International Criminal Court

Trial Chamber IX

Situation: Republic of Uganda

In the case of The Prosecutor v. Dominic Ongwen - ICC-02/04-01/15

Presiding Judge Bertram Schmitt, Judge Péter Kovács and

Judge Raul Cano Pangalangan

Trial Hearing - Courtroom 3

Monday, 19 March 2018

(The hearing starts in open session at 9.34 a.m.)

THE COURT USHER: [9:34:58] All rise.

The International Criminal Court is now in session.

PRESIDING JUDGE SCHMITT: [9:35:23] Good morning, everyone.

Good morning, Mrs Mezey. I hope I pronounce your name correctly.

WITNESS: UGA-OTP-P-0446

(The witness speaks English)

THE WITNESS: [9:35:31] Yes, it's Mezey, but that's fine.

PRESIDING JUDGE SCHMITT: [9:35:34] Then it was not correctly. Mezey.

Then, Mrs Mezey, welcome in the courtroom.

Could the court officer please call the case.

THE COURT OFFICER: [9:35:42] Thank you, Mr President.

The situation in the Republic of Uganda, in the case of The Prosecutor versus Dominic Ongwen, case reference ICC-02/04-01/15.

And we are in open session.

PRESIDING JUDGE SCHMITT: [9:35:53] And I call for the appearances of the parties. Mr Black first.

MR BLACK: [9:35:56] Good morning, your Honour. Colin Black for the Office of the Prosecutor, together with Benjamin Gumpert, Colleen Gilg, Julian Elderfield, Beti Hohler, Pubudu Sachithanandan, Jasmina Suljanovic, Yulia Nuzban, Shkelzen Zeneli, Kamran Choudhry, Agnese Valenti and of course our case manager, Ramu Fatima Bittaye.

PRESIDING JUDGE SCHMITT: [9:36:24] I fully understand that you have to have a quick look to the back to recall all of them who are here in the courtroom for the Prosecution.

MR BLACK: [9:36:29] I could not have memorised that one.

PRESIDING JUDGE SCHMITT: [9:36:30] Of course not.

Ms Massidda for the Legal Representative of the Victims.

MS MASSIDDA: [9:36:36] Good morning, your Honour, I will not mention the OTP members who took refuge in our bench today.

For the Common Legal Representative, Orchlon Narantsetseg, Caroline Walter and myself, Paolina Massidda.

PRESIDING JUDGE SCHMITT: [9:36:49] And for the second team, so to speak, Mrs Hirst.

MS HIRST: [9:36:52] Good morning, Mr President, your Honours, Megan Hirst with James Mawira.

PRESIDING JUDGE SCHMITT: [9:36:57] Thank you.

MR BLACK: [9:36:58] Your Honour, I realise as I look at the bench that Adesola Adeboyejo is here as well.

PRESIDING JUDGE SCHMITT: [9:37:05] You can be assured that this has not been unnoticed by me, and I would have mentioned it of course.

And now for the Defence. Mr Ayena, please.

MR AYENA ODONGO: [9:37:15] Good morning, Mr President and your Honours. Today I am assisted by Chief Charles Achaleke Taku, Mr Thomas Obhof, Mr Rowse, Michael, Mr Tibor Bajnovic, Ms Abigail Bridgman and Ms Sandor Eniko. And our client Dominic Ongwen is in court.

PRESIDING JUDGE SCHMITT: [9:37:49] Thank you very much.

The Prosecution is now calling Mrs Mezey as its next witness. Good morning, I said this already, you are going to testify before the International Criminal Court and on behalf of the Chamber I would like to welcome you in this courtroom.

There should be a card in front of with a solemn undertaking to tell the truth. Could you please be so kind to make this undertaking by reading the card out aloud.

THE WITNESS: [9:38:19] I solemnly declare that I will speak the truth, the whole truth and nothing but the truth.

PRESIDING JUDGE SCHMITT: [9:38:26] Thank you very much. There are a few practical matters that you should have in mind when giving your testimony. We can, I think, make this quick. You see and recognise that everything we say here in the courtroom is written down and interpreted, and to allow for the interpretation it is important to speak at a relatively slow pace and, of course, only start speaking when the person asking you a question has finished the sentence. If you have any questions yourself, you can raise your hand and then I will give you the floor.

We will then start your testimony.

Mr Black.

MR BLACK: [9:38:57] Thank you very much, your Honour.

QUESTIONED BY MR BLACK:

Q. [9:39:01] Professor Mezey, good morning. We haven't met. I'm Colin Black. We spoke on the phone.

A. [9:39:10] Yes.

Q. [9:39:11] It's nice to meet you, thank you for coming. And I would just underline what the Presiding Judge said about trying to speak slowly. I am a serial offender at this, so what I try to do is, if I can't speak slowly, I at least take pauses between sentences or in the middle of sentences and that helps.

A. [9:39:26] Yes.

Q. [9:39:26] Thank you. Could you state your name, please, to start.

A. [9:39:28] My name is Gillian Clare Mezey.

Q. [9:39:35] Thank you. I am going to be asking you questions about several different topics and just so you have an idea of where we are going and to orientate the Judges as well, I will tell you what they will be. I will ask you a few questions about your professional experience; some procedural questions about your report and the materials that you used to draft it; questions about concepts and especially terminology that appears in your report and, to a lesser extent, the other reports of experts in the case. I will give you an opportunity to comment on the chart of testimonial extracts that you were sent in January, and, finally, I will ask you some questions about your conclusions in the report.

So let me start with your professional qualifications. I note for the Chamber and the rest of us that at tab 2 of the Court binder near the end is the Professor's CV. Tab 2 is UGA-OTP-0280-0786 and the CV starts at page 0830.

And Professor Mezey, you probably noticed as you reviewed materials our system here; we number each page uniquely so that we can refer to them and that's what we call an ERN, evidence registration number, and oftentimes to point you to particular pages, I will use that.

A. [9:41:01] Right. I use these files, do I?

Q. [9:41:02] Yes, exactly.

A. [9:41:03] Yes.

Q. [9:41:04] Those -- I will come to the content of those binders in a minute --

A. [9:41:06] Okay.

Q. [9:41:07] -- but those are for you to refer to when you need them.

A. [9:41:08] Okay.

Q. [9:41:09] Professor, I see that you received your MBBS in 1980; is that correct?

A. [9:41:15] That's correct.

Q. [9:41:15] For those of us who are not familiar with the educational system in the UK, what kind of degree is that?

A. [9:41:20] That is a five-year medical degree, it is a Bachelor of Science, a Bachelor of Medicine which consists of a, essentially, biochemical education for the first two years, followed by three years of clinical medicine focussed on working with patients, diagnosing, assessing and treating medical conditions.

Q. [9:41:46] And was that degree specialised already in psychiatry or was this a general degree?

A. [9:41:53] This is a general degree in medicine, which then qualifies you as a medical practitioner.

Q. [9:42:00] Your CV states that you became a member of the Royal College of Psychiatrists in 1984 and then a fellow of that college in 1999. Could you briefly tell us what's required to become, first, a member and then a fellow of the Royal College of Psychiatrists?

A. [9:42:16] Yes. After obtaining a degree in general medicine, I went on to study psychiatry, which was at the Maudesley Hospital and Institute of Psychiatry in South London; that normally takes three to four years. And that specialises in the

assessment, diagnosing and treatment of mental health conditions. You have to then take various examinations. I passed the examinations and, as a result of that, obtained my membership of the Royal College of Psychiatrists and that was in 1984. The fellowship of the Royal College of Psychiatrists is awarded to psychiatrists as a result of a combination, really, of the -- of their experience and the longevity of their work, but also is a recognition of a degree of status by the college in terms of their contribution to psychiatry as a whole in the UK and internationally.

Q. [9:43:37] And you became a fellow in 1999, correct?

A. [9:43:44] In 1999, yes.

Q. [9:43:46] Thank you. And you have gone on then to be a member of the faculty of forensic psychiatry for the college?

A. [9:43:53] Yes.

Q. [9:43:53] And later, a college psychiatry adviser as well, is that right?

THE INTERPRETER: [9:43:59] Your Honour, could we please ask the parties to speak slowly and give the interpretation time to interpret.

PRESIDING JUDGE SCHMITT: [9:44:05] Yes, indeed. Mr Black, you have heard it, and you have already blamed yourself before you committed the offence, so to speak. So please, speak a little bit slower.

MR BLACK: [9:44:17] Thank you, your Honour.

Q. [9:44:18] I don't know if you could hear, but we have been asked to speak more slowly. I find it is very challenging, especially when both of us speak and understand English.

A. [9:44:28] Yes.

Q. [9:44:29] I also saw at -- actually, before I go on, I would just like to comment, all of us in the courtroom have the transcript in front of us, so you may notice that often

time even I will be, instead of looking at you, looking down at my computer and it's meant as no disrespect, I am simply following along the written word --

A. [9:44:51] Yes.

Q. [9:44:52] -- as well. I see at paragraph 16 of your report that you are a member of the Royal College of Psychiatrists, Forensic Psychiatry Quality Network.

A. [9:45:04] Yes.

Q. [9:45:05] What kind of work does that network do?

A. [9:45:11] If I can explain; first, after qualifying as a general psychiatrist, I then undertook a further specialisation in forensic psychiatry, which is essentially the psychiatry related to the courts, where psychiatrists specialise in the assessment of risk and the management of risk associated with mental health disorders. Forensic psychiatrists treat individuals generally who have committed serious offences in conditions of security and that was the -- that was essentially my clinical work in the years after qualifying as a forensic psychiatrist. I served on the faculty of the Royal College of Psychiatrists, of the forensic psychiatry faculty of the Royal College of Psychiatrists in a -- and I had a number of roles. One of the roles was to act, if you like, as a quality controller for forensic psychiatry services within the UK to ensure that those services meet the quality standards that are expected within forensic services treating mentally disordered offender patients.

Q. [9:47:05] Thank you. And so that -- the reference to the psychiatric quality network, is that a quality control function?

A. [9:47:13] That's correct.

Q. [9:47:13] And of course I am only hitting on a few points from your very extensive CV because it will be in evidence in the case so the Chamber will have it to refer to. Currently, you are both a professor of forensic psychiatry and also

a consultant forensic psychiatrist at St George's, University of London; is that right?

A. [9:47:33] That is correct.

Q. [9:47:34] So do I understand that you both teach and also see patients at this time?

A. [9:47:40] That is correct. However, since submitting my CV, I have taken partial retirement from my NHS consultant job. I am now an honorary consultant working in Springfield Hospital, which is the clinical base of my work.
I remain employed by the St George's University, which relates to my academic research and teaching work.

Q. [9:48:22] In your CV, you provide a summary of your work, your current work, and I won't go through it all, but you mention a specialist expertise in the assessment and treatment of mentally disordered criminal offenders and the relationship between mental disorder and offending behaviour.
How did you develop that specialist expertise? Was that a result of education or of practice or of both?

A. [9:48:50] I would say both. That -- essentially, that is a description of what forensic psychiatrists do; they study the relationship between mental disorder and offending behaviour.
I also happened to have developed a special interest in psychological trauma and its relationship to offending behaviour, but the experience comes from one's training; it comes from exposure over a number of years to individuals who have committed serious offences and who are also mentally unwell; it also comes from my academic post from research, from my own professional development from attending conferences, training and a whole range of situations, and from my colleagues who are another source of learning and information.

Q. [9:50:11] I also note that you have experience as an expert witness in court proceedings. Could you estimate how many criminal cases you've served as an expert in?

A. [9:50:25] It is difficult to estimate the total, but I would say around 20 to 30 a year.

Q. [9:50:33] And what is your role typically in those cases?

A. [9:50:39] I'm always attending court as an expert witness to give an opinion, essentially, on mental disorder or mental illness; its relationship to any offending behaviour; the culpability of the individual; the individual's fitness to plead and to provide any recommendations to the court with regard to disposal, particularly medical recommendations such as hospital orders, which may be required for individuals who are mentally unwell and who would be made more vulnerable if they receive a prison sentence.

Q. [9:51:38] Do you ordinarily appear by appointment of the court or do you appear for one of the parties in the case? How does that work?

A. [9:51:49] I have appeared on both sides. I have been instructed by the Crown Prosecution Service for the prosecution. I am also often instructed by defence lawyers. And in civil cases I, if I maybe just mention, I also have experience in the civil courts acting for both plaintiff and defendant and in the family courts.

Q. [9:52:32] Thank you very much.

At paragraph 12 of your report, you describe your role in these proceedings at the ICC as providing, "... the judges with an objective, independent psychiatric assessment of Mr Ongwen ..." When you state that your duty lies to the Court and to justice rather than to any of the parties in the proceedings, is that still your understanding of your role here today?

A. [9:52:57] Yes.

Q. [9:52:59] Professor, it is obvious that you have extensive experience as a forensic psychiatrist in the UK. You have relatively less experience internationally; I would like to ask you a couple of questions about that. You were involved in two missions to the former Yugoslavia in the early 1990s, correct?

A. [9:53:21] Yes.

Q. [9:53:21] Tell us what you did there.

A. [9:53:24] I was the expert member of the EC -- an EC mission to the former Yugoslavia on two occasions, in 1991 and in 1993. This was during the conflict. I was asked go because of concerns about allegations of rape and sexual abuse of women during the conflict. My expertise at the time was in relation to psychological trauma, particularly trauma following sexual and domestic violence. I was a member of a four-person team who went out to the former Yugoslavia, and it was an investigative mission, essentially to try and assess the extent to which these acts were taking place, to interview victims of these alleged acts and to assess the impact and also the treatment needs of victims.

Q. [9:55:01] Thank you. London is also a famously cosmopolitan city. In your practice in the UK, do you have an opportunity to deal with people from other cultures -- patients, I mean?

A. [9:55:16] Yes.

Q. [9:55:17] What's the cultural make-up of the patients that you see, for instance, at the Springfield Hospital?

A. [9:55:22] We have a very diverse population within Springfield. The make-up is probably 40 per cent black and minority ethnic patients under our care. Many of the patients in the unit who are transferred from prisoners -- sorry, from prison, are

non-UK citizens. A number of them, in fact, have been asylum seekers. Certainly, in the last six months, a couple of patients have been non-English speaking. All of my patients are male. So we have a very, a very diverse ethnically mixed patient group, which largely reflects the area of London that we serve.

Q. [9:56:42] Thank you. I am going to ask you now to wrestle with the binders. So if you could please look for binder number 2, tab number 2, excuse me. Tab 2 of binder 1. And do you recognise this document, Professor?

A. [9:57:10] I do.

Q. [9:57:11] What is that?

A. [9:57:12] That is the report I wrote on 8 August 2017.

Q. [9:57:18] Please turn to page 31 of the report. That's the ERN ending in 0816, if that helps.

A. [9:57:39] Yes.

Q. [9:57:40] Whose signature do you see at the bottom of that page?

A. [9:57:42] That is my signature.

Q. [9:57:44] Now, that signature comes at the end of an expert declaration. Now, is that standard language for this kind of report in your jurisdiction?

A. [9:57:55] Yes.

Q. [9:57:55] Paragraph 12 of that declaration, I note it refers to part 19 of the Criminal Procedure Rules. Are those the rules for expert witnesses in criminal courts in the UK?

A. [9:58:06] Yes.

Q. [9:58:07] And do you confirm today, as stated at the bottom of page 31, that the contents of this report are true to the best of your knowledge and belief?

A. [9:58:17] Yes.

Q. [9:58:19] Okay. Staying in that tab for just a moment, after your signature, if we could flip through the pages together, I am just going to describe what we see very briefly. There is appendix 1, which is some diagnostic criteria from the DSM-5, then there is the letter of instruction that you received from the Prosecution. At the page ending 0823, you see an annex to that letter of instruction with materials that you received.

A. [9:58:54] Yes.

Q. [9:58:54] If you keep flipping, 0828 is a list of additional material.

A. [9:59:02] Yes.

Q. [9:59:02] And starting at 0830, that's your CV, which continues to the end of the tab. Have you recognised all those documents?

A. [9:59:12] Yes, I have.

Q. [9:59:12] And have I described them correctly?

A. [9:59:15] Yes.

Q. [9:59:15] Professor, the Rules of Procedure and Evidence at this court allow for a report such as yours to be entered into evidence if you don't object. Do you object to the submission of the report?

A. [9:59:26] No.

Q. [9:59:27] Thank you.

Your Honour, I think that covers the Rule 68(3).

PRESIDING JUDGE SCHMITT: [9:59:33] Indeed. You can proceed.

MR BLACK: [9:59:34] Thank you.

Q. [9:59:35] Professor Mezey, let's look back at that list of materials again in tab 2, starting at page 0823.

And, in fact, as you're flipping, everything in these two binders at the witness stand,

that's a hard copy of the material in this list and the following list starting at page 0828, so if there is anything during your testimony that you think would be useful to refer to, please say so and we can -- and I can help you try to find it in the binders.

A. [10:00:14] Thank you.

Q. [10:00:14] I won't ask you about everything, certainly, but I would ask you to look, look at your report, actually, at paragraphs 19 to 35.

A. [10:00:38] Yes.

Q. [10:00:39] You have it? There, you make reference to extracts from clinical records?

A. [10:00:43] Yes.

Q. [10:00:44] I'm sorry to have you flip pages, but if you could look at tab 10 of the binder and when you get there, just flip through them.

A. [10:01:01] Mm-hmm. Yes.

Q. [10:01:05] And then in the binder number 2 at tab 44, if you could look briefly at those documents.

A. [10:01:37] Yes.

Q. [10:01:37] And are those the clinical reports from which you took the extracts?

A. [10:01:42] Yes, it appears to be.

Q. [10:01:44] Just one -- you can close the binder. Just one minor point of clarification, in those records there are references to a "PSA" at the detention centre, and, if it helps, paragraph 33 of your own report refers to a visit from the PSA.

A. [10:02:03] Yes.

Q. [10:02:04] What does PSA stand for, if you know?

A. [10:02:07] It's a very good question. I understood it -- I understood that to

mean the psychiatrist or the psychologist for the other side, but I am not sure what the initials precisely stand for.

Q. [10:02:24] Okay. Thanks. Perhaps we can find someone --

A. Yes.

Q. [10:02:28] -- else to explain that for us. That's all for my -- what I would call housekeeping questions.

I am going to turn now to --

PRESIDING JUDGE SCHMITT: [10:02:37] Mr Black, since you obviously know it and it might not be a big mystery what it is, if you know it, simply tell us what does "PSA" mean.

MR BLACK: [10:02:50] I'm sorry for the continued mystery, your Honour, I don't know what it means.

PRESIDING JUDGE SCHMITT: [10:02:53] You don't know. Okay, so I --

MR BLACK: [10:02:54] I could guess, but I'm afraid my guess wouldn't amount to anything.

PRESIDING JUDGE SCHMITT: [10:02:55] Okay, so then somebody else must enlighten us. So please continue.

MR BLACK: [10:03:01]

Q. [10:03:02] Professor, now I am going to turn to asking you about some of the concepts and terminology in your report.

You are the first of several mental health experts who will come testify here, so I am hoping to take advantage of your knowledge so we can understand some of the specialised vocabulary.

You've already started to explain what forensic psychiatry is. But, first, what's the difference between psychiatry and psychology?

A. [10:03:37] A psychiatrist is a medical practitioner; so a psychiatrist will have obtained a degree in medicine and will be licensed to practice in any branch of medicine, but essentially they've chosen psychiatry, that is, mental health as their specialty.

A psychologist is not medically qualified. They have not qualified in medicine, but they specialise in the -- understanding psychological processes; so they are able to assess and describe, essentially, normal mental health processes, psychological processes, and they are also expert in assessing aspects of an individual's personality, how people function in day-to-day situations.

Psychologists tend to be experts in the normal mental health processes; whereas, psychiatrists specialise in abnormal mental health processes and abnormality of mind.

Psychiatrists -- I'll slow down for a moment. Psychiatrists are trained to diagnose abnormal mental states, to diagnose mental illnesses. Most psychologists do not have that expertise.

Q. [10:05:29] And this is implicit, I guess, in your description of forensic psychiatry, but what's the core difference between what a forensic psychiatrist does and what a clinical or a treating psychiatrist does, if there is a difference?

A. [10:05:45] There is really no difference. Forensic psychiatrists simply differ from clinical psychiatrists in the fact that they tend to treat individuals with more severe and more complex mental-health conditions. They also treat individuals who are considered to be dangerous, if I can use that word, or certainly who represent a risk to other people or a severe risk to themselves and they have more experience in giving evidence in court, that is, in considering the interface between medicine or clinical psychiatry and the law and trying to bring those together in a way that is coherent and clear.

Q. [10:06:56] What does a forensic psychiatric evaluation or assessment typically entail?

A. [10:07:06] The assessment is essentially a thorough psychiatric or mental state examination, which is something that most psychiatrists would do in any case. It is the equivalent to the physical examination that physicians would do. So a physician would perhaps listen to a person's chest if they were complaining of shortness of breath. A psychiatrist will conduct a similar examination of a person's mental faculties by asking standard questions which include a number of set headings, such as, how does a person look; how do they behave; how do they interact with you; do they make eye contact; do they appear straightforward or evasive.

It will also include standard questions to elicit psychopathology. So these would be questions around mood, mood states, sleep, appetite, the form and content of the individual's thought processes; so that could include what we describe as hallucinations, that is, hearing voices. It could include false and unshakeable beliefs, such as delusions and other phenomenology that would help to tease out whether or not there is mental disorder present and, if so, the nature of that disorder.

Now, in addition to the mental state examination conducted with the individual, forensic psychiatrists tend to also rely on other material, particularly documentation about the offence; what witnesses say; what other medical or psychiatric reports might say; what witnesses say. They use these different sources of information to -- to triangulate all the information in order to, in order to try and understand whether there are consistencies or discrepancies, which they may need to challenge and to try and essentially tease out what is the most probable or likely diagnosis and where, where there are matters that fit that diagnosis and where there are matters that don't fit.

Essentially, forensic psychiatrists would like to think that they adopt a more critical and, I would say, forensic approach to the assessment of mental disorder than colleagues who may not have experience in that kind of legal arena.

Q. [10:11:58] This is very helpful, and you're anticipating several of my questions.

A. [10:11:59] Okay.

Q. [10:12:00] Before I ask you more about triangulation, you were not able to personally conduct a mental state examination of Mr Ongwen; is that correct?

A. [10:12:11] No, that is correct, yes.

Q. [10:12:12] And why was that?

A. [10:12:15] Mr Ongwen did not wish to, to meet with me.

Q. [10:12:22] How did that affect your ability to assess his mental health?

A. [10:12:30] It would have been desirable to assess Mr Ongwen because there are a number of matters that I would have wanted to put to him, and obviously the direct mental state examination could not be carried out.

The -- however, I had an advantage in being provided with an enormous bundle of documentation which gave different perspectives and provided different sources of information on -- which reflected on his mental state over a period of time; including the medical records, including witness statements, including video material. I therefore felt that having all this information gave me a very accurate picture and a very good picture of Mr Ongwen's mental state and his level of functioning over a period of time, including the period that I was particularly being asked to comment on.

Q. [10:14:08] Thank you.

You started explaining what triangulation was. Could you tell us a bit more about why it's important to take this critical approach in the forensic psychiatric

content -- context, excuse me.

A. [10:14:30] The reason is because many of the individuals that I assess in a forensic context have something to gain from what we would call "faking bad" or malingering is another word. That there are -- many of the defendants I see who are charged with serious offences are trying to exculpate themselves or to remove responsibility or remove the blame for what they have done in some way, thereby reducing their culpability. And it is well recognised in forensic settings that malingering is common, faking bad is common, amnesia or claimed amnesia is very common, and one, therefore, has to be careful not to simply rely on the individual's account alone. One has to be careful to confront the individual with apparent discrepancies or inconsistencies in their account, and particularly where their version of events or what they say about themselves differs markedly from all other sources of information about how they have been acting, how they have been behaving. And this is peculiar in a way to the forensic setting because of the incentive for individuals to produce symptoms of mental illness as a way of either gaining some benefit or escaping punishment in some way.

Q. [10:17:16] And this critical analysis that you have explained about challenging discrepancies, does that typically appear in a report that's prepared in this context or is that something that is just in the background of the psychiatrist's mind?

A. [10:17:33] One would expect to see evidence in a report that that approach had been adopted.

Q. [10:17:43] Did you see evidence that that approach was adopted by the Defence experts in this case, doctors Akena and Ovuga?

A. [10:17:53] I did not.

Q. [10:17:54] Now I am going to turn to some questions about the three disorders

that appear in the Defence expert report and which you also addressed in yours. Many of us have heard now the term PTSD, unfortunately, and we have some idea of what post-traumatic disorder means, but can you explain from a medical perspective what is PTSD?

A. [10:18:25] Post-traumatic stress disorder, do you want the long version or the short version?

Q. [10:18:33] Why don't we start with the short version and then --

A. [10:18:34] The short version --

PRESIDING JUDGE SCHMITT: [10:18:37] I would also suggest the short version.

THE WITNESS: [10:18:39] The short version. Yes. Post-traumatic stress disorder is one of the few diagnoses, in fact, the only diagnosis in psychiatry that is said to be caused by an external traumatic event. It's a -- it's a serious mental health condition; it is a diagnosis in both of the internationally accepted diagnostic classification systems, that is, the ICD-10 and the DSM-5.

Essentially, the -- for a condition, the condition to be diagnosed, the individual must have experienced a severe or life-threatening trauma, a threat to their life or they must have witnessed a threat to the life of somebody close to them, that is directly witnessed or been threatened with sexual violence or been a victim of sexual violence. The trauma severity threshold is very high; that is called criterion A. A number of individuals, although not all individuals, who experience a severe trauma, criterion A, may then go on to develop the characteristic symptoms of PTSD, which essentially involve re-experiencing the trauma, and this can be in the form of recurrent, intrusive, unbidden memories or images or thoughts or feelings related to the trauma. Or they can take the form of recurrent and persistent nightmares related to the trauma or they can take the form of reliving. And reliving the trauma, for individuals with PTSD,

means that the individual feels and acts as if they were back in the traumatic situation where they believe they are going to be killed.

It is almost as if they lose touch with the here and now and they are transported back in time, and that is also described by many as a dissociative response. The word "flashback" is sometimes used to describe these sudden intrusive memories and thoughts of the trauma. They are the re-experiencing symptoms. I'm sorry, it's rather long, I will -- I will speed up a little.

PRESIDING JUDGE SCHMITT: [10:22:18] No, no, it is okay; it is very interesting. Please continue.

THE WITNESS: [10:22:23] They are the re-experiencing symptoms.

Alongside the re-experiencing symptoms, one sees there are avoidance symptoms, post-traumatic avoidance, and post-traumatic avoidance refers to the individual trying to avoid or push away situations that remind them of the trauma or bring, bring the trauma into their mind or they stop themselves from thinking about the trauma or from talking about the trauma or from being in a situation where they have to remember the trauma. Because, exposure to memories or thoughts or reminders of the trauma lead to a severe intensification of distress and that can be manifest by the individual, what we sometimes describe as a -- *individuals appear emotionally frozen. They're constricted because they're -- they're unable to feel. They are unable to feel happiness; they are unable to feel joy; they are unable to engage in normal day-to-day experiences because they close their mind off to these experiences for fear that they may find themselves in a situation where they are having to, once again, be confronted with the traumatic event.

The final cluster for PTSD are what's known as the hyperarousal symptoms, and what you see with people who have PTSD is that they are often on the edge of their seats.

They're in a state of high arousal. They are very, very sensitive to environmental threat; they are very sensitive to what is going on around them and tend to over react. It's something we call the startle response; so -- whereas, most of us can screen out noises, disturbances from outside, people with PTSD are hypersensitive to these stimuli and tend to react to them as if they represent a potential threat.

Their whole system is -- it's tuned so that they are often restless, they cannot relax, they cannot sleep, they cannot settle in a sense or they cannot calm themselves down. They are the hyperarousal symptoms and that, essentially, describes the symptoms.

But just to say, finally, for a diagnosis of PTSD to be made, the criterion also require that the individual has to experience what's called either significant clinical distress *associated with the symptoms, because if they are not distressed, in a sense, there's *no significant disorder, or they must manifest significant functional impairment.

So these symptoms aren't just there and the person can get on with their life and their day-to-day activities in the normal way. These symptoms are so severe and so intrusive that they stop the individual from being able to carry on with their normal day-to-day functioning. They cannot work. They cannot study. They cannot lead normal family lives. They don't interact with their friends. All their -- all their functioning is significantly impaired. So put together or when one puts that together, that would allow one to diagnose post-traumatic stress disorder.

PRESIDING JUDGE SCHMITT: [10:28:01] May I just put one question to you: How are the difficulties to -- I think mainly you would try to establish such a diagnosis at a certain point in time, meaning today, so to speak.

THE WITNESS: [10:28:14] Yes.

PRESIDING JUDGE SCHMITT: [10:28:15] Going back in time, how difficult might it be to put such a diagnosis into place? Years -- years ago, for example, would there

be, for example, the question of functional impairment be of some relevance or how would you try to address this --

THE WITNESS: [10:28:38] Yes.

PRESIDING JUDGE SCHMITT: [10:28:39] -- going back in time now?

THE WITNESS: [10:28:39] Yes. Well, it can certainly be done and there are many, many examples of studies that have looked at individuals both prospectively and also retrospectively, which is what you are asking about.

In terms of how PTSD develops, when does it develop following a trauma, how long does it last for, what is the natural history of the disorder, and, it tends to fluctuate; so there are two ways: One way is by the mental state examination and it is, in fact, possible when one talks to an individual who has experienced a trauma, and without using leading questions, to encourage the individual to describe the impact of the trauma, to describe the impact of the trauma on their -- on their sleep, on their thinking, on their emotion -- on their emotions, on their behaviour.

Now, it becomes more difficult the longer the period of time between the trauma and the time of examination, but nevertheless, one can obtain, I think, a reasonably accurate representation of how an individual was functioning and feeling and behaving through their own account sufficient to be able to make a probable diagnosis of PTSD historically. Just to say the other way that one can do it, and perhaps to support a direct examination, is that there are a number of validated measures of PTSD, some of which have been validated and developed to diagnose historical cases of PTSD as well as current PTSD. So ideally, one might want to supplement a mental state examination with the inclusion of one or two of those measures.

PRESIDING JUDGE SCHMITT: [10:31:22] Thank you. Judge Pangalangan has a

question.

JUDGE PANGALANGAN: [10:31:29] Thank you, Mr President.

Madam Witness, is it not possible for the patient to -- to game the system? To fake it so that by his answers he can lead you to conclusions that, that he wants? In other words, he might be crazy, but he is still smart or maybe street smart or bush smart, but still, well, to lead you on anyway to concluding that he has these symptoms.

For instance, I see the language in the report. He says he feels -- he wakes up in a strange country where there are godly people who speak different languages. For me, that is a literal description of The Hague detention centre, and in this context, it sounds like he is crazy, but you can actually read it another way. Please.

THE WITNESS: [10:32:29] I completely agree. First, there are two issues, I suppose. One has to -- one is to look at the context, both the cultural context and the situational context in which people are reporting symptoms. It's important not to necessarily define something as representing psychopathology if it is simply an expression of that individual's cultural or religious background, even if we don't understand it.

In reference to your first question, absolutely it is possible for individuals to fake symptoms. There are a number of papers talking specifically about post-traumatic stress disorder being faked by -- this relates to Vietnam veterans, in fact, for the purpose of gaining compensation. But in many contexts, it is possible to fake PTSD or other symptoms. The symptoms of PTSD are now quite well known and quite well rehearsed and so one has to be particularly careful about not just taking the word of the individual alone, but cross-checking with how do they present, you know, they may talk about being on edge, they may talk about being sensitive to threat, but if they're able to engage *in a three-hour interview and appear relaxed throughout the whole of that interview, then that would appear to negate a symptom that they are

complaining of.

So it comes back to my previous point about the need, the importance of not being too credulous, the need to be critical and challenging, and the need to cross-reference what you are being told with other sources of information and what you see before you.

JUDGE PANGALANGAN: [10:35:08] Thank you, Witness.

Thank you, Mr President.

PRESIDING JUDGE SCHMITT: [10:35:12] Mr Black.

MR BLACK: [10:35:13] Thank you, your Honour.

Q. [10:35:15] It is very interesting. I hesitate to return to more mundane details. But, very briefly, Professor, you mentioned both the DSM-5 and the ICD-10. Those are kind of the working manuals that psychiatrists use in their work; is that right?

A. [10:35:35] Yes.

Q. [10:35:36] Are both of those used internationally?

A. [10:35:38] Yes.

Q. [10:35:43] Now, the DSM-5 actually talks about cultural differences in the expression of PTSD, did you take that into account in drafting your report?

A. [10:35:58] I did. One has to take that into account, but the criteria for DS -- for post-traumatic stress disorder nevertheless stay the same. The way the symptoms are manifested may alter somewhat according to the individual's background, culture, they may even be affected by factors such as age or gender. But nevertheless one still requires the core criteria to be met before you can make the diagnosis.

Q. [10:36:39] One of the various materials that you received is an expert report by Dr Elizabeth Schauer -- "Schauer", I don't say that right, but close -- for another case here in the ICC, it is tab 15 of the binders, if you would like to look at it. I am not

sure it's necessary that you do, but on page 13 of her report she made the following statement. I will read it out to you:

"The considerable similarities and consistencies in the clinical manifestations of psychopathology across diverse affected groups globally tend to outweigh cultural and ethnic differences."

And then she talks about core symptoms of PTSD.

Do you agree that the core symptoms of PTSD manifest themselves more or less similarly across cultures?

A. [10:37:32] Yes, and in fact PTSD is one of the few diagnosis that has been very much studied across different cultures because of its utility in relation to victims of war trauma and terrorist attacks, and therefore it has been validated across many different cultures and languages.

Q. [10:38:01] And one vocabulary question, I read the word, what I would say psychopathy, and you would probably say psychopathy --

A. [10:38:07] Yes.

Q. [10:38:07] -- being from different countries that speak the English language, what is psychopathy?

A. [10:38:20] I'm -- well, psychopathy is a term which was developed to describe a form of personality disorder, that is, individuals who do not have any regard for the rights or feelings of other people, who seek to gain gratification for themselves, regardless of the consequences in terms of punishments or the consequences in terms of harm done to other people. It's often associated with a glib, a glibness and a superficial charm. It does not represent a mental illness, but it is much closer to personality structure.

Q. [10:39:25] And what is psychopathology?

A. [10:39:30] Psychopathology is the description of a whole range of abnormal mental processes, from thinking, emotion -- or emotions, behaviours; so psychopathology are -- is the collection of abnormal symptoms that go towards making a diagnosis. It is distinct from psychopathy.

Q. [10:40:10] Thank you for that -- that explanation.

Another kind of vocabulary question; in some of the extracts of clinical records there is reference to PTSS as opposed to PTSD, could you explain what that means?

A. [10:40:28] Yes. The DSM diagnostic criteria stipulate a threshold for each of the clusters of symptoms. So the individual must have experienced at least one re-experiencing symptom, they must have experienced two avoidance symptoms and two hyperarousal symptoms and there must be this disorder of functional functioning or clinical distress. Very often individuals who have experienced a severe trauma will develop one or two symptoms that could be consistent with a diagnosis of post-traumatic stress disorder, but they fail to meet the threshold criteria, which means either the symptoms are not severe or persistent enough, or they fail to obtain the number of avoidance symptoms or the number of hyperarousal symptoms that are required for the full diagnosis. Post-traumatic stress symptoms, so PTSS, which is described in the records, reflects a fact that somebody has a few symptoms which could be consistent with PTSD, but they are not suffering from a clinically significant disorder; they do not meet the threshold for the full diagnosis.

MR OBHOF: [10:42:34] Your Honour, before we go on, I know you asked about acronyms. The Dutch acronym for PTSD is PTSS, as found in the Dutch version of the DSM-5 under 309.81, which we also have an internet copy available under the Defence binder, but if you look at the Dutch versions of these medical reports, it says PTSS symptoms. And when it was translated, one of them or two of them used

the acronym PTSD in English, but the proper Dutch acronym, post-traumatische stress stoornis, which my Dutch is very bad, I apologise, is PTSS. So I would like to make that known to the Court before we proceed.

PRESIDING JUDGE SCHMITT: [10:43:22] At least it cannot be damaging to have it on the record. So we have to verify it, of course, later on. Thank you, Mr Obhof. Mr Black.

MR BLACK: [10:43:33]

Q. [10:43:34] Professor, in Dr de Jong's report, the Court-appointed expert's report, he refers to complex PTSD, what does that mean?

A. [10:43:45] Complex PTSD, first of all, is not a diagnosis. The suggestion that PTSD may have a more diffuse and complex presentation was made in the States in the 1980s and this reflected concern that the classic PTSD diagnosis did not reflect certain situations where the trauma was repeated, recurrent, persistent, and particularly where the trauma was developmental, so that the trauma that started in childhood or as a teenager and went on for years; because PTSD was particularly developed post-Vietnam to reflect acute and fairly short-lived traumatic experiences. And so it was suggested that trauma that was developmental, that started early, the sort of trauma experienced by survivors of childhood abuse, victims of torture, victims of domestic violence, was manifested not in the core re-experiencing avoidance and hyperarousal symptoms, but as a diffuse distortion of the individual's personality, so the individual's whole personality structure and development was shaped by their experience of being a victim of trauma. And that could be manifest in abnormalities around their identity, how they see themselves, how they relate to other people, how they manage and process their emotional states, how they, how they are able to manage their behaviour, for example, poor impulse control, problems

around anger.

So the complex PTSD, what complex PTSD was trying to convey was that there was a disorder of functioning, there was a disorder of emotions and interpersonal relations and behaviour that was a consequence of repeated exposure to trauma, but it did not manifest itself in the classic PTSD symptoms. But was nevertheless, nevertheless is important to understand that because of the impact that the trauma has on the individual's personality.

It was never adopted as a formal diagnosis because it was felt that it lacked the validity and consistency to warrant a diagnostic classification. But nevertheless, intuitively and in clinical practice it is a concept that is well understood.

Q. [10:47:56] Now *I am going to return to something that the Presiding Judge touched on in his question.

Much of the information in the reports by Dr de Jong and the Defence experts concern symptoms currently reported by Mr Ongwen.

Now, even if one were to assume that he has a mental disorder now, would that necessarily mean he had a mental disorder in 2002 to 2005?

A. [10:48:25] No.

Q. [10:48:25] And why not?

A. [10:48:28] Because mental disorders are not permanent enduring states of mind. Mental disorders typically tend to arise sometimes, sometimes in, as a response to events, life events, for example, but they may arise spontaneously. And they, they remit and they recur at various times. That is the typical presentation and so one cannot assume that if an individual develops a mental disorder at a particular time, that that has occurred beforehand or that it will necessarily occur in the future.

Q. [10:49:34] And PTSD in particular, does that always develop more or less

immediately after a psychological trauma or can its onset be delayed?

A. [10:49:47] The majority of cases develop immediately. We think around, only around 20 per cent of -- can I start that again, actually. Delayed PTSD is recognised as a phenomenon. The rates of pure delayed PTSD where no symptoms have existed following the trauma in the past, but which appears six months, a year, a few years later, out of the blue, is very rare. It's about 1 per cent. It's very rare. There are more cases where you see delayed -- cases of delayed PTSD where in fact what you are seeing is not the disorder suddenly appearing de novo, but it's what we would call a reactivation of symptoms, so that there may have been a few symptoms around in the past, but then sometime later the individual tips over, if you like, from having post-traumatic stress symptoms floating around to developing the full disorder, if that makes sense. So it looks like delayed PTSD, but in a way it's a -- it represents the natural history of the disorder, which is that it is a condition that can appear and then remit, often in response to life events.

So the majority of cases and what you would expect to see in PTSD is that in the majority of cases you see the disorder in its full form appearing within a few weeks to a few months of that trauma having taken place.

Q. [10:52:05] And what about someone who was subjected to several distinct psychological traumas over many years, would PTSD necessarily start after the first or might it only develop later as a consequence of several of those traumas together? Can you help us understand that?

A. [10:52:24] Probably the closest, the closest would be, for example, the Vietnam War veterans, many of whom developed a more delayed picture of PTSD which is after they had been removed from battle. And that is partly because when you are in the middle of a war zone in a way you have to mount defensive strategies,

coping strategies, and so some of the symptoms of that disorder may be masked or suppressed to some extent for survival, so one does see a delay in some cases. It would usually then be expected to be manifest immediately or soon after that person is taken out of the, of the traumatic situation.

Having said that, one would normally in those situations expect to see some evidence of distress or dysfunction or evidence that that person was under severe stress. Because if they are not under severe stress, if they are not experiencing feelings of fear, horror or helplessness at the time, then they will not then go on to develop post-traumatic stress disorder because that is a disorder which reflects their inability to process events that are overwhelming and terrifying.

Q. [10:54:29] Just a couple more questions on PTSD.

Doctors Akena and Ovuga in their report, which is at tab 7 of the binder, if you would like to look.

A. [10:54:43] 1 or 2?

Q. [10:54:45] Binder 1. And that is UGA-D26-0015-0004, your Honours. And it's page 8 of the report, so 0011.

They refer to Mr Ongwen, I guess reporting, suffering severe punishment, being given 280 strokes of the cane, being imprisoned for a long time, fed intermittently and being forced to carry heavy loads before finally being put on death row. Now, Professor, if that account is true, could that also have caused psychological trauma to Mr Ongwen, those things had happened?

A. [10:55:32] Yes.

Q. [10:55:32] And would it be possible that any PTSD or any post-traumatic stress symptoms that he has now might result at least in part from those experiences which happened after 2005, as opposed to necessarily the ones that happened before 2005?

A. [10:55:48] It is certainly possible. It would be important to look at the -- it's important to look not just at the form of symptoms, but at the content of the symptoms so that if, if the symptoms, if re-experiencing and avoidance symptoms and hyperarousal symptoms relate directly in their content back to those events, then one might infer, one could infer that the post-traumatic stress disorder has arisen as a result of those experiences. One would need to look at that, but in theory it would be entirely possible, having had those experiences, to go on to develop PTSD following that.

Q. [10:56:44] And as far as you could tell, did doctors Akena and Ovuga, did they make any serious attempt in their report to try to sort of I guess put a time on when these symptoms arose and which trauma it may have been in his life that could have caused them?

A. [10:57:06] No.

MR BLACK: [10:57:08] Your Honour, it's three minutes to the usual break time. I'm about to move to a different topic.

PRESIDING JUDGE SCHMITT: [10:57:12] I think it makes sense then to have a coffee break until 11.30.

THE COURT USHER: [10:57:18] All rise.

(Recess taken at 10.57 a.m.)

(Upon resuming in 11.32 a.m.)

THE COURT USHER: [11:32:29] All rise.

PRESIDING JUDGE SCHMITT: [11:32:48] Mr Black, please continue.

MR BLACK: [11:32:54] Thank you, your Honour.

Q. [11:32:55] Professor, I am going to move now to the second of the three conditions. Depression or depressive disorder is something which, again, many of

us have heard about and have a nontechnical understanding of what it means. But can you explain from a medical point of view what is depression or, particularly, depressive disorder?

A. [11:33:16] A depressive disorder is a disorder of mood, characterised by a persistent severe lowering of mood, sadness, hopelessness, despair, often associated with an inability to see any future, or to feel hope about the future. There is often a high risk of suicide associated with the disorder.

The more severe conditions will be associated with disruptions in the individual's physical health and functioning, so symptoms would include a reduction of appetite, loss of weight, disruption to sleep, particularly inability to go off to sleep and waking early in the morning. One would generally see a diurnal variation in the mood, with more severe symptoms earlier in the day.

The individual would become socially withdrawn. They tend to lose their interest in engaging in former activities or interacting with other people. There is often a disruption to the individual's cognitions so that they are unable to concentrate well. They are thinking more slowly than usual. You often see, in fact, what we call a retardation, so that the person's speech is slowed down, their movements are slowed down, they lack spontaneity in terms of both expressing themselves, but also in terms of their facial expressions or ability to verbalise or vocalise.

They often express unreasonable feelings of worthlessness, low self-esteem and guilt, sometimes to an extreme extent so that they feel guilty about the wars in the world, or the fact that people are starving. They feel guilty about things that they cannot possibly be held responsible for.

And in severe depressive states one also may see what we would describe as psychotic symptoms, so psychotic depression is often a term used synonymously

with severe depression.
Psychosis essentially refers to the fact that the individual is so ill, is so unwell that they have lost touch with reality. And they may, at the same time, experience the classic depressive psychotic symptoms of depressive hallucinations, so that they may - they experience voices, they have a sense of - they can hear voices, usually voices that are telling them that they are dirty, that they are unworthy, that they are a burden on their friends and family, that they don't deserve to live.
That is one aspect of the psychotic symptoms people experience.
The other psychotic representation of a severe depressive disorder would be depressive delusions. And these are false and unshakeable beliefs about themselves or the world.
And again, one recognises these as depressive because they are, they are very black, they are bleak and black. They may include a person telling you that they can smell themselves rotting from the inside, that they have lost part of their brain, that they are stagnating, that they are putrid. So they will be depressive delusions about themselves or depressive delusions about the world, that the world is coming to an end, that they are responsible for the world coming to an end. That their children are going to be killed, or sexually abused.
They are delusions because they are false, because they are not explicable by a person's cultural or religious background, and because they are unshakeable, so that however much, however hard you try to confront the individual with information that challenges those beliefs, they are -- they will not, they will not be convinced.
Q. [11:39:11] And what are the requirements to diagnose someone with this disorder which you have described?
A. [11:39:20] The requirements?

Q. [11:39:21] Yes, for a diagnosis.

A. [11:39:23] Well, as I said before, that they manifest the symptoms. There isn't the same sort of threshold, there are different levels of severity of depressive disorder that occur, from mild to moderate to severe.

Severe would usually include the psychotic state. Each of those conditions will have a markedly different effect on the individual's ability to function on a day-to-day basis.

At the mild level of depression, the individual may in fact be able to continue with their social *commitments, they may be able to continue to work.

At the severe end one would expect to see a complete cessation of that individual's ability to function normally.

Q. [11:40:30] Are there tools available to help measure the severity on the kind of scale that you have suggested?

A. [11:40:38] There are some tools which can help to confirm one's clinical impression. But, in fact, in order to diagnose depression the best, the best tool is to carry out a mental state examination to assess whether the individual is currently suffering from symptoms suggestive of a depressive disorder.

PRESIDING JUDGE SCHMITT: [11:41:09] And my pet question, so to speak, referring to what I already asked with the other one.

THE WITNESS: [11:41:15] Yes.

PRESIDING JUDGE SCHMITT: [11:41:16] How to determine such a diagnosis in the past, what would you do to do that? It would, I think, in my opinion, perhaps be difficult to rely upon what you see now, what is the state of affairs, the state of the mental health of the patient now.

THE WITNESS: Yes.

PRESIDING JUDGE SCHMITT: [11:41:38] So how would you try to near yourself what might have been the state of the mind of the person in the past?

THE WITNESS: [11:41:45] Yes. Well, again, that the longer the period of time between the time that you are trying to assess and the time of examination, the more difficult.

One would need to try and locate that individual, as far as possible, to try and get them to focus on the time period that you are looking at, and to get them to describe their functioning, their feelings, their behaviour, their thinking around that time.

Now, again, the questioning would need to be done by a combination of direct and open questions, because what one does not want to do, clearly, is to prompt an individual who may already be quite suggestible.

So it is, it is a difficult task, but the process that you would go through would essentially be the process that you are going through currently. So rather than saying, "How are you feeling now? How are you sleeping now? How long have you had these problems for? When did they start? What is the pattern?" instead of asking those questions in the current, you would ask them the same questions or get them to hopefully spontaneously report those symptoms in the time period that you are focusing on.

PRESIDING JUDGE SCHMITT: [11:43:28] And if you don't have this information because you don't have the possibility to have an interview, what would you do then?

THE WITNESS: [11:43:37] Well, one looks at the other reports. So, in my case, thinking about whether Mr Ongwen had a depressive disorder in 2003-2005, I obviously read the reports of the other psychiatrists very carefully to see whether there were, whether these symptoms were reported, clearly having occurred around the time period, whether they were spontaneously reported by Mr Ongwen, or

whether they were described by the clinicians without there necessarily having been a spontaneous report. And I would look at all other evidence that I was given that relate to that time period that provided me with a window in terms of being able to assess his mental state indirectly.

So, for example, if there was video material or witness statements relating to that time period, then that information might tell me a bit about whether he was perceived to be tearful, whether he was perceived to be unable to function, whether he was -- appeared to be highly aroused, whether he was behaving in a way that appeared incomprehensible, or bizarre, or abnormal to people around him.

PRESIDING JUDGE SCHMITT: [11:45:20] Thank you.

Mr Black.

MR BLACK: [11:45:23] Thank you, your Honour.

Q. [11:45:26] A couple of questions about, kind of vocabulary, about these tools. In Dr de Jong's report, that's tab 5, if you care to look, the ERN for the record -- oh, actually there is not an ERN for this, it is a Court document. It is confidential annex II to filing 702, but it is tab 5.

And, Professor, if you look at pages 5 and 6, he refers to something called the Hopkins Symptom Checklist-25, the Harvard Trauma Questionnaire and a Patient Health Questionnaire number 9. What are those?

A. [11:46:10] These are measures or scales that have been used to assess symptoms of depression, anxiety and trauma.

Q. [11:46:18] And are those, all three of those commonly accepted in the forensic context?

A. [11:46:25] They are validated questionnaires. It would partly depend on how they were applied, because one would have to be careful to ensure that they had been

translated appropriately. And not all the measures are always validated cross culturally, so one would need to be a bit cautious about interpreting the measures.

Q. [11:46:52] And what does that mean, "validated", in a different language or a different culture?

A. [11:47:00] Validated means that they demonstrate what they are set up to demonstrate, that, that they will -- if a measure has been validated as a measure of depression, then that, what that means is it doesn't matter who applies the measure or in what context you apply the measure, that it will still give you an accurate, an accurate result in terms of being able to diagnose the condition.

Q. [11:47:44] And is the validation, that's actually done by, like, a field study or (Overlapping speakers)

A. [11:47:53] Yes. Yes.

Q. [11:47:54] Another tool mentioned, I believe in your report, is the Hamilton rating scale for depression. Is that similar to these others we have just looked at?

A. [11:48:02] Yes.

THE INTERPRETER: [11:48:03] Message from the interpretation, could there be a little pause between sentences.

MR BLACK: [11:48:10] My apologies.

PRESIDING JUDGE SCHMITT: [11:48:11] I think you have heard it. And I would like to ask the interpreters if -- I assume, but you can contradict me, that the Acholi language perhaps needs a little bit more time than the English language?

THE INTERPRETER: [11:48:23] Yes, sure. The Acholi language has many expressions to explain one English term.

PRESIDING JUDGE SCHMITT: [11:48:30] It would be similar, I think, if we compare it with German. English is a very straightforward quick language, so perhaps we

keep this in mind in the following hours.

MR BLACK: [11:48:43] Thank you. I apologise.

Q. [11:48:49] Professor, at paragraph 52 of your report, which is tab 2 again, you note that Dr de Jong found Mr Ongwen to score at 24 on this PHQ-9. And that is near the maximum score; is that correct?

A. [11:49:08] That's correct. Twenty-seven is the maximum score.

Q. [11:49:14] Nevertheless, Mr Ongwen's clinical presentation as described by the other psychiatrists is being, is said to be happy, and he was assessed as having mild symptoms of depression using the Hamilton rating scale. What conclusions, or what do you draw from those apparent discrepancies relating to his mood?

A. [11:49:45] Could I just say that these scales measure current illness or pathology; not historic, current.

Coming back to the question, it relates to what I was trying to explain earlier, which is that in forensic work one is used to -- well, one has to be aware of the potential for faking bad, for exaggerating symptoms or for malingering.

Now, there is clearly a discrepancy between Mr Ongwen's presentation on a day-to-day basis, and in the interview itself with Professor de Jong, and the scale, which would suggest a very severe level of depression currently. And this presentation is incompatible, I would suggest, with somebody who is severely depressed. So one has to work out what the cause is, or what the reason is for that discrepancy.

Q. [11:51:08] Now at paragraphs 53 and 87 of your report you comment on suggestions by Dr de Jong, and also by the Defence experts, that Mr Ongwen may have been concealing or covering up his depression. At paragraph 111 of your report you characterise that as not plausible or psychologically coherent, and why do

you say that?

A. [11:51:37] Well, I think if one is going to speculate on the possibility of somebody concealing their symptoms it would be important to demonstrate in the report and examination that you have tried to test this out with the individual, that you have made that suggestion to the individual and explored that as a possibility. I suggest that it is not plausible for two reasons, the main reason being that individuals who are suffering from a severe mental disorder of any degree may be somewhat guarded about describing their symptoms, or evasive, but, nevertheless, the nature of these mental illnesses are that the individual does not have control over their symptoms. They cannot control their loss of appetite, they cannot control their insomnia, they cannot control their low mood and their tearfulness and their feelings of hopelessness, and so the *notion that somebody may conceal their symptoms is, is not psychologically coherent, if I can put it that way.

I suppose the second reason is that, if one is going to speculate on somebody concealing their symptoms, it is important to try and take that forward and to explain why an individual may wish to be concealing their symptoms. And so coming back to malingering or faking bad, there is a very plausible reason, psychologically plausible reason, why somebody may want to appear to be more unwell than they are in a case such as this.

It is more difficult to explain why somebody may try and appear to be better or well, why they may conceal distress in a case like this, because it cannot be to their advantage.

So for those reasons, and because his presentation is, is so inconsistent with the measures, I suggest that Professor de Jong's suggestion is implausible and psychologically not coherent.

Q. [11:54:37] Now, one point that you have made already in this context is that a lot of the symptoms that we are talking about relate to the present.

A. [11:54:50] Yes.

Q. [11:54:50] Not directly to the past. Would it be possible at least that, even if you assumed that Mr Ongwen was suffering from some level of depression today, would it be possible that his symptoms had arisen at some time -- that's not a good question. I think you have made clear that that doesn't mean that he suffered from depression in 2002 to 2005 --

A. [11:55:16] Yes.

Q. [11:55:16] -- which is the time of the indictment here. Is there any way to know or to enquire as to when those symptoms or that disorder may have arisen?

A. [11:55:28] There would be if one was able to conduct a mental state examination. But in a sense -- in a report of this kind it is important to show your workings, if I can put it that way. It's very important to be very clear about what is a historical diagnosis, as opposed to what may be a current diagnosis, and to show how and to try and demonstrate the chronology of the development of that condition, when it started, when it got worse, when it got better. And, unfortunately, I was not able to find evidence of that methodical approach in Professor de Jong's report.

Q. [11:56:35] I understand. Thank you. That's useful.
And even among the materials that you did have, were there other facts, such as his current detention, or the fact that he is far from his family, which might also explain changes in someone's mood?

A. [11:56:52] Yes, absolutely. Depression is -- the risk of depression is highly associated with what we call negative life events, bad things that happen. Particularly around loss, so bereavement would be a risk factor for depression. But

also the loss of other important things in one's life, one's values, one's home, one's country, one's language. And threat is associated with depression. And clearly, Mr Ongwen is in a different culture, a different environment, he is under a great deal of stress, facing a lot of uncertainty. All of those factors would be, all of those elements would be considered risk factors for developing both depression and anxiety symptoms.

Q. [11:58:01] And, in your opinion, did doctors Akena and Ovuga especially, did they sufficiently consider those alternative explanations in their report?

A. [11:58:13] I found no evidence to suggest they had, no.

Q. [11:58:19] I will turn now to the third of the three disorders, dissociative disorders, and this is probably the one lest familiar to most people, certainly it was to me. Please explain what dissociative disorder is.

A. [11:58:37] Dissociative identity disorder?

Q. [11:58:40] Well, actually, and hopefully I can be clear about our terminology, first, what is a dissociative disorder? And then I will ask you if there are several different kinds of dissociative disorder.

A. [11:58:54] Yes. Could I just start by saying that it was quite difficult from the reports of the other experts to be clear about which disorder they were referring to, which dissociative disorder they were referring to, because there are different conditions, all of which use the word dissociation, dissociative.

What dissociation means, essentially, is that dissociation is a disruption to the person's identity, to their sense of self, their sense of agency. A dissociative disorder essentially represents a fragmentation to the individual's ordinary psychological processes, so their memory, their consciousness, their perceptions, their feelings. And the key condition where this appears in the DSM is dissociative identity disorder.

Shall I -- can I just?

Q. [12:00:22] Please, go ahead.

A. [12:00:23] So dissociative identity disorder is the main condition that where dissociation is, the key feature of the -- sorry, if I can start again.

Dissociative identity disorder characteristically involves a disruption to the person's identity, and what you see are two or more distinct personalities operating, essentially, side by side. Neither personality knows of the other person's existence.

Now that is classic dissociative identity disorder. Where that occurs one sees marked discontinuities in the person's sense of self and in their sense of agency.

And you typically see alterations in memory, in perceptions, in consciousness, in their motor functioning associated with the disorder.

Not surprisingly, because the two personalities are almost operating *independently and in different *worlds, different universes from each other, very often the person is not aware that they have the disorder, but it is noticed by other people.

And to make a diagnosis, again, one generally sees marked problems in the individual's social functioning or their occupational functioning or functioning on a day-to-day basis. Or they are very severely clinically distressed.

It is an enduring condition. It doesn't really remit, or you don't relapse or remit in the way that other illnesses might do, because it's the individual's identity, it's stable, static and enduring.

Q. [12:03:05] How common is dissociative identity disorder?

A. [12:03:09] It's pretty uncommon. I can't give you a percentage. It tends to be diagnosed more in the States. All I can say is that in my 30 years of practising as a psychiatrist I have not seen a -- I have seen one case of dissociative identity disorder.

It's seen as being unusual, highly unusual, in comparison to other dissociative states

which are much more common.

Q. [12:03:46] And am I right that dissociative identity disorder is what might colloquially or formerly be called multiple personality disorder?

A. [12:04:01] Yes.

Q. [12:04:01] To help us understand this in a bit more depth, do healthy people also dissociate?

A. [12:04:11] Yes.

Q. [12:04:12] How is that? What kind of a daily experience might a healthy person have which involves some level of dissociation?

A. [12:04:19] Okay. Well, a simple example is you may be driving along a road and suddenly you -- the road looks unfamiliar or you realise that you have gone past a spot that you are meant to have stopped at or hadn't even noticed that you were there. So it is that lack of noticing, lack of registering what is going on that would be seen as a very brief transient dissociative episode, entirely non-pathological.

Q. [12:05:01] And so I guess then what is required for it to have become pathological, what degree of difference or of impairment are we talking about for this to be a severe mental disorder?

A. [12:05:16] For the dissociative identity disorder it's to do with the chronicity, it's to do with the level of distress experienced by the individual, it's to do with the extent to which the disorder prevents that individual from, from leading a full and -- from participating fully in society.

It's also to do with the, if you like, the extent to which that disorder interferes with the individual's psychological processes, their ability to process information, to concentrate, to communicate, to engage. And so there is a difference both in terms of duration and chronicity as well as severity and impairment.

Q. [12:06:32] How long do dissociative episodes tend to last, or is there a commonality?

A. [12:06:42] If I can just expand on what I said before, dissociative identity disorder is chronic and enduring. There are variations within the DSM which recognise that there are other forms of dissociative disorder which may not amount to dissociative identity disorder. And the reason that I am slightly struggling is because I had difficulty in determining from Dr de Jong's report and Dr Akena's report which form of dissociative disorder they were referring to. There is a short-lived dissociative disorder described which usually lasts for hours, at the most, which is often precipitated by extreme trauma or stress, and it is characterised by the individual not being entirely in touch, either with themselves or with their surroundings.

And the terms that are used, I think they are used in the experts' reports, are terms such as derealisation, so that the courtroom or the world, it seems, doesn't seem solid, it seems slightly unreal as if you are looking at the world around you through a net curtain. That's derealisation.

Depersonalisation is where you, you don't feel as if you are entirely solid yourself. You feel -- people describe themselves as feeling slightly strange or almost, almost drugged, to a certain extent. And I think depersonalisation, derealisation, I think there was one other. But these are features that are suggestive of an acute dissociative reaction usually when that individual has been placed under extreme stress. Sometimes it can be associated with drug use or alcohol use, but I don't think that's relevant in this case.

So it is a variation of dissociative identity, but, unlike dissociative identity, it is short-lived and episodic and usually precipitated by an external event and usually

resolves spontaneously.

Q. [12:10:06] Professor de Jong in his report, and this is again tab 5, page 7, if you would like to look at that. Here they use -- at least uses the label "Other Specified Dissociative Disorder". Is that something different than dissociative identity disorder?

A. [12:10:26] It is. But normally one would expect the expert to state which other identified dissociative disorder they are referring to, because there are four or five.

Q. [12:10:45] And his report does not make that clear; is that correct?

A. [12:10:51] His report does not make that clear. What most of these conditions, though, are not chronic enduring life-long conditions, but are episodic conditions.

Q. [12:10:57] The Defence experts at page 13 of their report, they actually refer -- let me check, this is tab 7. I just want to make sure I use the right language.
They actually mention multiple personality disorder. And I guess at page 14 of their report --

A. [12:11:27] Is this the Dr Akena report?

Q. [12:11:30] It is, correct.

A. [12:11:31] Page 14. Yes.

Q. [12:11:34] At page 14 they have a sentence which says, quote:
"During an episode of dissociation, an individual automatically (without deliberate conscious awareness), assumes another personality for whom mental capacity to know right from wrong does not exist."
Which of the variants of dissociative disorder would that seem to relate to, if you can tell?

A. [12:12:06] They are talking about dissociative identity disorder. That is the first condition that I refer to.

Q. [12:12:12] Do you agree that a person with dissociative disorder does not have the mental -- necessarily does not have the mental capacity to know right from wrong?

A. [12:12:22] No. That does not follow. It might occur, but there is no particular reason why the personalities of somebody with dissociative identity disorder should have any less ability to distinguish right from wrong than the personality of individual without the disorder.

Q. [12:12:45] You have explained how if someone has two or more personalities they may not know what the other one is doing. Imagine that one of those personalities was doing bad things or was incapacitated, would there be -- what about the other personality, would that necessarily be affected or would that potentially continue to behave in a healthy and normal way? Are all of the identities ill?

A. [12:13:24] You know, it's a very, very unusual condition, and I think it is also one that psychiatrists don't understand particularly well. As I said, one -- each personality is unaware of the existence of the other personality. When they are behaving in a way that they are behaving they are aware of what they are doing and understand what they are doing, it is not just accessible to the other individual. I think -- what I understand from the report to be beginning to say here is that, certainly it is recognised in forensic psychiatry, in psychiatry in general, that if an individual dissociate -- that if an individual has dissociated during an act, so when one sees an offender, let's say the individual is alleged to have assaulted their neighbour, if they are claiming to have assaulted their neighbour whilst in a dissociative state, for whatever reason, then they would not be expected to know about or remember or to be able to describe any elements of the assault. They would have complete amnesia for the assault, because what dissociation does is it cuts off or

disrupts your memory to the extent that you cannot register or retain what you are doing at that time.

So amnesia is entirely consistent, in fact necessary, for a diagnosis of a dissociative state. Whether you call that part of a dissociative identity disorder, or some other dissociative episode, it would, it would be the same thing.

Q. [12:15:57] As you know, some of the crimes alleged in this case continued over months or years, including forced marriages, slavery, and the use of child soldiers. How likely is it that a person would be in a dissociative state for months or years on end?

A. [12:16:20] It would not happen. Dissociative states, as I said before, are very short-lived. They would last for minutes or hours. They would not persist for years. The only condition that would persist is this multiple personality disorder where there are the distinct personalities operating separate from each other.

But, again, it's confusing because the word dissociation happens in both places, but with dissociative personality disorder the individual committing the acts would be aware that they were committing the acts at the time and would know about them. It is only the other personality who would not be aware of it.

I hope I am not making this over -- overly complicated.

Q. [12:17:30] I don't think so. If I am complicating it I also apologise. But I think, I think to understand, if a person has identity A and identity B, if a crime lasts for three years, how likely is it that that person would be only an identity A or only an identity B?

A. [12:17:54] It would be, it would not -- it would be more than unlikely. It would be, I would suggest, impossible.

Q. [12:18:06] And even if one accepts the idea that identity A might assault his or

her neighbour, and identity B not realise it, you know, if a person was involved in bank fraud over the course of seven years and something like that, and came back into identity B, identity B would still be able to realise what was happening; is that right?

A. [12:18:31] Yes. Yes. And if I can just be clear, these are not just exaggerations or reductions in aspects of your personality. It is not just that personality B is a bit more quarrelsome or a bit more extrovert than personality A, they are separate distinct personalities so, you know, to the extent that in the literature they tend to be individuals who are operating different stages of their lives, they have different careers, they have different family structures, different values. They separate, essentially, as separate people and these separate people are observed by everyone around them. So we all have different aspects of our personality which express themselves at different times to a greater or lesser extent. So I am not talking about that, I am talking about very separate people as if you are operating with two separate individuals.

Q. [12:19:51] And am I correct that one kind of illustrative example of that is possession, like a religious possession, that people are seen to be possessed by spirits?

A. [12:20:01] That is one of the examples given in the DSM, yes.

Q. [12:20:13] Professor de Jong in his report also refers to something called conversion disorder. What is that?

A. [12:20:22] It's a disorder where individuals are usually very conflicted about two opposing values that they have, or life goals, or desires. And rather than being able to express that conflict or articulate that conflict, the conflict, the conflict is expressed through, often through, if you like, a physical manifestation of the distress, so a conversion disorder might, might be represented. This is a psychoanalytic,

psychodynamic notion more than psychiatric. But, for example, an individual who is very conflicted or ambivalent about going to war may, may suddenly develop a paralysis of their right leg which has no physical basis for the condition, but it does allow them to excuse themselves, if you like, from having to be confronted with the stresses of war, but actually also at the same time to retain a degree of self-respect and dignity because it gives them a viable excuse.

That is a very simple reason but, essentially, it's the translation or conversion of mental distress and conflict into physical manifestation of that conflict.

Q. [12:22:10] But it doesn't sound like it involves the kind of incapacitation of a dissociative identity disorder. It is something very different, right?

A. [12:22:22] It is something very different, yes.

Q. [12:22:24] You have already explained most of the terms I had on my list, but there are a couple more.

At paragraph 74 of your report you just note Dr de Jong says he tested Mr Ongwen for narcissism, found no sign of narcissism. What does that refer to?

A. [12:22:41] Well, narcissism is a common term, but narcissistic personality disorder, it's a -- one of the many personality disorders. It's, again, a chronic, enduring developmental condition affecting the personality, so not a mental illness. Usually manifested by individual sense of grandiosity, entitlement, seeing themselves as the centre of the world, often slightly sensitive to criticism, considers themselves superior, considers themselves to have an important mission in life that people ought to recognise.

Q. [12:23:36] Thank you. And then the other term, which I think it is in the DSM, it is in Dr de Jong's report, it's differential diagnosis. Can you tell us what that is and how it relates to what you do?

A. [12:23:48] When one has conducted a mental state examination and read through the paperwork, sometimes a single diagnosis is -- becomes very clear. But there is quite a lot of overlap in symptomatology in psychiatry, so there are some symptoms that may be compatible with several different diagnostic conditions. And when one has completed an examination it may then be impossible to say for certain this is the diagnosis, because there might be other mental conditions or explanations that could equally well account for the presentation. So what we talk about is usually such-and-such being a primary diagnosis or the most likely diagnoses, but other differential diagnoses are those diagnoses which perhaps ought to be considered as possibilities.

Q. [12:24:58] Thank you. I understand that better now than I did before.

I am going to change gears, in a way.

Those are all my questions about terminology for the moment.

And now I would ask you to turn to tab 4 of binder number 1 and there is a document there entitled "Material Drawn from the Courtroom Proceedings: For Consideration and Possible Commentary by the Prosecution's Mental Health Experts".

Do you have that in front of you?

A. [12:25:32] Yes.

Q. [12:25:33] Do you recognise that document?

A. [12:25:34] Yes.

Q. [12:25:34] And do you recall receiving an email - I can tell you it was on 25 January of this year - from the Prosecution which included this as an attachment; is that right?

A. [12:25:43] Yes.

Q. [12:25:43] Thank you.

And the ERN, for the record, of that document is UGA-OTP-0283-1386.
The email which was sent to you by Mr Gumpert asked you and the other Prosecution experts to review these extracts and to come to court prepared to comment on any which you considered might, one, illustrate or perhaps cast doubt on a point or conclusion in your report, or, two, assist the judges in determining how to interpret particular evidence in this case.
Now, have you indeed reviewed this chart prior to coming to court?
A. [12:26:35] I haven't had a chance to look through it in detail prior to today's hearing, but I certainly read it carefully when you sent it to me.
Q. [12:26:46] And based on that reading are there any particular extracts that you would like to comment on you think would help us?
A. [12:26:57] Well, if I could say just generally that I found no evidence from the transcript that you sent me of, of any, any suggestion of mental instability or behaviours that might amount to instability being reported in any of the abstracts.
Q. [12:27:26] Perhaps I could jump in and ask you to look at extract number 6. And this is testimony from a former colleague of Mr Ongwen in the LRA, who testified basically that he had lived with Mr Ongwen for a long time, knew him very well, that he was good at being a commander and speaking to his soldiers, that he was very knowledgeable in military matters.
What, if anything, does that suggest to you about Mr Ongwen's mental health condition at that time?
A. [12:28:05] That he was functioning normally. At least there was no obvious impairment in his ability to engage, to make decisions, to process information, or to interact with other soldiers.
Q. [12:28:29] Have a look at extract number 9, if you would, please. And it is

really kind of the second page at the bottom of page 9 of this chart.
Here a person who we -- the Prosecution believes to be Mr Ongwen is reporting on an attack, a place called Odek, and he reports -- well, he goes through the kinds of weapons and ammunition that were recovered, five SMG guns, 30 full magazines of ammunition, a 60-millimetre mortar.
Would you expect that a person that had been dissociating during the attack could then give a report with this kind of detail about what was done during the attack?
MR OBHOF: [12:29:23] Objection, your Honour.
They are asking her to comment, when a lot of this transcript -- while the Court itself transcript is there, the other part of the extract where it has the alleged translation of the -- of the intercept. It's mostly unintelligible inside of there. I mean, for her to try to understand what was going on and what he was actually reporting, and this is only one of the many people who saw this, this isn't a fair representation for the doctor to make any type of assessment upon.
PRESIDING JUDGE SCHMITT: [12:29:58] Mr Black.
MR BLACK: [12:29:59] Well, your Honour, she is an expert. I think we could say, "Assuming this is accurate what would it tell you?" And take it at that.
PRESIDING JUDGE SCHMITT: [12:30:04] It is all - when it comes to the testimony of experts - not all, fortunately, but many things are about assumptions, hypothesis, so it's also clear the material that has been presented to you, and that you are asked now to comment on, clearly does not necessarily mean that witness A, B, C has said the truth or whatsoever, that we make an assessment at that point in time. It only means that the expert, that Mrs Mezey is asked, "If this were true, what would you say from your expert point of view?" And that we leave it and then you may ask the question and you may answer it under the hypothesis this acutely reflects what has

been said.

THE WITNESS: 12:30:55] Yes, I understand.

PRESIDING JUDGE SCHMITT: [12:30:57] And, of course, I don't have to tell you that in the end we have to determine as a chamber if this indeed has been said in a way that we can ascribe it to Mr Ongwen or not.

Please answer.

THE WITNESS: [12:31:11] Well, as I said before, if, if Mr Ongwen had been dissociating, or indeed was affected by any severe mental condition, he would not have been able to recall or to relate the detail of what happened or very much, if any, detail of what happened at the time.

PRESIDING JUDGE SCHMITT: [12:31:44] In the meantime, I have a question to you, Mr Black. Do you think you will finish before the lunch break?

MR BLACK: [12:31:50] (Microphone not activated) Sorry, I don't think I will finish before the lunch break, but I shouldn't have too much. I will certainly finish in the early half of the next session.

PRESIDING JUDGE SCHMITT: [12:32:03] Given that, I would already perhaps ask Mrs Mezey if you could, in a relatively extensive lunch break, *read into this material again. It is not so many pages from -- I think you will be very quickly through the material and you might perhaps comment upon it after the lunch break.

So Mr Black, please continue.

MR BLACK: [12:32:27] Thank you, your Honour, I appreciate that suggestion. And what I will do then is skip this part and we can come back to it later on.

PRESIDING JUDGE SCHMITT: [12:32:33] I think so. It costs too much time now at the moment. You would have to put everything and, out of fairness, word by word to the expert and I think this costs too much time at the moment and it might be

quicker then after a break.

THE WITNESS: [12:33:01] I wonder if I could just --

PRESIDING JUDGE SCHMITT: [12:33:02] Of course --

THE WITNESS: [12:33:03] Could I just say --

PRESIDING JUDGE SCHMITT: [12:33:03] I told you in the beginning, if you raise your hand I give you the floor.

THE WITNESS: [12:33:09] It was just one matter which I was -- mentioned during the break to the clerk.

Earlier on a question was raised -- well, the statement was made about PTSS, post-traumatic stress symptoms, being included in the DSM-5. I have a copy of the DSM-5. I am fairly clear that PTSS is not a diagnosis in the DSM-5. It is not included within the handbook and I just wanted to say to the Court that I do have a copy and, if that would assist the Court, then I am very happy to pass that on. But it may be that there is already one available in court.

PRESIDING JUDGE SCHMITT: [12:33:56] Mr Black, what would you say to that?

MR BLACK: [12:33:58] I was going to say thank you very much. I have a copy. I believe that copies are available in the library; is that right? Yes. So it is a standard reference book.

PRESIDING JUDGE SCHMITT: [12:34:09] Yes, it is a standard. And I know it from Germany too. So I would even say this is what -- the content of it is a fact of common knowledge, I would say. If anybody has a different opinion. But it's a book, it's a -- something that is, as I understand it, used all over the world. And then we can simply look -- exactly, look into it.

I don't have such a nice version that you have, Mr Gumpert. Please, Mr Black, continue.

MR OBHOF: [12:34:39] Your Honour.

PRESIDING JUDGE SCHMITT: Mr Obhof, shortly.

MR OBHOF: [12:34:40] Just so the witness knows. I was only drawing distinction that the acronym for PTSD in the Dutch language is PTSS, and that's why in the reports it always uses PTSS. Because as you see with the PSO and PSA, those acronyms are not translated into English, they leave the acronyms generally in the original Dutch language.

PRESIDING JUDGE SCHMITT: [12:35:05] So there seems to be a slight difference in your approach what you meant. But as I already said, what is -- the content of this manual is absolutely clear, everybody can read it, can go to the library, or even look it up online.

Please, Mr Black.

MR BLACK: [12:35:21] Your Honour, I have a proposal. The last bunch of my questions are really about the conclusions in her report. I could start them now but I think it would make more sense to leave it to the end. If we could take the lunch break now it would be more convenient.

PRESIDING JUDGE SCHMITT: [12:35:35] Absolutely, I pick that up. But I would like, perhaps, to enquire for planning purposes if already the Defence knows how long they might question the expert?

MR AYENA ODONGO: [12:35:49] Mr President and your Honours, upon reasonable consideration we would risk to say that we shall take not more than three sessions, meaning that we can complete tomorrow.

PRESIDING JUDGE SCHMITT: [12:36:11] That is very helpful information. So that would mean that we - after the break, which will be until 2 o'clock - we will finish the examination by the Prosecution, and tomorrow we start with the Defence.

And we take it that you would need three sessions.

Okay. Thank you very much.

Then Mrs Massidda, I don't assume that the LRVs will have any questions.

MS MASSIDDA: [12:36:37] Good morning, your Honour.

Actually, we sent a request for questioning this witness last Friday. I might have three to four questions, but we will review the transcript of hearing during the lunch break and it's highly possible that I will not question this witness.

PRESIDING JUDGE SCHMITT: [12:36:58] Yes. You know, I assumed that, although I knew a little bit that you requested to question.

Let me put it this way, we will look at any questions to *this expert, because she completely relates to Mr Ongwen *personally, very critically, so to speak.

So lunch break until 2 o'clock.

THE COURT USHER: [12:37:20] All rise.

(Recess taken at 12.37 p.m.)

(Upon resuming in open session at 2.00 p.m.)

THE COURT USHER: [14:00:39] All rise.

PRESIDING JUDGE SCHMITT: [14:00:58] Good afternoon, Mr Black. You have still the floor.

MR BLACK: [14:01:04] Thank you, your Honour.

Q. [14:01:07] Good afternoon, Professor. I hope you had some time to eat a bite.

PRESIDING JUDGE SCHMITT: [14:01:13] But at the moment you are a little bit voiceless, so to speak, but you will be helped with that. Thank you.

MR BLACK:

Q. [14:01:23] Professor, I'm going to ask you now about tab 4.

A. [14:01:25] Yes.

Q. [14:01:26] Did you have time to look at this a little bit more over the lunch break?

A. [14:01:32] Yes. I stopped before the final page, but I, yeah, reminded myself of the contents.

Q. [14:01:37] Fantastic. Well, if you would, please, you don't have to go through each of them, but if you would pick out some that you think could be useful to the Judges, please take us through them.

A. [14:01:48] Right. Okay, well, I think a number of them are of interest. The number -- if I can just name them -- give the number, would that be acceptable?

PRESIDING JUDGE SCHMITT: [14:02:03] Yes, I think we can follow then.

THE WITNESS: [14:02:07]

For number 1, I think what we are seeing there is that Mr Ongwen had a degree of knowledge and agency over, over what was going on, so he was issuing orders - I think this also applies to number 2 - he was issuing orders and commands. And, in fact, if I can make a general statement and then I'll state them by different numbers, if that would help.

I think many of these extracts refer to the fact that Mr Ongwen was in many cases giving commands or giving orders, that he was not directly under the command of anybody else, and that suggests a degree of control and a degree of agency. It also negates any suggestion of duress, that is, an individual, in a sense, being coerced to commit acts for fear of violence to themselves or harm to themselves.

There are a number of entries which also indicate that he has moral awareness or an awareness of the difference between right and wrong and is able to differentiate, at least in his own mind, between those he considers to be legitimate victims or legitimate targets and people who are not legitimate targets.

It would be helpful, there are -- number 3, number 3 seems to me that here he is describing a man, Mr Ongwen, who rises up through the ranks because of his ability as a fighter, because he is respected by the men and that's repeated by several individuals, and who is, I suppose, regarded as being solid and reliable. As Mr Ongwen, when Mr Ongwen becomes a commander, he is taking more responsibility for his actions and he's described as tough, I think, which is an interesting word; one that would not normally be applied to individuals who were psychologically unstable or appear to be somehow fragile and unpredictable. He appears to be tough. He appears to be resilient.

In number 4, I think, the thing that comes out to me in this is that Mr Ongwen is able to -- he knows what is happening, he's able to describe his actions and explain and justify his actions in a way that makes sense to himself. So his behaviours are not being portrayed as behaviours that are inexplicable to him or out of his control or behaviours and actions that he is not aware of.

Again, in number 5, there is a reference to his skills as a soldier, the fact that he's admired and respected as a soldier and as a good fighter. There's a picture of a man who is again rational and who is in control of himself and of the men under his command. Again, this would be inconsistent of somebody in a state of mental ‘ distress.

MR BLACK:

Q. [14:06:57] Could I --

A. Yes.

Q. I'm sorry, Professor. I was just -- I think the numbering was to me at least confusing. Are you referring to the page numbers or to the numbers at the very far left-hand column?

A. [14:07:09] I think I was referring to the far left-hand column.

PRESIDING JUDGE SCHMITT: [14:07:12] Mr Black, that's clear.

MR BLACK: Okay.

PRESIDING JUDGE SCHMITT: She follows one after the other.

MR BLACK:

Q. [14:07:16] Then the contents in number 5, the reference to skill as soldier --

A. [14:07:21] I apologise. Have I --

PRESIDING JUDGE SCHMITT: [14:07:22] This might be that it is meant number 6.

THE WITNESS: [14:07:26] I apologise.

MR BLACK: That's what I was trying to --

PRESIDING JUDGE SCHMITT: [14:07:27] But I think the way the witness expert wants to get forward is one by the other, after the other.

THE WITNESS: [14:07:35] Yes, I apologise. My numbering has gone wrong. I think this is the same person, P-0231. There is also again a sense, thinking about the questions we are being asked to address, that is, did he know what he was doing, did he know the unlawful nature or the wrongfulness of his actions and was there any impairment in his ability to control his behaviour?

Again, number 6, I think there is a, there is a clear indication here and in a number of other entries, again, about Mr Ongwen being able to distinguish in his own mind between there being legitimate and non-legitimate targets, between certain actions being considered to be morally justifiable and others not being acceptable. And these are rules which he appears to have applied in a reasonably consistent and at least internally psychologically coherent way. Again, several witnesses talk about that. In number 8, I think this is number 8, there is a description of Mr Ongwen apparently persuading Joseph Kony not to kill --

MR OBHOF: [14:09:08] Your Honour, could we go into private session for this, please. This part is confidential. This part she's discussing right now is listed as confidential in the transcripts.

PRESIDING JUDGE SCHMITT: [14:09:22] Mr Black.

MR BLACK: [14:09:25] Yes.

PRESIDING JUDGE SCHMITT: [14:09:26] We go into private session.

Thank you, Mr Obhof.

MR OBHOF: [14:09:29] Sorry about that, Doctor.

(Private session at 2.09 p.m.) Reclassified into public.

THE COURT OFFICER: [14:09:34] We are in private session, Mr President.

PRESIDING JUDGE SCHMITT: [14:09:36] That we are in private session has nothing to do with you, of course, personally, but it simply has to do something with the content of what we are going --

THE WITNESS: I understand.

PRESIDING JUDGE SCHMITT: -- to discuss now.

THE WITNESS: I understand.

PRESIDING JUDGE SCHMITT: Mr Black.

You were simply referring now to this number 8. Simply continue what you wanted to say.

THE WITNESS: [14:09:53]Yes, the concerns about individuals with mental illness is that they are perhaps unstable, that they are less resilient in many ways and they are more susceptible to coercion or being controlled.

Now, number 8 suggests that in fact rather than acting out under duress, if I could put it that way, Mr Ongwen was able to resist orders, if this is accepted by the Court, he was able to resist orders that were given to him and he was able to stand up to the

commander, to Joseph Kony, if there are actions that he himself felt were not justified. And this kind of emotional resilience, again, suggests a -- both the fact that he had a moral compass about certain actions not being acceptable, others being more legitimate, but also that he was not in fear of -- for his life, he was not unduly susceptible to being dominated by other individuals or being controlled by other individuals, particularly by Joseph Kony.

PRESIDING JUDGE SCHMITT: [14:11:29] Thank you. I think we can go back to open session. I would suggest, and it might be like always we have to look later on if redactions can be lifted.

Open session.

MR BLACK: [14:11:45] I think you're right, your Honour. I think we can proceed in an open session. I thought about how to do this and it's difficult because it's a few details that might be identifying to some of the protected numbered witnesses, but *most of what the professor is going to say will presumably be fine in public. What I would offer is just to try to be attentive, as Mr Obhof was, and we'll try to step in if it seems like something should be --

PRESIDING JUDGE SCHMITT: [14:12:08] I agree, but from the answers of the witness, I would also assume that we can avoid going to private session all too often, I would say, from the nature of the answers that the witness gives.

MR BLACK: [14:12:22] I think that's right.

And perhaps, Professor, if you could try to avoid, you know, describing the content and focus on what conclusions you can draw from it.

THE WITNESS: Yes.

MR BLACK: If that's --

PRESIDING JUDGE SCHMITT: [14:12:35] Yes. I accept it and Mrs Mezey has

largely done it this way.

Open session.

THE WITNESS: [14:12:45]Continue with number --

MR BLACK: [14:12:47] Just a moment.

THE WITNESS: [14:12:50]I apologise.

(Open session at 2.12 p.m.)

THE COURT OFFICER: [14:12:57] We are back in open session, Mr President.

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(Upon resuming in open session at 2.53 p.m.)

THE COURT USHER: [14:53:48] All rise.

PRESIDING JUDGE SCHMITT: [14:54:07] The Chamber would appreciate it if the Defence would address what has happened to clear this from the side of Defence towards the Bench and everybody else here in the courtroom. If you said something about it, we would appreciate it, Mr Obhof or Mr Taku.

MR TAKU: [14:54:35] May it please your Honours, unfortunately, I wasn't here when this occurred. I had to take my medication which I forget this morning. But before I leave the floor to Mr Ongwen -- I mean to Mr Obhof, I will clearly state, your Honours, that when I saw the material here, material drawn from the courtroom proceedings on -- I read through the expert report that was submitted to us and to the Court, which you gave permission that the evidence will be based on, I didn't find this as part of that expert report. And I also knew --

PRESIDING JUDGE SCHMITT: [14:55:14] Mr Taku, no, I'm not, I'm not now -- after what has happened, and you were not present, after what has happened before the break, I'm not listening now to any intervention, any discussion about what material might or not be part of the expert's testimony.

What has happened before this unfortunate break was really severe and it was serious and this is why I would appreciate very much and the whole Chamber would appreciate it very much if there would be a sort of declaration by the Defence. And

no litigation about any material that has been submitted or not submitted or part of the testimony or not.

MR TAKU: [14:55:58] Yes, your Honour. I will address the issue put to me now, although the issue I wanted to raise we will come back to it subsequently.

Your Honour, this is a matter for which the Court has been fully apprised of from detention, from the physicians. You had an update about the condition of Mr Ongwen. You read the different reports before you. In one instance before the Court it happened when one of the witnesses, I think P-3, came to testify. Therefore, your Honours, although what I've seen from the transcript and what I've been told is serious, extremely serious, it is something that was easily foreseen.

And what I can say before I leave the floor to Mr Obhof is that we need critically to think about how we will handle this matter for the future of the proceedings. For me, sometimes I get worried about how we will conduct the proceedings until the case ends. When I look at these reports, although we don't have all the reports from detention, but the ones that we can have are from the Registry and which the Court -- it's only the Court that is updated about this, and therefore, your Honours, what happened is extremely serious and I would like Mr Obhof, who was present, to put it on the record.

PRESIDING JUDGE SCHMITT: [14:57:22] If you want to say something, Mr Obhof. Otherwise we could simply adjourn and I say a few words before we do that.

MR OBHOF: [14:57:29] Just very briefly, we're having -- we've contacted the detention centre and they are bringing Mr Ongwen's psychiatrist or psychologist in to talk to him as soon as he gets in.

PRESIDING JUDGE SCHMITT: [14:57:42] So it is perfectly clear, we have already said, but this was quite a while ago, that if any disruption continues or appears again,

that we would have to take measures according to Article 63(2). And we will say now that if Mr Ongwen refuses to come tomorrow or if he comes and any only slight disruption of the proceedings occurs on his part, we will take this measure, which means that he would have to follow via video link from the detention centre.

If - and we would appreciate that, of course, very much - Mr Ongwen calms down until tomorrow, and we would appreciate if the Defence could take part in such a calming down, so to speak, and he would appear tomorrow, then it would be a sign of understanding by your client if he would give the Court a short declaration and would say something to that effect.

We adjourn the proceedings for today and resume at 9.30 with or without the accused.

THE COURT USHER: [14:59:09] All rise.

(The hearing ends in open session at 2.59 p.m.)

RECLASSIFICATION REPORT

Pursuant to the Trial Chamber' IX's instructions, ICC-02/04-01/15-497, dated 13 July 2016, the public lesser redacted version of this transcript is filed in the case.