment of glucose control.
19 His LDH is a liver enzyme and it is only marginally raised and
20 does not indicate any problem that would have a bearing on his
21 fitness to stand trial.
22 His creatinine at 126 indicates a very mild degree of kidney
23 impairment. That creatinine has not increased over time. It has
24 been stable at that level.
25 If we go to the haematology results his haemoglobin is at the low

1 limit of normal. I would not be at all concerned about that
2 level of haemoglobin in a person of his age. And the others are
3 measures of his red blood cells, not of significance in the
4 presence of that haemoglobin.
5 [16:03:30]
6 His other haematological results don't indicate any significant
7 impairment. The only other abnormality is a very slight
8 elevation of his prostate specific antigen, the PSA. And again,
9 that sort of level is not of significance. Nuon Chea has had
10 extensive investigations of his urological system and there is no
11 ongoing problem.
12 Q. Thank you. And also there's the medical report of the 22nd
13 of February 2011, which I don't believe you had seen until this
14 time you assessed Nuon Chea, and this is one that you've referred
15 to previously where the MMS score is referred to.
16 A. I felt I should include this. I had not done any formal
17 mental test scoring when I saw Nuon Chea because I was concerned
18 about the accuracy of any results I might get, and therefore,
19 this report, I thought, was of importance. It did indicate a
20 normal mini mental state examination score in a situation which
21 was where the assessment was separate from trial considerations.
22 This was part of a normal medical assessment. And I therefore
23 felt that it could be taken as a true accurate reflection of his
24 cognitive function.
25 Q. And when you are sceptical about getting accurate results

1 on this sort of testing administered by you, this is the exact
2 opposite of your usual situation where someone's trying really
3 hard to show that they are capable of managing their own affairs,
4 living independently and the like. Is that the case?
5 A. That is correct. Had I had any indications of impaired
6 intellectual function in the history or in my examination I would
7 have proceeded to tests but did not feel I needed to.
8 Q. Thank you. Now, returning to your updated report, your
9 evaluation refers to the various reports that you've reviewed,
10 and we've considered those already, dealing first with
11 cardiovascular disease, could you summarize your findings in your
12 most recent report please?
13 [16:06:20]
14 A. As far as Nuon Chea's cardiovascular disease is concerned,
15 this is stable at present. He is not troubled by angina,
16 although he has symptoms of shortness of breath, they are not the
17 sort of symptoms of shortness of breath that would indicate
18 cardiac failure.
19 He does have some tiredness, which may well be reflected -- may
20 be the result of a number of different factors to which
21 cardiovascular disease may contribute, but also I think his lack
22 of physical activity, his difficulty with mobility making
23 everything more of an effort, I think that's more likely to be
24 contributing to his tiredness.
25 Q. Thank you. The cerebrovascular disease and cognitive

1 function, which we've already, to a degree, covered, perhaps
2 though the cerebrovascular disease could you comment on that,
3 your findings in relation to that?
4 A. Yes. Nuon Chea had a stroke in 1995. This was a small
5 stroke affecting the connections within the brain, the white
6 matter within the brain, a lacuna stroke, not the sort of stroke
7 to be associated with cognitive impairment.
8 As I've indicated in my report, he does complain quite frequently
9 that his brain is not normal; that he does have difficulty
10 because of that. If there had been any underlying neurological
11 disease to account for that I would have expected progression
12 over the four years since this was first noted in the defence
13 counsel's application for assessment, and I would have expected
14 to see change on, for example, the CT head scan,
15 [16:08:03]
16 Q. Yes. And one final question from me, Professor Campbell.
17 Is there any aspect of your examination of Nuon Chea's physical
18 or cognitive function that would lead you now to recommend
19 further expertise in relation to him for examination for the
20 purposes of fitness to stand trial?
21 A. I did not feel that further assessment was needed.
22 Q. Thank you, Professor Campbell.
23 JUDGE CARTWRIGHT:
24 President, I have no further questions, but it looks like Judge
25 Lavergne does.

1 THE PRESIDENT:

2 Thank you, Madam Judge. Thank you, Professor.

3 Does any other judge off the bench would like to take the floor?

4 Please go ahead, Judge Lavergne.

5 QUESTIONING BY THE BENCH:

6 BY JUDGE LAVERGNE:

7 Q. Yes. I have a simple question in relation ---

8 MR. PESTMAN:

9 I'm sorry to interrupt again but my client raised his hand and he

10 indicated that he would like to make -- to state something.

11 Thank you.

12 [16:09:51]

13 THE PRESIDENT:

14 We are running out of time. I would like to give the floor to

15 Judge Lavergne first, and if we still have time at the end of

16 today's session we will give the floor to Mr. Nuon Chea,

17 otherwise, he will be given the floor later tomorrow morning.

18 Please?

19 MR. NUON CHEA:

20 Past and present is different. My disease has changed. In the

21 past I can walk even though I have a stroke, but later on I have

22 to depend on my walking stick, and now I have to walk with six

23 legs, choosing my supporting staff.

24 My health has been decreased. It's not that I do not believe in

25 doctors but my health conditions has changed. It becomes worse

1 and worse both physically, emotionally, as well as my
2 intellectual abilities. That is why I'm saying that what is in
3 the past and what it is now is different, and what is now will be
4 the consequence of what will be in the future, and this will
5 change. It will change in a negative way. Nothing stays the
6 same.
7 So this is what I want to tell you, Mr. President. It is not
8 that I do not believe in medical doctors. It's not that I
9 believe in medicine.
10 MR. PRESIDENT:
11 This is what you feel. And now we are examining is the objective
12 evidence that we have before us, and we will consider what we
13 have before us and consider it as such.
14 So please go ahead, Judge Lavergne.
15 [16:12:27]
16 JUDGE LAVERGNE:
17 Q. Yes. So I'm going to ask a question regarding the current
18 condition of Mr. Nuon Chea, the Accused, and in particular in
19 relation to his complaints regarding his lumbar problems, because
20 he brings up problems and issues about being seated for more than
21 an hour and a half, and I believe that he also -- yes, he said
22 that he has trouble being seated for a long period, and I believe
23 that I read in your report that however you said that there was
24 no problem regarding his ability to stand trial.
25 So could you be a bit more clear about this specific point.

1 Should we consider, for example, to find a solution to alleviate
2 this problem, for example, to come up with a well-suited chair,
3 or should he be lying, or is this completely irrelevant?
4 MR. CAMPBELL:
5 A. No, I think it's an important point. When I first saw Nuon
6 Chea I asked him specifically about his ability to sit and he
7 indicated that he could sit for two to three hours. His time of
8 an hour and a half was more to do with his ability to concentrate
9 rather than to sit.
10 I think though the facilities within the holding cells are well
11 set up, and if he is having problems sitting for that length of
12 time then you should be made of them.
13 We did look for a particular seating for Ieng Sary but that issue
14 was not raised as being necessary when I spoke with Nuon Chea.
15 Q. Thank you. I have no further questions.
16 THE PRESIDENT:
17 Thank you, Judge Lavergne. Thank you, Professor Campbell.
18 It is now appropriate for us to adjourn. So I would like to
19 announce the adjournment of our today's session now and we will
20 resume our hearings tomorrow on the 31st of August 2011 beginning
21 from nine o'clock in the morning.
22 [16:15:05]
23 Security guards, I instruct you to bring The Accused Person back
24 to the detention facility and bring him back tomorrow by nine
25 o'clock in the morning.

1 All rise.

2 (Judges exit courtroom)

3 (Court adjourns at 1615H)

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