1 International Criminal Court
2 Trial Chamber IX
3 Situation: Republic of Uganda
4 In the case of The Prosecutor v. Dominic Ongwen - ICC-02/04-01/15
5 Presiding Judge Bertram Schmitt, Judge Péter Kovács and Judge Raul Cano
6 Pangalangan
7 Trial Hearing - Courtroom 3
8 Tuesday, 19 November 2019
9 (The hearing starts in open session at 9.31 a.m.)
10 THE COURT USHER: [9:31:29] All rise.
11 The International Criminal Court is now in session. Please be seated.
12 PRESIDING JUDGE SCHMITT: [9:31:45] Good morning, everyone.
13 Could the court officer please call the case.
14 THE COURT OFFICER: [9:31:53] Good morning, Mr President, your Honours.
15 The situation in the Republic of Uganda, in the case of The Prosecutor versus Dominic
16 Ongwen, case reference ICC-02/04-01/15. And for the record, we are in open session.
17 PRESIDING JUDGE SCHMITT: [9:32:17] I ask for the appearance of the parties.
18 Mr Gumpert for the Prosecution first.
19 MR GUMPERT: [9:32:23] Good morning, your Honours, Ben Gumpert, with me
20 today Beti Hohler, Jasmina Suljanovic, Hai Do Duc, Nikila Kaushik, Grace Goh,
21 Pubudu Sachithanandan, Adesola Adeboyejo, Colleen Gilg, Colin Black and
22 Sanyu Ndagire.
23 PRESIDING JUDGE SCHMITT: [9:32:36] Thank you.
24 And for the representatives of the victims, Ms Massidda first.
25 MS MASSIDDA: [9:32:41] Good morning, Mr President. For the Common Legal

1 Representatives team Orchlon Narantsetseg, Caroline Walter, and myself
2 Paolina Massidda.
3 PRESIDING JUDGE SCHMITT: [9:32:47] Thank you.
4 And Ms Sehmi.
5 MS SEHMI: [9:32:49] Good morning, Mr President, your Honours. On behalf of
6 the Legal Representatives for Victims, Anushka Sehmi and with me is James Mawira.
7 PRESIDING JUDGE SCHMITT: [9:32:55] Thank you.
8 And for the Defence, Mr Obhof.
9 MR OBHOF: [9:32:59] Good morning, your Honour. Today we have Beth Lyons,
10 Tibor Bajnovic, Eniko Sandor, Krispus Charles -- Ayena Odongo, Michael Rowse,
11 Chief Charles Achaleke Taku, Roy Titus Ayena, Gordon Kifudde, Dominic Ongwen is
12 in court, and my name is Thomas Obhof.
13 PRESIDING JUDGE SCHMITT: [9:33:20] Thank you.
14 And for the record, we have also the two potential additional -- no, one additional
15 expert, one potential additional expert, Professor Weierstall and Professor Ovuga.
16 And welcome of course to our expert witness today again, Mr Akena.
17 I give Ms Lyons the floor.
18 MS LYONS: [9:33:44] Thank you, your Honour.
19 WITNESS: UGA-D26-P-0041 (On former oath)
20 (The witness speaks English)
21 QUESTIONED BY MS LYONS: (Continuing)
22 Q. [9:33:46] Good morning to you and to everyone in the courtroom.
23 Before we get into where we left off yesterday, I just want to ask one question about
24 a description or definition, which is, is there a difference between a mental
25 disease -- a mental health disease and a mental defect in terms of your perspective?

1 A. [9:34:16] Good morning. Usually we use the words "defect" when we are
2 referring to disorders of childhood or disorders that people are born with, and then
3 "disease" as things that happen when individuals develop these disorders in
4 much -- in adulthood. Yeah, usually "defect" is used in child and adolescent
5 psychiatry. "Disease" and "disorders" are used in both child and adolescent and
6 general adult psychiatry.
7 I don't know whether that answers the question.
8 Q. [9:35:05] Yes, that's fine, thank you.
9 Yesterday, when we left off, we were looking at the report. It was the first report,
10 issues of remorse and guilt. And you -- I think we referred to the quote in the first
11 report where you reported on page 11 that Mr Ongwen did not appreciate the
12 wrongfulness of his acts during the time in the bush.
13 Could you explain why he couldn't appreciate the wrongfulness of his acts during the
14 time he was in the bush, please.
15 A. [9:35:57] As per what he told us, that was the norm, that was the modus
16 operandi, that's how they would operate and behave. But also even when he had
17 second doubts about those sets of rules and regulations, you wouldn't -- you don't
18 either express it or you wouldn't be given the avenue to express it or expressing it in
19 its own light was dangerous, was danger. It was costly, it would cost you your life,
20 yeah.
21 Q. [9:36:46] Thank you. Now, I would like to read a quote which you will find in
22 your binder 1, tab 20. It's a transcript from Dr Abbo and it's at pages 61 to 62. On
23 page 61, it's lines 18 to 25, and on page 62 it finishes up at lines 1 to 3. And then I
24 will ask a question about this.
25 A. [9:37:37] Which lines again?

1 Q. [9:37:38] Yeah, page 61, lines 18 to 25 and page 62, lines 1 to 3. We are at tab 20.
2 PRESIDING JUDGE SCHMITT: [9:37:58] And to make it clear for everyone, I
3 understand it that this was a question asked by Ms Gilg at the time, but a quotation
4 from the reports. So that everyone is clear now.
5 MS LYONS: [9:38:11] Thank you very much, your Honour.
6 PRESIDING JUDGE SCHMITT: [9:38:12] Simply to make it clear for everyone.
7 MS LYONS: [9:38:18] Thank you.
8 Q. [9:38:18] Now the quote is this:
9 "What is however clear is the unfavourable environment over which he" - referring to
10 Mr Ongwen - "had no control as an abducted child growing into an adult negated his
11 capacity to refrain from doing wrong because he was not presented with an
12 alternative way of life in the bush, despite knowing that what he was doing was
13 wrong."
14 Now is that -- the question from Ms Gilg is:
15 "Is that a reference back to your statement ... a few minutes ago ... that Mr Ongwen as
16 a child, an adolescent, lacked control over his immediate environment?"
17 Dr Abbo's response is: "Yes."
18 And it is confirmed by Ms Gilg.
19 The question is, what is your response to the quote? And what is your
20 understanding about the issue of control and the effect of an adverse environment on
21 whether a person in that environment, specifically Mr Ongwen, had control?
22 A. [9:39:45] The description that we often got from him was that the environment
23 was quite hostile. "Unfavourable" I think is a lighter term. The environment in
24 which they were living was hostile.
25 As a child, you knew that if you -- if you went off script or if you did something that

1 was not in line with what was prescribed, you would end up dead. But I think as an
2 adult -- later on he says that as an adult, he kept on talking about the security. He
3 kept on -- he kept on telling us that the security would be aware of what -- what was
4 going on, I think -- there were spies around you and they would report directly to the
5 boss. And any form of deviation from prescribed norms was costly; that's what he
6 said.
7 And I think that kind of resonates with what I see here, that the environment was
8 hostile and it was very difficult to have a different version of thought processes in the
9 situations in which, in which these people were living. Yeah.
10 Q. [9:41:41] Now let me ask you as a psychiatrist, how do you assess in your work
11 whether a person can tell right from wrong or make a judgment? How do you
12 figure it out?
13 A. [9:41:51] First, I think you need to -- you need to understand the context in
14 which that person comes from and prescribed norms in that context, and that's very
15 important. And then you see whether they live within those prescribed -- that
16 context. Because even in -- even in hostile environments where there are prescribed
17 rules for which the outcome is death if you defied them, some people still broke those
18 rules. Some people still went ahead and did other things that were not in line with
19 what -- what was said.
20 So I think the first thing that I would do would be to -- the first things that I do is to
21 find out under what circumstances this person grew up, where they came from, what
22 was the norm, what was the rule, what was in the rule, and then we assess whether
23 they conformed to it or not.
24 Usually, in our trade, we -- the question that many psychiatrists ask, they look
25 innocent, but questions like: How many schools did you attend in your primary?

1 And most people who don't follow rules will attend three, four, five schools in their
2 primary, they would be dismissed, they would be suspended, they would break the
3 laws, they would do all sorts of things. So that -- that is, that is how we would assess
4 for such a construct.
5 I don't know whether this answers the question.
6 Q. [9:43:34] That answers it for now.
7 A. [9:43:35] Okay.
8 Q. [9:43:36] Let me ask you -- one moment, please.
9 I had one question about your last answer, just one clarification from the transcript.
10 I'm sorry, I'm not able to read the screen here.
11 You mentioned the boss a few minutes ago. It says, let's try this:
12 "I think there were spies around you and they would report directly to the boss".
13 Just for clarification, to whom does "the boss" refer?
14 A. [9:44:15] That would be Joseph Kony or the spirit, and he used to use those
15 words interchangeably.
16 Q. [9:44:24] Okay.
17 A. [09:44:24] Yeah.
18 Q. [9:44:25] Thank you. Now we are talking about right and wrong right now,
19 but you've described yesterday a number of conclusions related to the mental
20 diseases of Mr Dominic, which have continued during now and during the
21 charged -- and also going backwards to the charged period.
22 Now can you describe for us briefly how these diagnoses, there was PTSD,
23 dissociative disorder, severe --
24 A. [9:45:10] Depression.
25 Q. [9:45:11] -- depression, I think -- how -- the question is, did they affect this

1 sense -- this judgment -- his judgment of right and wrong? Is there a relationship
2 between the disease and whether a person in general or Mr Ongwen in specific can
3 determine right or wrong, tell what's right or wrong?
4 A. [9:45:40] I recall in one of the interviews he told us how he -- one morning, they
5 were, they were praying, they had called his colleagues for prayers, and then he
6 started smelling blood, then he started smelling gun powder, then somehow he
7 figured out, through some other means that we couldn't understand properly, that
8 they were about to be attacked. So he picked his gun and then he ran towards the
9 enemy. Then a fight, a gun fight broke out which they won.
10 He says that he had very hazy memories of that particular event, including the fight
11 itself. But then when he came back, his colleagues told him that that is something
12 that normal people wouldn't do. And at that point, he was -- he says he wasn't fully
13 aware about what was going on. That was one incident.
14 I think he described another incident like that in Sudan in the 1990s. Apparently
15 there was one particular outfit that was known for being dangerous and ferocious,
16 but he asked his seniors at that point whether he could go and attack them, and then
17 they went and attacked them and won.
18 But the second one he says that -- I think his colleagues told him that he had the spirit
19 of fighting basically. He had something in him that would control him or would
20 take care of him during those fights and he wouldn't get harmed or injured.
21 We were shocked. I think we said, "But how could you do this? I mean, how can
22 you -- how can you expose yourself and the lives of your escorts and your soldiers to
23 such -- such a situation?" And there really wasn't a clear answer to that. He -- he
24 wouldn't say that. Sometimes he'd drift off and say, "Well, if I'd died in battle,
25 maybe life -- things would've been better."

1 So I think some of the challenges that he had really affected the way he would think
2 and do things and the way he would -- the way he would lead life, I think even as
3 soldier, because at the end of the day, he says he was a trained soldier. There are
4 things that I think normal soldiers wouldn't do in their life. Yeah.
5 Q. [9:49:09] Let me ask you, when you refer to challenges, are you referring to the
6 mental health illness as a challenge --
7 A. [9:49:19] Yes.
8 Q. [9:49:21] Thank you. Now we will be dealing in the second report with
9 Professor Ovuga much more the issue of moral reasoning, but I wanted to raise one
10 question now because it seems appropriate.
11 I think Professor Weierstall made a distinction in his report -- I'm sorry, in his
12 transcript, where he talked about that there's a different capacity of moral reasoning
13 and psycho -- sorry, I don't want to misquote you -- psychosocial functioning between
14 somebody who's eight and nine and somebody who's 13. There's an age difference.
15 So basically the principle, if I may say it without objection, is that age affects a moral
16 reasoning and capacity.
17 PRESIDING JUDGE SCHMITT: [9:50:13] I think we have it still in our minds, of
18 course. I think we don't need -- Mr Gumpert, we don't need the exact quotation. I
19 think if --
20 MS LYONS: [09:50:20] I have it here --
21 PRESIDING JUDGE SCHMITT: [09:50:22] -- if we ask the question like you did it,
22 that does the age of abduction --
23 MS LYONS: [9:50:29] Okay.
24 PRESIDING JUDGE SCHMITT: [9:50:30] -- affect the possibilities to establish
25 a stable moral understanding? For example, does it make a difference if a person is

1 abducted at the age of eight or 13, for example.

2 MS LYONS: [9:50:50]

3 Q. [9:50:51] And abducted, if I may add, and -- sorry, if I may add, and abducted

4 into -- forcibly abducted into the LRA, we're talking about, let's assume.

5 PRESIDING JUDGE SCHMITT: [9:50:55] Of course we are talking about that.

6 MS LYONS: [9:50:58] All right. All right. Just so I -- I'm sorry.

7 Q. [9:51:00] Does the age make a difference in the reasoning and development?

8 A. [9:51:06] Yes, I would think so. But in this case, I think I would want to qualify

9 it -- I would want to qualify that statement by trying to elaborate a bit more on what

10 happens after the abduction to the people and how that has a much more significant

11 impact.

12 Yesterday, I talked about the individual from whom we got a collateral history. I

13 talked about a gentleman who was -- who was abducted shortly -- I think a couple of

14 years after him, and another young man who was abducted many years later on.

15 And there was a distinction in between how they perceived the spirit. The young

16 man actually didn't think there was a spirit. The older man thought there were

17 spirits.

18 So I think the circumstances under which these young men and women were exposed

19 to when they were still younger, most likely had a much longer impact on their lives

20 than the lives of other people who were abducted much later.

21 Of course, it is -- if you put that into the context of somebody who does not have

22 alternatives to life, somebody who is probably trying to recover from the loss of

23 a parent or somebody who is just trying to figure out what exactly is going on in this

24 outfit that they don't even know about, chances are that you're likely to end up with

25 long-lasting damage to somebody's brain, yeah.

1 Q. [9:52:58] Thank you. Now a few minutes ago you talked about a hostile
2 environment; that was the word that you used. Now, one of the views that has been
3 put forward by the experts from the OTP is, "Look, Mr Ongwen is
4 functional" - right - and various conclusions have been drawn based on his, quote,
5 "functioning" in the LRA.
6 Now I would like you -- and one of those conclusions is, and certainly I think it was in
7 Professor Weierstall's report, that it was highly unlikely he was suffering from mental
8 diseases that you identified - the PTSD, the major depressive disorder and
9 dissociative disorders - because he was functioning. That may have simplified it, but
10 basically the link was, "You're functioning here. Therefore, the disease -- it's hard to
11 make -- you can't make the argument that there is a disease that's stopping you from
12 functioning if the disease isn't there."
13 So what is the relationship between the diseases and how do you understand this
14 notion of functioning, from your perspective?
15 A. [9:54:38] Let me give you an example of something which we use. There is
16 a term which we call the treatment gap for mental disorders or mental illnesses the
17 world over. And this treatment gap in some places is as high as 75 per cent.
18 Meaning, 75 per cent of individuals don't receive the treatment that they need to
19 receive for the illnesses that they have. Maybe 25 per cent of people get treated. In
20 many parts of Africa, sometimes it drops like 10 per cent.
21 But in those same environments, there are individuals who have mental illnesses.
22 Are they functioning? Well, they're leading a daily life but with struggles. Because
23 unlike infectious diseases, a mental illness is not going to kill you like tuberculosis or
24 HIV does, but it's going to unleash a certain amount of torrential suffering that you
25 can't escape from.

1 You're going to live with this for a long time. It reduces your life span significantly,
2 by 10 years in some situations; it's just like smoking cigarettes.
3 So you have a situation where people are living and they seem to be going on with
4 their daily activities, and they seem to be seen as okay. But also remember that the
5 routines within the LRA at that time really were constricted to a few things, most
6 likely.
7 I don't know what they were, but we're not talking about somebody who
8 has -- who -- we're not talking about people who are involved in highly productive
9 activities here. We're talking about people who are barely surviving and everything
10 else around it is surviving, and, and -- okay, avoiding getting killed or killing or
11 something like that.
12 So it is -- many people function within that context. Again, if we just look at
13 demographics of mental illnesses and we say 5 per cent of the population at any one
14 point has some form of depressive illness, and maybe there are a hundred people in
15 this -- in this place, then we say maybe five of them, maybe zero, maybe three, maybe
16 five, maybe 10 - who knows - have some form of depression. But we're all here and
17 we're all somehow doing work.
18 So without -- again, without a detailed assessment of a mental illness, it is difficult to
19 figure out whether somebody had it or not. It is difficult to simply see whether
20 somebody had a mental illness or not because for you to actually say somebody has
21 a mental illness, you need to have some objective assessment -- structure to be precise.
22 So it's possible that the client was going through the motions within the ranks, but I
23 think the evidence we have is that he was, he was struggling under the burden of
24 a number of illnesses, yeah.
25 Q. [9:58:27] Now, I would like you to take -- sorry, if I can find it. I would like

1 you to take a look, please, at Professor Weierstall's report at tab 10 in the first binder,
2 and we're looking -- and that is ERN, the report starts at UGA-OTP-0280-0674 and I'm
3 looking now at what would be pages 22 and 23 and for the ERNs, it would be ending
4 in 0695 and 0696.
5 A. [9:59:33] Okay.
6 Q. [9:59:34] So take a look and then tell us what these are and then I will
7 have -- what you think -- what you're looking at and I will have a question --
8 A. [9:59:45] Just the lines again?
9 Q. [9:59:46] Yes. Just take a look at the comments, the documentation on page 22
10 and 23. It's documentation from reports from treating psychologists, I presume,
11 from the detention centre. It's on 22 and then there is some on 23 here. Okay?
12 The question is simply, based on this information on 22 and 23, which are the excerpts
13 from the DC reports, does this support, quote, "an adequate level of functioning" or
14 not?
15 A. [10:01:26] You know clinical notes are written differently from notes that are
16 written for other purposes, like this one, for example. And I see that during the
17 assessment there were -- there were points when the client was angry, where he was
18 tired, where -- where he had poor sleep. But again, you can -- like we talked
19 yesterday, we said, you know, some of these things are what we call somatic
20 symptoms; so they point towards an illness, but they don't necessarily help in that
21 diagnosis per se.
22 So when I see a patient, I say, Today the patient is tired. Today the patient is jolly.
23 Today the patient laughed a bit. Maybe today the patient is angry. But really that
24 doesn't point too much towards how well the patient was functioning per se.
25 I think there's evidence that there's some improvement because I see that some of the

1 notes were in April of that year, some of the notes were in September, some of them
2 were in October, there are places where he was laughing and cheerful. Yeah, I think
3 it's -- it's difficult to, to look at a functioning here, because the notes also are not
4 necessarily arranged in chronological order. So on page 23, you have something that
5 is on 24 September. Then you have notes on the -- okay, maybe they're going down
6 in chronological order --
7 PRESIDING JUDGE SCHMITT: [10:03:33] No, no, you are right. It is also difficult
8 for you to comment --
9 THE WITNESS: [10:03:36] Yeah.
10 PRESIDING JUDGE SCHMITT: [10:03:37] -- you're perfectly right. They are not in
11 chronological order, and that is of course also not easy to comment on that, and of
12 course we are talking about relatively recent developments and not about -- this is my
13 pet theme, so to speak, not about back in time the charged period here.
14 But no, it's okay the question, but I simply wanted to point it out and of course,
15 Mr Akena is also aware of it.
16 MS LYONS: [10:04:05] Your Honour, the issue of functioning goes back to --
17 PRESIDING JUDGE SCHMITT: [10:04:10] Absolutely, I did not intervene.
18 MS LYONS: [10:04:13] Okay, thanks. Okay.
19 Q. [10:04:15](Microphone not activated) Now let me ask you, take a look --
20 PRESIDING JUDGE SCHMITT: [10:04:19] Nevertheless, we need the microphone.
21 MS LYONS: [10:04:22] Yes, okay, the microphone is on. All right.
22 Q. [10:04:29] So I understand what you're saying about this. Now let me just ask
23 you though, can you turn to page 25 of the same report and it's the same ERN number
24 for the cover sheet, which is ending in 0674, and page 25 ends at 0698. And I'm
25 looking at the middle of the page, regarding question 3, the paragraph, it's actually

1 boldfaced, I believe, in my copy, probably yours too:
2 "Even if Mr Ongwen suffered from some of his experiences, it is highly unlikely that
3 his level of functioning was severely impaired, at least not for a longer period of time.
4 He must have adapted to the war scenario in order to make the achievements he
5 himself describes and which are not only limited to promotion in the armed force but
6 also include his support of other people and his psychosocial abilities."
7 Do you have any comment on this view that's expressed here?
8 A. [10:05:56] Maybe he maladapted.
9 Q. [10:06:01] Maybe he -- say that again, he maladapted?
10 A. [10:06:04] Yeah. You know, you can adapt.
11 Q. [10:06:04] Yeah.
12 A. [10:06:05] But you can also maladapt to be able to go through tough times. So
13 what do we mean, what do we mean "maladaption" in mental health?
14 So a number of people suffer from mood disorders, primarily, and then they end up
15 using substances. Mood disorders and then anxiety disorders, then they end up
16 using substances. The substances becomes a maladaptive behaviour to an illness, so
17 they may -- okay, let me give an example of -- a much better example. People -- okay,
18 rock stars, for example, they may need to stay awake for a long time and then they
19 may start to take pills that keep them awake. They may have anxiety,
20 stage-fright -- or whatever it is, and then they start to use pills. So they develop
21 a maladaptive behaviour, so on the surface it looks like the person is actually doing
22 well, but the reason as to why that person is supposedly doing well is a maladaptive
23 one.
24 So it's possible that the client did adapt to the hostile environment in which he was
25 operating, but that adaptation is something that we need to maybe explore or we

1 needed to have explored, or we need to think about critically and need to know
2 exactly what it was, yeah.
3 Q. [10:07:45] Are you saying, so I understand it, the maladaption is a negative
4 response or unhealthy response to the situation? Is that what you're saying?
5 A. [10:08:01] Yeah, something like masking, for example. If you, if you're
6 depressed, severely depressed and instead of reporting sadness you smile and report
7 happiness, that's a maladaptive behaviour. That's a behaviour that doesn't help you
8 to get out of the situation in which you are in. But most times it is subconscious; it's
9 not entirely on the will of the person; so a number of people actually maladapt to this
10 without necessarily knowing. Sometimes it's conscious, sometimes it's subconscious.
11 Q. [10:08:35] Okay, let me -- let me just. This may be too --
12 A. [10:08:39] Quick?
13 Q. [10:08:40] No, too -- no, I think your -- I'm not sure my wording is correct, but let
14 me try.
15 So what you're saying is, what you see or what you observe, you know, especially
16 based on reports, but what you observe may not in fact reflect the reality of the total
17 situation. Is that part of what you're saying?
18 A. [10:09:03] Not all the time. I mean, our interaction with, with the client
19 provides us with the information that he was struggling for a very long time. But
20 what we see and what we engage with, and I think somewhere in our reports also we,
21 we do acknowledge that, you know, in the beginning it was, it was difficult to
22 actually tell that this gentleman was having all sorts of challenges that he was dealing
23 with, which became apparent with time.
24 So what I mean, it's possible that individuals who are suffering from mental illnesses
25 adjust their lifestyles, adjust the way they interact with others, in a manner that makes

1 them fit in that society, at least for that period of time.
2 Q. [10:10:02] If you were a soldier, especially a child soldier in an armed conflict, if
3 you undertook, for example, a mission that was considered risky, would this be an
4 example of maladaptive behaviour?
5 A. [10:10:20] What do you mean?
6 Q. [10:10:25] Well, let me, let me ask it this way: Is there a relationship between
7 a person's willingness to take risks --
8 A. [10:10:38] Okay.
9 Q. [10:10:38] -- and the issue of maladaptive behaviour, is taking risks a form of
10 maladaptive behaviour? We talked about, you know, a rock star taking pills to, you
11 know, to stay awake and to perform, but is risky behaviour - whatever that might
12 be - an example of maladaptive behaviour?
13 A. [10:11:01] Sometimes, yes, maybe not all the time.
14 But I think let's get back to the scenarios under which these individuals were exposed.
15 So they would lose -- so they would lose comrades in very difficult situations like
16 crossing a river, some people would just drown in that process, but others would
17 cross. Children would drown in the process of crossing -- of crossing a river.
18 But then, you also needed to continue living in that society without raising any form
19 of suspicion; you needed to do something that showed that you were leading
20 a normal life. But trauma simply doesn't just go away. If you've just observed
21 a comrade shot in battle, you don't come back home and start smiling and laughing
22 and doing stuff like that.
23 But the structure of the establishment at that point did not have opportunities for
24 individuals, for example, to recover or to express their problems. They were just
25 concerned with the physical treatment of wounds, for example. It was -- it was rare

1 that they performed things that helped them to adjust accordingly. The only times
2 that they were exposed to such situations was maybe when they were going through
3 rituals to go to battles or when they were going through rituals when they had come
4 back. But, again, also when they had came back from the battles, the rituals were
5 done in such a manner that they were told that those who were injured or those who
6 were dead, deserved it because they had disobeyed the spirit or something like that.
7 But the body and the mind has to find a way of dealing with that trauma. Somehow
8 along the way, you need to deal with the challenges that you're going through. If
9 you've seen your people dying every day, if you're exposed to excruciating hunger, I
10 think the client reports a certain point in time when food was rationed to the point
11 that every individual was given 10 seeds of beans per day to eat, that's like two
12 spoons, and that's what they had to survive on. So he said many people just simply
13 perished in that process.
14 Now, how do you adjust to that? So the body has to figure out a subconscious
15 means of adjusting to that and the brain has a way in which it does that, yeah.
16 Q. [10:14:11] In the situation of Mr Ongwen as a child soldier, how would the
17 context - the orders from the boss, Joseph Kony - how would that or would that have
18 any effect on his functioning or his appearance of functioning?
19 A. [10:14:41] First of all, those orders were frightening orders, like -- I think like I
20 said yesterday, that the orders were always followed with death. Somewhere along
21 the way there was death in that order. People would die. That was a given,
22 somebody was going to die, either within the ranks or outside.
23 But, I mean if you're getting this repeatedly, you're going to have to put up a brave
24 face to be able to survive, at least in the, in the short -- in the immediate. When you
25 receive those orders, you must execute them. Remember that you are, as a kid,

1 you're controlled by the spirits, so you must -- you must know exactly what's going
2 on and you must do it well. But as an adult, I think later on in his life, you're
3 controlled by the intelligence. The intelligence was all over the place, and these
4 people are watching you and they are taking back information.
5 So in the immediate term, you needed to put up a very brave face for you to be able to
6 survive death, at least at that point or at least that the information goes back to the
7 boss that you didn't defy his orders.
8 I don't know whether that makes sense. But I mean these are the kinds of things that
9 the client repeatedly kept on telling us, that once an order came and you defied it, you
10 were in -- problems. You would die. You wouldn't -- you wouldn't survive.
11 Something like that, yeah. And he kept on saying this repeatedly.
12 Q. [10:16:15] Related to this I want to move on quickly to the issues of resilience, an
13 issue which has been brought up in a number I believe -- really -- reports from the
14 victims' experts. Can you explain briefly what resilience is? Is it a coping strategy
15 or a survival strategy or some other kind of mechanism? How would you describe it
16 from your perspective?
17 A. [10:16:46] I think you've described it already from my perspective.
18 Q. [10:16:52] Okay. All right.
19 A. [10:16:53] And that's --
20 Q. [10:16:53] You have to say because I can't testify.
21 A. [10:16:55] Okay. So resilience basically is one's ability to adjust, adapt and do
22 everything within their means to survive a gruelling exercise. Resilience can be built
23 internally, like you can -- you can actually decide to be resilient by yourself, like
24 in sportsmen, for example.
25 But resilience can also be psychological and that's why you have all these stories of

1 how kids who were abused when they were still young, end up growing old and then
2 giving testimony and then trying to change lives in the future.
3 So it's two ways. There's psychological resilience that you can build on your own.
4 Why people develop resilience and survive and why other people develop
5 resilience -- okay, other people don't develop resilience, and why other people
6 develop maladaptive resilience and become nasty and terrible is something that
7 maybe can be explained by the genetics of an individual or the environment in which
8 they are living.
9 But it was important that they developed resilience because in the immediate term,
10 they needed to survive and they needed to be resilient. And there was -- there was
11 really -- his description made it look like the options were not really there. There
12 were not options. There were not many options because they were told that if you
13 go home, one, we are either going to annihilate the whole village and then the whole
14 problem comes to you and your family, or the state will, you know, execute you or
15 something, so the only place that you can survive is here. But also within this place,
16 if you defied these orders you would be executed, something like that.
17 So they needed to develop some mechanism to cope and live in that context, yeah.
18 Q. [10:19:21] Now, does resilience immunise -- immunise a child soldier from
19 mental health issues?
20 A. [10:19:32] Very unlikely. Very unlikely. Very unlikely. Somehow,
21 20 -- many years later, I think the client still had graphic memories of what happened
22 to him a few days after he was abducted.
23 Q. [10:19:53] The last question on this is really -- it's based on something from
24 Professor Wessels. You don't have -- let me just read and I'll give the citation, if I
25 may, because of the time.

1 Professor Wessels was one of the victims' teams experts in this case, and I'm referring
2 to transcript at tab 23 for the record, for those who want to check it. Binder 1, it's
3 transcript 176, pages 35, lines 12 to 25. And what I'm interested in is the last phrase,
4 which I'll read for purposes of moving ahead here.
5 What Professor Wessels says is:
6 "When protective factors outweigh the risk factors, that's when we see resilience.
7 But resilience is dynamic and [that] is where the problem can come in. A child who
8 is resilient today will become -- may become quite overwhelmed and even
9 dysfunctional tomorrow if the protective factors are withdrawn and the risk factors
10 increase."
11 The question to you is, do you agree? And briefly, how does this apply to the
12 situation of Mr Ongwen?
13 A. [10:21:27] I would agree, but yeah, I do. You see, the client reported multiple
14 attempts to end his life many times, which we have documented here. And -- and
15 this happened in later life in his -- in his adulthood.
16 Somewhere along the way, something was giving. I think the burden was becoming
17 just way too much for him. The body has to give somewhere along the way. If you
18 don't treat these things or if you don't remove an individual who is exposed to such
19 amounts of -- of trauma from the source, something is going to give. Something
20 gives.
21 I mean, at the end of the day, we are all human beings. So I think resilience would
22 have its own limitations. That's what I would think. You can't be resilient all your
23 life. You, if you are exposed to the same challenges, something will give, yeah.
24 PRESIDING JUDGE SCHMITT: [10:22:46] Shortly -- Ms Lyons, I would shortly
25 remind you of the time.

1 MS LYONS: [10:22:51] Yes.
2 PRESIDING JUDGE SCHMITT: [10:22:52] Yes?
3 MS LYONS: [10:22:53] Yes. Now, your Honour, I'm going to move on to my last
4 section and I will start in public and then move in to private, if that's okay?
5 PRESIDING JUDGE SCHMITT: [10:22:56] The last section --
6 MS LYONS: [10:22:57] Dealing with the supplemental report.
7 PRESIDING JUDGE SCHMITT: [10:23:04] Yes, of course, yes, but what does this
8 mean in terms of time?
9 MS LYONS: [10:23:07] I need 10 minutes.
10 PRESIDING JUDGE SCHMITT: [10:23:09] Okay, fine.
11 MS LYONS: [10:23:10] I'm cutting --
12 PRESIDING JUDGE SCHMITT: [10:23:11] No, no, fine.
13 MS LYONS: [10:23:12] -- I'm cutting as much as I can.
14 PRESIDING JUDGE SCHMITT: [10:23:15] No, fine. Fine, you know, --
15 MS LYONS: [10:23:16] Cutting. Cutting. Cutting.
16 PRESIDING JUDGE SCHMITT: [10:23:17] -- "section" can mean in terms of time,
17 a lot of time or not so much time. 10 minutes is fine. Okay? Please continue.
18 MS LYONS: [10:23:28]
19 Q. [10:23:30] All right, I would ask you to turn, we're now -- can we please start in
20 private session, I can -- sorry. I just said we'd start in public session, I'm sorry.
21 All right, public session.
22 We're dealing with tab 9, which is the supplemental report of 25 January, and let me
23 just ask you a general question. It has been reported both in your reports and I
24 believe it was in Professor -- referred to in Professor Weierstall's testimony that there
25 were essentially eight suicide attempts - it was in public testimony - of the client.

1 Now, Professor Weierstall states in his report, which is at -- the report is ending
2 at -0674 and it's on page ending 0691 that:
3 "[...] it sounds" -- and I'm quoting, that:
4 "[...] it sounds very unlikely that an individual survives eight ... suicide attempts."
5 Without going into the details of the client, do you have a response to this conclusion?
6 MR GUMPERT: [10:25:02] Forgive me, why, without going into details? These are
7 suicide attempts during the charged period. There should be no avoidance of detail.
8 MS LYONS: [10:25:12] Then I would ask for a private session. I tried to ask the
9 question --
10 PRESIDING JUDGE SCHMITT: [10:25:16] No, no, why not simply -- I think we all
11 recall this, and Mr Gumpert is right, that we are talking about incidents during the
12 charged period and also potentially before, and the question would be -- you have
13 read it out to Mr Akena, the question would be what his comment on this, for
14 example, would be.
15 MS LYONS: [10:25:35] Okay.
16 PRESIDING JUDGE SCHMITT: [10:25:36] So simply we have this then -- his
17 answer then on the record. Yes?
18 I think you have heard it, Mr Akena --
19 THE WITNESS: [10:25:42] Yes --
20 PRESIDING JUDGE SCHMITT: [10:25:42] Yes --
21 MS LYONS: [10:25:42] I got (Overlapping speakers) Sorry, withdrawn.
22 PRESIDING JUDGE SCHMITT: [10:25:44] I don't see a problem to proceed here,
23 simply with the answer of the expert.
24 Mr Akena?
25 THE WITNESS: [10:25:55] It's unlikely, but it's not remotely impossible that you can

1 have multiple attempts and not die. So eight attempts -- yes, some people attempt
2 suicide once and die. Some people attempt it more than eight times and survive.
3 I think the client is testimony to the fact that you can attempt to kill yourself many
4 times and not -- not die. Maybe the methods were not lethal enough, but -- but we
5 have him here, yeah.
6 And -- and I think these attempts were clearly documented and we have evidence to
7 that fact; so they were not simply half attempts. They were proper suicide attempts,
8 yeah.
9 MS LYONS: [10:26:40]
10 Q. [10:26:41] (Microphone not activated) Does -- how does this --
11 PRESIDING JUDGE SCHMITT: [10:26:42] Microphone.
12 MS LYONS: [10:26:43]
13 Q. [10:26:44] How does this support the diagnosis you talked about yesterday of
14 suicide ideation?
15 A. [10:26:52] Fully, it's still there.
16 MS LYONS: [10:26:57] Your Honour, I would like to now ask some questions in
17 private session or if you prefer, I will ask the question and then you can rule. All
18 right? Either way. All right --
19 PRESIDING JUDGE SCHMITT: [10:27:07] I think that's better.
20 MS LYONS: [10:27:09] All right, that's fine. Okay.
21 Q. [10:27:10] The question is, you've examined -- and both you and Professor
22 Ovuga have examined Mr Ongwen previously and you have discussed in your
23 reports previous attempts at suicide, I believe dating back to 1997 in the reports.
24 Now, you recently observed him and met with him in 2019, was there a difference --
25 PRESIDING JUDGE SCHMITT: [10:27:54] I think --

1 MS LYONS: [10:27:54] (Overlapping speakers)
2 PRESIDING JUDGE SCHMITT: [10:27:55] -- I think we can answer this shortly in
3 private session.
4 MS LYONS: [10:27:59] Thank you.
5 PRESIDING JUDGE SCHMITT: [10:27:59] We go back to private session and answer
6 this in private session.
7 "Shortly" means for the audience that we are very quickly back in open session.
8 (Private session at 10.28 a.m.)
9 THE COURT OFFICER: [10:28:09] We are in private session, Mr President.
10 (Redacted)
11 (Redacted)
12 (Redacted)
13 (Redacted)
14 (Redacted)
15 (Redacted)
16 (Redacted)
17 (Redacted)
18 (Redacted)
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7 (Redacted)

8 (Redacted)

9 (Redacted)

10 (Open session at 10.30 a.m.)

11 THE COURT OFFICER: [10:30:24] We are back in open session, Mr President.

12 MS LYONS: [10:30:38] One moment, your Honour.

13 Q. [10:31:11] At the moment, I don't have any more questions on the supplemental

14 report. Unless there is something that the doctor feels should be addressed right

15 now. I don't have --

16 A. [10:31:33] Nothing from my side.

17 Q. [10:31:36] Okay. All right. To end, I want to ask you one other question

18 which is not about the report -- public session, right?

19 I want you to turn, please, to transcript 20 in binder 1, and it's transcript 166 from

20 Dr Abbo, page 47, lines 5 to 9.

21 A. [10:32:25] The binder, please?

22 Q. [10:32:28] Yes, I'm sorry, binder 1.

23 A. [10:32:30] Binder 1.

24 PRESIDING JUDGE SCHMITT: [10:32:35] And it is page 47. They are not

25 chronological --

1 MS LYONS: [10:32:41] No, they're not. They're not. They're --
2 PRESIDING JUDGE SCHMITT: [10:32:41] -- but Mr Akena has always found it
3 quickly, so he will (Overlapping speakers)
4 MS LYONS: [10:32:46] Okay, yeah, right. They're not because we skipped in
5 between in the interests of saving the trees.
6 THE WITNESS: [10:32:51] Yeah, I think I'm going to have challenges here.
7 MS LYONS: [10:32:53] Okay.
8 THE WITNESS: [10:32:54] Yeah, so which -- which --
9 PRESIDING JUDGE SCHMITT: [10:32:54] Mr Akena, it's -- 47 is after 23. It's not
10 logical, but I understand the system --
11 THE WITNESS: [10:32:58] Yes.
12 PRESIDING JUDGE SCHMITT: [10:32:59] -- I think you --
13 THE WITNESS: [10:33:02] I don't see the grey thing. Where is it?
14 MS LYONS: [10:33:06]
15 Q. [10:33:06] Right, it's binder 20 --
16 A. [10:33:07] 20.
17 Q. [10:33:08] -- sorry, tab 20 in binder 1.
18 A. [10:33:14] Tab 20, okay. Okay.
19 Q. [10:33:22] Okay. Now, we're going to look at lines 5 to 9 --
20 A. [10:33:30] On which page?
21 Q. [10:33:32] On page -- it's page 47. You're missing pages in between.
22 PRESIDING JUDGE SCHMITT: [10:33:48] Please read it out I would say, it's only
23 four lines. You can read it so that the public also knows what we are talking about.
24 MS LYONS: [10:33:55] Yes. Okay.
25 Q. [10:33:58] And let me say that this comes from a -- it comes from an excerpt

1 where a Ugandan army intelligence officer describes an encounter with Mr Ongwen
2 in September 2006, during the peace talks, and I will ask you to comment on it. I will
3 read it out, starting at line 5:
4 "Okay, then the -- that same witness towards the end he requests Mr Ongwen to
5 release the children that were with him, but Mr Ongwen then refused, according to
6 this. But this could be interpreted as -- because he says, he says that," --
7 Mr Ongwen says --
8 -- "'You call these kids children, but I call them my soldiers. So we are talking about
9 my soldiers. We are not talking about the children you are talking about.'"
10 This is a quote in the transcript from Mr Ongwen, attributed to him. What I'm
11 interested in is what is your interpretation of Mr -- what Mr Ongwen is saying?
12 A. [10:35:23] He -- he thinks the -- the children as soldiers, and they're under his
13 command. They're his -- his comrades. They are part of his system, I think.
14 Q. [10:35:50] Now, Dr Abbo, a few lines down, makes interpretation. It's lines 10
15 to 14. What she says is:
16 "[...] this could be interpreted as his concept, Mr Ongwen's concept of a child which
17 could have been carried on from -- from his own experience of having been abducted
18 as a child and he became a soldier then and so his [consent] of a child is a soldier and
19 not a child because that is what he experienced as himself."
20 That is her interpretation, looking at lines 10 to 13.
21 Do you have any -- what is your position on that? Or what -- any views on that, on
22 her interpretation? Basically, he sees himself as a child.
23 A. [10:36:48] A number of times the client actually told us that he would need to
24 learn many things afresh; that he still looks at himself as that kid who was abducted
25 at that point. That he just doesn't know how -- he doesn't know how to live. He

1 looks at the point where he would be able to sit in a mango tree and be told stories
2 that older people tell others as they're growing up.
3 And I think he said this a couple of times. That he was still -- I mean, he was still
4 stuck in the '80s. He had grown physically, but he was still stuck in the '80s, and he
5 was looking to that opportunity when he would go home and -- and also be -- have
6 the opportunity to learn things from older people.
7 So I think, I want to agree with my colleague that I think there's a -- there's a
8 remote -- she's -- she's a child psychiatrist --
9 Q. [10:37:52] Mm-hmm.
10 A. [10:37:53] This is what she does for a living. I want to agree that there is
11 a -- there is a chance that a lot what we see in the client now, that -- that behaviour,
12 really he needs to relearn many things. He needs to learn many things, yeah.
13 Q. [10:38:07] Would you describe that behaviour now that you're observing as
14 childlike behaviour?
15 A. [10:38:13] You see, one day we were supposed to see the client. And then the
16 client was supposed to come down with a -- with some -- some food for us. The
17 rules were that he needed to bring it in plastic plates -- plastic containers. And he
18 said he wants to bring it in metallic containers. There was a massive altercation.
19 We couldn't see him. We were there at the detention centre, we were waiting 10, 15,
20 20, 30 -- one hour, with proof, we couldn't see him.
21 So we said, "Oh, wow, this guy's actually a child." You know, he's throwing
22 a tantrum like a child. But to a certain extent there's a lot that the client
23 would -- there's a lot of behaviour that you would actually still see in a young -- in
24 a young child in him, with all due respect to -- to him and the fact that he's not a child
25 anymore, but I think chronologically, Dominic is still -- is still quite young, yeah.

1 Q. [10:39:28] Thank you.
2 MS LYONS: [10:39:29] That ends my direct of Dr Akena and I thank him for his
3 testimony.
4 PRESIDING JUDGE SCHMITT: [10:39:37] Thank you, Ms Lyons.
5 Mr Gumpert, you said yesterday that you would need three sessions, does this still
6 apply? Is it still true? I'm just asking.
7 MR GUMPERT: [10:39:54] Estimates are slippery things. I believe, as I said
8 yesterday, that I will need the equivalent of a full day.
9 PRESIDING JUDGE SCHMITT: [10:40:02] Okay. Then I would suggest - although,
10 we are relatively close to 11 o'clock - that you start and that we then adapt our sitting
11 hours today according to this need.
12 You have the floor, Mr Gumpert.
13 QUESTIONED BY MR GUMPERT:
14 Q. [10:40:24] Dr Akena, my name is Ben Gumpert and I'm asking questions on
15 behalf of the Prosecution.
16 Your role right from the start of your interaction with Mr Ongwen has included
17 making recommendations for his treatment, hasn't it?
18 A. [10:40:41] Yes, it has.
19 Q. [10:40:45] You spoke yesterday of having formed a therapy alliance with your
20 client?
21 A. [10:40:55] Therapeutic alliance.
22 Q. [10:40:56] You said both, actually.
23 A. [10:40:58] Okay.
24 Q. [10:40:59] As a treating physician, it's your duty to the person you're treating to
25 attempt to secure for him the treatment which will be of greatest benefit to his health.

1 Yes?
2 A. [10:41:16] That's correct.
3 Q. [10:41:18] Would it be fair to say that in your opinion, the mental health of your
4 client would benefit most from a disposal by this Court that would enable him to
5 resume life among his family in a domestic environment in Uganda, where he could
6 be treated and rehabilitated?
7 A. [10:41:45] I think he can still get some treatment in his current state in this
8 place (Overlapping speakers)
9 Q. [10:42:03] That's not -- sorry.
10 A. [10:42:05] And then whatever the Court decides, then we'll see whether he
11 continues to get the treatment from home or wherever it is, but ...
12 Q. [10:42:19] That's not the question. The question is, you as his treating
13 physician, you want him - you've told us - to get the best treatment. Is it right that in
14 your opinion, the most beneficial treatment would be that which I have described?
15 A. [10:42:42] But Mr Gumpert, I have no control over that.
16 Q. [10:42:45] That's not the question. I'm asking your opinion. You're his doctor,
17 you have an opinion on how he --
18 PRESIDING JUDGE SCHMITT: [10:42:53] We let Mr Gumpert continue for one
19 further attempt and then we move on.
20 Yes?
21 MR GUMPERT: [10:42:59]
22 Q. [10:42:59] You're his doctor, you have prescribed or you have recommended
23 treatment on - I count - at least three separate occasions?
24 A. [10:43:08] Yes, sir.
25 Q. [10:43:09] (Redacted)

1 (Redacted).
2 A. [10:43:09] Aha.
3 Q. [10:43:10] -- opinions about what is good for him. And I have no doubt that
4 you have opinions about what treatment would be best for him. Is it in broad terms
5 the treatment I have just described?
6 A. [10:43:27] Mr Gumpert, when we see patients across the world, we make
7 recommendations for them to get treatment. Sometimes they get the treatment
8 under our watch. Sometimes they get the treatment under the watch of our
9 colleagues. Sometimes they get the treatment from home. Sometimes they get it
10 from a hospital; sometimes they get it from a prison. I don't think I am ... and
11 that -- that is decided by a number of factors. And again I think the Court would
12 decide where -- where the client gets treated from.
13 PRESIDING JUDGE SCHMITT: [10:44:23] We move on, Mr Gumpert. We move on.
14 And the witness has of course no control of what might come out here, that's also true.
15 And he has answered it -- sort of. Please move on.
16 MR GUMPERT: [10:44:35] Can I ask that the witness be provided with a binder of
17 documents.
18 PRESIDING JUDGE SCHMITT: [10:44:41] Of course, why not. I would have
19 assumed that he has it perhaps already?
20 MR GUMPERT: [10:44:48] It is not.
21 PRESIDING JUDGE SCHMITT: [10:44:51] Yes, then we do this, please.
22 THE WITNESS: [10:45:11] Okay.
23 MR GUMPERT: [10:45:11]
24 Q. [10:45:12] Now in addition to your role as a treating physician, you understand
25 that you're here as a forensic expert with an objective duty to the Court, right?

1 A. [10:45:25] Yes.
2 MS LYONS: [10:45:28] Your Honour, I just want to make one clarification.
3 The -- the issue of being a treating physician, it is --
4 PRESIDING JUDGE SCHMITT: [10:45:42] Ms Lyons, you don't have to make
5 comments on the questions of Mr Gumpert. And the answers, the Chamber is really
6 experienced enough to put everything here into perspective.
7 MS LYONS: [10:45:56] (Microphone not activated) Okay --
8 PRESIDING JUDGE SCHMITT: [10:45:57] Yes, you don't need to comment on that,
9 that's really not necessary.
10 Please, Mr Gumpert.
11 MR GUMPERT: [10:46:02]
12 Q. [10:46:02] Would you turn to tab 1 of the binder that you've just been handed.
13 That is a document, which is the Ethics Guidelines for the Practice of Forensic
14 Psychiatry, published by the American Academy of Psychiatry and the Law.
15 I want to read to you from the third page of that document. The ERN is
16 UGA-OTP-0287-0015 and the page that I am quoting from is 0017.
17 It's down at the foot of the page, about five or six or seven lines up from the bottom:
18 "Forensic evaluations usually require interviewing corroborative sources, exposing
19 information to public scrutiny, or subjecting evaluees and the treatment itself to
20 potentially damaging cross- examination."
21 You wouldn't dispute that proposition, would you, Doctor?
22 A. [10:47:40] It would have helped if I'd understood the context under which this
23 document is here.
24 Q. [10:47:55] Well, Doctor, can you answer the question? This is a widely known
25 document describing the duties of forensic psychiatrists; that's the capacity in which

1 you are appearing. My question to you is, would you agree that the job which you
2 have to do requires you to be critical, to look at corroborative sources, to expose
3 information to scrutiny. Yes?
4 MS LYONS: [10:48:27] I have just one short objection --
5 PRESIDING JUDGE SCHMITT: [10:48:30] Ms Lyons, please do not -- please do not
6 interrupt constantly. It is -- this is a -- it is fair also of the -- fair to explain to the
7 witness what kind of document it is. Mr Gumpert has done this.
8 And in this document, he has read out to you a phrase and I think since it deals with
9 your profession, you can comment on it. But it's also fair that you are required to
10 know what we are talking about --
11 MS LYONS: [10:49:00] (Microphone not activated) Simply that was all I was
12 raising as a -- which is --
13 PRESIDING JUDGE SCHMITT: [10:49:05] Yes, be it widely known or not, we can't
14 assess this but I think we have now an understanding.
15 And Mr Akena, you --
16 THE WITNESS: [10:49:09] Yes.
17 PRESIDING JUDGE SCHMITT: [10:49:09] -- can answer it. The question is
18 relatively clear.
19 THE WITNESS: [10:49:16] Yeah. I think Mr Gumpert, this is -- I don't think this is
20 limited to forensic psychiatry, I think --
21 MR GUMPERT: [10:49:27]
22 Q. [10:49:27] Just answer from your point of view whether you'd agree. That's
23 what I'm asking you.
24 A. [10:49:32] Every -- every medical practitioner agrees that they need to get
25 corroborative evidence, they need to undergo scrutiny and they need to be peer

1 reviewed. I think that's -- I think that's normal medical practice.
2 Q. [10:49:46] Well, let me refine the question. You sitting there doing your job for
3 this Court, it's part of your duty to scrutinise what Mr Ongwen told you, to seek
4 corroborative sources, to be critical about what he told you. That's part of your job,
5 isn't it?
6 A. [10:50:09] And we did that to the best of our abilities.
7 Q. [10:50:13] So your answer is just yes?
8 A. [10:50:15] I think so.
9 Q. [10:50:16] Thank you. Let me take a couple of examples. A moment ago, you
10 spoke about the eight suicide attempts which your client told you he had made before
11 he met you. You recall?
12 A. [10:50:40] I think I said there were eight suicide attempts in total. Some of
13 them were reported to us by the client. Some of them were reported to us by the
14 people at the detention centre. I think we have documented those things very
15 clearly in our report.
16 PRESIDING JUDGE SCHMITT: [10:51:00] And we are talking now about -- we're
17 talking about the charge period and potential attempts that have been mentioned in
18 some of the reports and in the evidence by the witness that might have been
19 before -- a date before this time.
20 MR GUMPERT: [10:51:17] Your Honours, I'm talking about the eight attempts
21 which this witness recorded he was told about by Mr Ongwen, giving the years --
22 PRESIDING JUDGE SCHMITT: [10:51:23] We have it (Overlapping speakers)
23 MR GUMPERT: [10:51:25] -- while he was in the bush.
24 PRESIDING JUDGE SCHMITT: [10:51:31] We have it still in our ears; it was a couple
25 of minutes ago. Absolutely. Please proceed.

1 MR GUMPERT: [10:51:38]
2 Q. [10:51:39] So I'm not talking about anything which happened in the prison.
3 You told us a moment ago, "I think these attempts were clearly documented" as
4 though there was no dispute that they had happened. Where? Where are they
5 clearly documented?
6 A. [10:52:00] In our report.
7 Q. [10:52:02] So in other words, what you were telling the Court was, "He's told us
8 that these things happened and because we've written it down, it's clearly
9 documented." Yes?
10 A. [10:52:15] Yeah.
11 Q. [10:52:15] Thank you. I want to take another example. In your report of 28
12 June of 2018, that's at tab 8 of the Defence binder, you refer to an incident concerning
13 one of the Prosecution expert witnesses in the courtroom. You refer to it twice. The
14 relevant pages are 0953 and 0954. You quote Mr Ongwen's --
15 A. [10:53:03] Just -- just a minute, just a second, I think -- I need some help with the
16 microphone. I'm just hearing it from one side. The headphone, only one side,
17 please.
18 (Pause in proceedings)
19 MR GUMPERT: [10:53:23]
20 Q. [10:53:23] I'm sorry, I gave the wrong second ERN. It's 0964. 0953 and 0964.
21 Those are the two references.
22 A. [10:53:42] Which binder again, sir?
23 Q. [10:53:44] The binder which you were looking at while Ms Lyons was asking
24 you questions, the Defence binder, tab 8.
25 A. [10:53:47] Okay.

1 Q. [10:53:56] It's pages 0953, 0964.
2 A. [10:54:14] Yes, 0953, yes.
3 Q. [10:54:16] Yes, you quote Mr Ongwen's recollection of what happened in his
4 own words. He told you that, quote:
5 "The [...] expert became Kony" -- or "Kony" as people sometimes say -- "in my eyes."
6 He told you he had stood up to confront the witness and addressing her as Kony, he
7 told you that he'd said, quote:
8 "'Now that you are here, tell court what happened in the bush'."
9 Do you recollect Mr Ongwen recounting that experience to you?
10 A. [10:54:58] Yeah -- yeah.
11 Q. [10:55:00] Yes. Now you know, don't you, that there is a transcript made of
12 what people say in the courtroom.
13 A. [10:55:10] Yes.
14 Q. [10:55:11] Did you ask to check Mr Ongwen's account against that transcript?
15 A. [10:55:26] I can't recall, but I think we -- we tried as much as possible to find out
16 from the Defence team the events that surrounded that interaction on that day,
17 because the client had described a number of other things that had happened
18 before -- before that. So we -- I -- I can't recall off head what kind of information I
19 got to -- to corroborate that evidence.
20 Q. [10:56:09] Well, let's look at it now, shall we? It is at tab 3 of the binder which I
21 have provided you with just a moment ago.
22 PRESIDING JUDGE SCHMITT: [10:56:27] Is this -- had this been public or was this
23 private?
24 MR GUMPERT: [10:56:33] This was public, I believe. There was only two and a
25 half minutes I think or three and a half minutes of the total (Overlapping speakers)

1 PRESIDING JUDGE SCHMITT: [10:56:45] But I would like to have this checked
2 before we discuss it in open session.
3 MR GUMPERT: [10:56:53] In fact, one can tell. The first three lines 20, 21 and 22
4 were in public (Overlapping speakers)
5 PRESIDING JUDGE SCHMITT: [10:57:04] Yes, I see it, and then we went to closed
6 session. So we can proceed like this.
7 MR GUMPERT: [10:57:01] Yes.
8 PRESIDING JUDGE SCHMITT: [10:57:02] Because we do not want to be
9 contradictory, yes.
10 MR GUMPERT: [10:57:12] No, I understand. I'm sorry, I should have --
11 PRESIDING JUDGE SCHMITT: [10:57:13] No, no, it's not a problem; we have
12 figured it out.
13 MR GUMPERT: [10:57:17]
14 Q. [10:57:18] So here we are, Doctor --
15 A. [10:57:20] Just a minute. Just a minute. Tab 3?
16 Q. [10:57:22] Yes.
17 A. [10:57:23] That is transcript 162?
18 Q. [10:57:25] Yes.
19 A. [10:57:26] Okay. Page 64?
20 Q. [10:57:27] Yes.
21 A. [10:57:29] Okay.
22 Q. [10:57:30] So what Mr Ongwen actually said interrupting Professor Mezey was
23 this:
24 "Your Honour, I do not want to listen to what the witness is saying. I thank you,
25 Witness. You have been -- you are the one who is talking -- you came here to

1 give -- you came here to give evidence."

2 Now I'm afraid, we must go into private session for a couple of lines.

3 PRESIDING JUDGE SCHMITT: [10:58:01] Shortly to private session.

4 (Private session at 10.58 a.m.)

5 THE COURT OFFICER: [10:58:05] We are in private session, Mr President.

6 (Redacted)

7 (Redacted)

8 (Redacted)

9 (Redacted)

10 (Redacted)

11 (Redacted)

12 (Redacted)

13 (Redacted)

14 (Redacted)

15 (Redacted)

16 (Redacted)

17 (Redacted)

18 (Redacted)

19 (Redacted)

20 (Redacted)

21 (Redacted)

22 (Redacted)

23 (Redacted)

24 (Redacted)

25 (Redacted)

1 (Redacted)
2 (Redacted)
3 (Redacted)
4 (Redacted)
5 (Redacted)
6 (Redacted)
7 (Redacted)
8 (Redacted)
9 (Redacted)
10 (Redacted)
11 (Redacted)
12 (Redacted)
13 (Open session at 11.00 a.m.)
14 THE COURT OFFICER: [11:00:37] We are back in open session, Mr President.
15 MR GUMPERT: [11:00:51]
16 Q. [11:00:52] It's the same thing again, isn't it, Doctor? You're in a therapeutic
17 alliance with your client. You're bound to want to take what he says -- how he
18 describes things as being right, but you're not taking the trouble to make objective
19 checks to see if they're reliable. That's true, isn't it?
20 A. [11:01:18] We asked for the evidence of events that had happened on that day.
21 Q. [11:01:22] But you didn't get --
22 A. [11:01:23] Actually --
23 Q. [11:01:24] -- the transcript?
24 A. [11:01:25] -- I actually remember asking for that evidence, because we knew
25 that this information is recorded and we knew this would actually provide us

1 a chance to understand what was going on.
2 Q. [11:01:37] So it's the Defence lawyers' fault, is it, that they didn't get you what
3 you asked for?
4 A. [11:01:45] I don't know.
5 Q. [11:01:46] Well, when you didn't get it, you thought this was important, what
6 did you do about it?
7 A. [11:01:52] Mr Gumpert, we asked for many things from the Defence team. We
8 asked for a lot of information. We asked the Defence team to allow us to interview
9 the people who lived with the client. We asked for a lot of information. We get
10 some. We don't get others. That's -- that's how it is in medicine, sir. You don't get
11 everything you want. You can't get all the collateral history you need.
12 PRESIDING JUDGE SCHMITT: [11:02:18] But we have an answer here --
13 THE WITNESS: [11:02:20] Yes.
14 PRESIDING JUDGE SCHMITT: [11:02:20] -- Mr Gumpert.
15 THE WITNESS: [11:02:21] I hope that helps.
16 MR GUMPERT: [11:02:24] I don't know, Doctor.
17 Q. Going back to Prosecution tab number 1 --
18 PRESIDING JUDGE SCHMITT: [11:02:31] Yes, okay. We are now past 11.
19 Perhaps we have a break for half an hour. And then, as I already suggested, we
20 would want to have a two-hour session, a shortened lunch break and the potential to
21 go until 4.30 then in the afternoon.
22 So we have now a break until, yeah, half an hour, let's say.
23 THE WITNESS: [11:02:56] Half an hour. Okay.
24 THE COURT USHER: [11:02:57] All rise.
25 (Recess taken at 11.03 a.m.)

1 (Upon resuming in open session at 11.32 a.m.)
2 THE COURT USHER: [11:32:52] All rise.
3 Please be seated.
4 PRESIDING JUDGE SCHMITT: [11:33:13] Mr Gumpert, please proceed.
5 MR GUMPERT: [11:33:16] Shkelzen Zeneli has joined us since the break.
6 PRESIDING JUDGE SCHMITT: [11:33:21] Yes, far in the back.
7 MR GUMPERT: [11:33:23] Indeed.
8 Q. [11:33:25] Doctor, one of the grave professional difficulties facing you in this
9 case is that you are trying to diagnosis a man's mental state in 2002 to 2005 but you
10 didn't get to examine him for the first time until 2016; that's right, isn't it?
11 A. [11:33:48] Yes, it is.
12 Q. [11:33:49] Now, in any domestic criminal trial where you were acting as a
13 mental health expert, you would ask the person concerned what they remembered of
14 the charged crime, say it was a murder, what they remembered about it, what they
15 were thinking at the time, wouldn't you?
16 A. [11:34:13] I think everybody would ask that.
17 Q. [11:34:14] I'm just --
18 A. [11:34:15] Yes, yes.
19 Q. [11:34:15] -- asking you, Doctor.
20 A. [11:34:20] I would, I would, yeah.
21 Q. [11:34:21] Now, reading your reports, I can't see that you've ever discussed with
22 Mr Ongwen what he was thinking, what he was -- can now remember about any of
23 the charged crimes. Did you ever do that?
24 A. [11:34:38] He said he didn't commit the crimes.
25 Q. [11:34:42] But that would be true, quite possibly, of your person accused of

1 murder domestically. They might say "I was defending myself" or "I was
2 provoked" or "I was under duress", or indeed they might say "I've got an alibi". But
3 you would ask them about each of the crimes, wouldn't you?
4 A. [11:35:11] We asked him about his mental state between the periods of 2002
5 and 2005.
6 Q. [11:35:17] Well, let's come back to brass tacks. I want to take counts 50 to 57 as
7 an example. These are charges of forced marriage, torture, rape, sexual slavery and
8 enslavement. And I'm going to ask you about those crimes, those charges in respect
9 of just one of Mr Ongwen's alleged victims, a lady who has given evidence. I'll refer
10 to her by her witness code, D-227. Now, there's a public document, the Document
11 Containing the Charges, like the indictment in your system or mine. Have you
12 familiarised yourself with that document?
13 A. [11:36:03] I can't recall everything that is in it off head.
14 Q. [11:36:17] So you've read it, but I don't expect you to be able to remember all 70
15 charges.
16 PRESIDING JUDGE SCHMITT: [11:36:23] Ms Lyons, but really shortly. What is --
17 MS LYONS: [11:36:24] My short objection is I am not sure where the Prosecution is
18 going with this. I believe that 227 testified in a Article 56 proceeding. And I don't --
19 PRESIDING JUDGE SCHMITT: [11:36:40] No, no --
20 MS LYONS: [11:36:42] He's not an expert -- as you've said, he's not an expert on
21 legal matters. He's talking from his position as psychiatrist and I think the questions
22 on cross --
23 PRESIDING JUDGE SCHMITT: [11:36:52] No, Ms Lyons --
24 MS LYONS: [11:36:52] -- should reflect that.
25 PRESIDING JUDGE SCHMITT: [11:36:53] No. Ms Lyons, I cannot allow this that

1 you interrupted this way because we are not yet so far that there is any reason for any
2 objection. Mr Gumpert did not ask any legal question with legal background. He
3 simply asked if the witness has familiarised himself with the confirmation of charges,
4 and there is an answer yes or no, and whatever would follow out of this. And
5 I would of course intervene if Mr Gumpert would ask something from the witness
6 which would amount to an assessment of legal matters. I would, I would simply
7 step in by myself.
8 Please proceed, Mr Gumpert.
9 MR GUMPERT: [11:37:37]
10 Q. [11:37:40] As I understand it then, you've never asked him about any of the
11 factual matters which he is accused of committing as crimes?
12 A. [11:37:56] I've asked him a lot about his mental state in the period on which he
13 was accused. And that's my expertise, sir, I'm sorry.
14 PRESIDING JUDGE SCHMITT: [11:38:05] Mr Gumpert, I think sometimes simply
15 we take the answer and then move on.
16 MR GUMPERT: [11:38:10]
17 Q. [11:38:10] He can remember particular attacks, can't he? You reported his
18 description of his participation in particular battles, in 1999 in Sudan and around 2003
19 in Ongako. He told you what he remembered about those attacks, how he felt at the
20 time of those attacks, didn't he?
21 A. [11:38:35] In the context of his mental health, yes.
22 Q. [11:38:40] Aren't those vital questions in your opinion? If the Judges are going
23 to have a chance to decide on whether he had the capacity to understand what he was
24 doing, to control his actions, isn't it necessary for you, one of the two doctors, the only
25 two doctors who were able to ask him about his mental state at the time of these

1 charged crimes, to ask him what he was thinking?
2 A. [11:39:11] Earlier on I said that the client denied committing the crime, so asking
3 the question based on that did not yield the results that we wanted.
4 Q. [11:39:26] Sorry, you did or you didn't ask him those questions?
5 A. [11:39:31] We asked him broadly. We said you are accused of committing a lot
6 of crimes, 70 plus. These are serious crimes for which you can go to prison for a long
7 time. He said "I didn't commit the crimes". We stuck to mental health between the
8 period of 2002 and 2005. That was what we were asked to do and that's exactly what
9 we did.
10 Q. [11:40:00] You never sought to understand whether he was saying he didn't
11 commit the crimes because he was under duress or had an alibi, you didn't even go
12 that far?
13 A. [11:40:12] That's not my area of expertise, I think. I'm not competent enough to
14 figure out whether somebody has committed a crime or not. But I'm competent
15 enough to find out whether the period through which he's accused of committing the
16 crimes he had a mental illness or not, and I think I stuck to that.
17 Q. [11:40:35] You've described mental disease as pathoplastic, haven't you?
18 A. [11:40:43] Pathoplastic?
19 Q. [11:40:45] Yes. It's in your third report. It means they fluctuate in their
20 effects.
21 PRESIDING JUDGE SCHMITT: [11:40:53] Where is it in the report? Could you
22 please give us the reference.
23 MR GUMPERT:
24 Q. [11:41:05] It's in relation to obsessive compulsive disorder and is suggested as an
25 explanation as to why it was that this wasn't diagnosed at first. Does that refresh

1 your memory, Doctor?

2 A. [11:41:21] Let's take a look at the construct that we -- that was raised.

3 Q. [11:41:30] Page --

4 MS LYONS: [11:41:31] Could we have the page? Yeah. For us, page (Overlapping

5 speakers).

6 PRESIDING JUDGE SCHMITT: [11:41:34] Page 21.

7 MR GUMPERT: [11:41:36]

8 Q. [11:41:37] 21, indeed.

9 A. [11:41:38] Binder 1?

10 Q. [11:41:40] In the Defence binder.

11 A. [11:41:42] Okay.

12 Q. [11:41:44] Five lines up from the bottom.

13 PRESIDING JUDGE SCHMITT: [11:41:46] Indeed. And for the record, it's

14 UGA-D26-0015-0968.

15 THE WITNESS: [11:41:54] Let me just -- sorry, let me just get it. That's binder what?

16 The grey thing?

17 MR GUMPERT: [11:42:01]

18 Q. [11:42:01] It's the Defence binder, the one you were looking at when Ms Lyons

19 asking you questions.

20 A. [11:42:07] Yeah, it has things from number 21 to 23, so that's --

21 Q. [11:42:11] And it's at Tab 8.

22 A. [11:42:12] Tab, okay. So let me call it tab. So tab 8, page --

23 Q. [11:42:17] And the last four digits are 0968.

24 PRESIDING JUDGE SCHMITT: [11:42:21] And it's page 21 of your report from 28

25 June 2018.

1 MR GUMPERT: [11:42:44]
2 Q. [11:42:45] Are you there now, Doctor?
3 A. [11:42:49] Yeah.
4 Q. [11:42:49] You say, five lines up from the bottom, "psychiatric conditions are
5 pathoplastic" your word, not mine.
6 A. Mm-hmm.
7 Q. [11:42:59] But it means they fluctuate in their effects, doesn't it?
8 A. [11:43:04] Yes, they do.
9 Q. [11:43:05] So we're looking here at a period of two and a half years. You would
10 expect, indeed it's uncontroversial, the effects of any mental disease he may have been
11 suffering would have fluctuated during that time, wouldn't it?
12 A. [11:43:26] You mean the time through which we saw him?
13 Q. [11:43:29] No.
14 A. [11:43:33] The charged period?
15 Q. [11:43:35] No. I mean the charged period. His illness, if he had any, would
16 have fluctuated in its effects during that period, wouldn't it?
17 A. [11:43:49] It could.
18 Q. [11:43:50] Well --
19 A. [11:43:51] It couldn't.
20 Q. [11:43:52] You say psychiatric conditions are pathoplastic, they vary in their
21 effects. Therefore, during a period of 30 months the effects of any diseases he was
22 actually suffering from would have varied, wouldn't they?
23 A. [11:44:10] There could be 30 months, there could be 1 month, there could be 6
24 months, there could be 5. Who knows?
25 MR GUMPERT: [11:44:18] I shall take your Honour's advice.

1 Q. You emphasised in your reports and indeed in your evidence the importance of
2 speaking to close associates of Mr Ongwen at the time the crimes were committed,
3 yes?
4 A. [11:44:34] That's correct.
5 Q. [11:44:38] And you conducted interviews in 2016 with four people who had
6 been his contemporaries, yes?
7 A. [11:44:51] That's true.
8 Q. [11:44:52] Because you thought it was important to know what the people who
9 were living with him, the people who were in his household, the people who were
10 sleeping in his bed remembered about the way he was behaving during the charged
11 period, yes?
12 A. [11:45:12] Correct.
13 Q. [11:45:14] And if you go to tab 9 -- sorry, that's the wrong tab. It's the
14 document which I -- the binder which I passed you and it is indeed tab 9. Are you
15 there now?
16 A. [11:46:07] Mm-hmm.
17 Q. [11:46:08] That is a series of charts setting out what four people, people who you
18 understood knew him well, said when you and Professor Ovuga interviewed them,
19 isn't it?
20 A. [11:46:22] The ones that we could be availed, those were the four.
21 Q. [11:46:28] So you would have liked to talk to many, many more people, yes?
22 People who knew Mr Ongwen at the relevant time. These are just the four that you
23 were availed.
24 A. [11:46:44] In ideal settings, yes.
25 Q. [11:46:45] Yes.

1 A. [11:46:47] Logistically I think it was impossible.
2 Q. [11:46:50] You know, don't you, that apart from those four, many other
3 individuals who knew Mr Ongwen have given evidence on oath in this trial?
4 A. [11:47:05] That's true.
5 Q. [11:47:06] Would you look at tab 14 in the same binder. Now, Doctor, until you
6 saw this document from the Prosecution on Friday, had you ever been provided by
7 the Defence with details of the testimony of witnesses in this trial who knew Dominic
8 Ongwen well?
9 PRESIDING JUDGE SCHMITT: [11:47:42] Ms Lyons.
10 MS LYONS: [11:47:43] My objection, my objection is this: The dealings, as I
11 understand it, and I may be wrong, your Honour, the dealings between the
12 Prosecution and their experts, the victims and their experts, and the Defence and their
13 experts are covered by a confidential relationship of work product. And it seems to
14 me that we're easing beyond that, what he got, what he didn't get. He indicated in
15 the reports, both doctors have indicated what they relied upon and in fact the prior
16 tab 9 was a Defence response to request that quotes be detailed. I don't quite see --
17 PRESIDING JUDGE SCHMITT: [11:48:31] No, but --
18 MS LYONS: [11:48:34] -- where we're going with this.
19 PRESIDING JUDGE SCHMITT: [11:48:37] I think it is absolutely acceptable and not
20 objectionable that the Prosecution in that case wants to establish what the factual
21 basis of the experts' report was and I think this does not go into anything what would
22 disturb in any way the relationship between an expert of the Defence in that case and
23 the Defence itself.
24 So you can of course, Mr Gumpert, ask more directly: Was this part, did you
25 recognise this, did you use this as part of your -- as one of the bases of your evidence?

1 And so on. And not blame someone or whatsoever. This is also possible, of course.
2 So that we avoid, avoid the problems that Ms Lyons sees here.
3 MR GUMPERT: [11:49:35] Very well. I'll do exactly that.
4 Q. [11:49:38] I'll come straight to the point, Doctor. This was new material, wasn't
5 it? Up until the time when the Prosecution provided this to you on Friday, you had
6 no idea what these 16 individuals who had known Mr Ongwen in the bush had
7 testified to this Court; that's right, isn't it?
8 A. [11:50:00] The information that we requested for -- from the team was meant to
9 help us make a diagnosis. We saw the client. We requested for us to be able to
10 observe or to gather information from collateral sources and these are things that we
11 believed that were much more reliable, interacting with the patients -- sorry,
12 interacting with the individuals who had lived with him.
13 So it is possible that some other information is available, but what we needed to do
14 our work was the client and collateral history, and then information from the
15 detention centre about what he was getting and how he was responding to treatment.
16 I think that's what most people would do in proper medical practice. I think it's a bit
17 difficult to simply rely on information that's -- I mean, unless you observe whatever it
18 is that's happening.
19 I don't know whether that answers your question.
20 PRESIDING JUDGE SCHMITT: [11:51:39] Ms Lyons, now we are not constantly
21 standing up and interrupting here. The witness --
22 MS LYONS: [11:51:45] I want to make a point (Overlapping speakers).
23 PRESIDING JUDGE SCHMITT: [11:51:47] At the moment the witness has simply
24 answered a question and not more and not less. And it's now the turn of
25 Mr Gumpert. Mr Gumpert has not said anything at the moment.

1 MS LYONS: [11:51:57] (Microphone not activated)
2 MR GUMPERT: [11:52:00]
3 Q. [11:52:02] So I think I gather from your answer you had no idea what was
4 contained in this document or in the transcripts he's drawn from until last Friday,
5 correct?
6 A. [11:52:15] Yes.
7 Q. [11:52:15] Thank you. Would you look at tab number 4 of the document I've
8 just passed to you, the folder I've just passed you. Are you there?
9 A. [11:52:40] Not yet. Be patient.
10 Q. [11:52:44] Fair comment. I apologise.
11 A. [11:52:47] Thank you. Number 4, right?
12 Q. [11:52:49] Number 4 indeed. Now, this is the first of a series of translations of
13 the medical notes made by the psychiatrist treating him in the prison before you were
14 involved.
15 A. [11:53:04] Okay.
16 MR GUMPERT: [11:53:06] Your Honours, just a warning about dates with this
17 sequence of documents. The originals are in Dutch. They have various dates
18 because at various times they have been stamped as they enter different
19 administrative records. So the first date one sees, for example, top right-hand corner
20 here, is somewhat misleading. This appears in fact to be a document which is dated
21 6 June as one sees at the top left.
22 PRESIDING JUDGE SCHMITT: [11:53:37] I understand now. Now I see it. Thank
23 you.
24 MR GUMPERT: [11:53:43] I'm grateful.
25 Q. [11:53:45] So the prison psychiatrist, Dr Lefrandt, recorded that his impression

1 of Mr Ongwen was that he was intelligent, charismatic and, despite all the suffering
2 in his life, cheerful. You've seen that document before, haven't you, Doctor?
3 A. [11:54:04] It looks familiar.
4 Q. [11:54:06] So you don't know whether you've seen it before?
5 A. [11:54:10] I've seen many things, Mr Gumpert.
6 Q. [11:54:13] Yes, we all have, Doctor. It's a question to you. It's either yes, no,
7 or I don't know, I suppose. Which is it?
8 A. [11:54:21] I'm just being cautious here. I'm saying the document looks familiar,
9 which means I may have seen it, I may not have seen it. I have seen documents from
10 the psychiatrist and from the detention centre. I don't know whether this is one of
11 them.
12 Q. [11:54:32] In August of that year, if you turn over to tab 5, the same doctor
13 records Mr Ongwen asking him jokingly whether he can get termites put on the
14 prison shopping list because he's having problems with Dutch food. And he noted
15 that Mr Ongwen's mood was good, he was able to make jokes, he was fooling around.
16 Be fair to say that those aren't the typical symptoms of a man suffering from major
17 depressive disorder, wouldn't it?
18 A. [11:55:09] Did the psychiatrist really understand when the client said termites?
19 Because termites is white ants, *ngwen*.
20 Q. Yes.
21 A. [11:55:18] It's dishes that's added onto people's meals. Maybe he wanted it to
22 be added to his list. Around that time they are readily available in northern Uganda.
23 I don't think this was a joke, but that's fine. I wasn't there, but I don't think it was a
24 joke. I think the client really wanted something different from Dutch food. But
25 that's my opinion. I may be wrong.

1 Q. [11:55:47] And my question, can you remember what it was?
2 A. [11:55:51] Unfortunately not.
3 Q. [11:55:53] No. So he is --
4 A. [11:55:57] Asking for food and --
5 Q. [11:55:59] -- able to make jokes and fool around, observes the doctor.
6 A. [11:56:04] Mr Gumpert, again this was a joke, maybe it wasn't. I think the
7 client was asking for what to eat.
8 Q. [11:56:12] Okay. Let's forget termites. Turn over the page, the last
9 observation the doctor makes. "The mood is good, he is able to make jokes and fool
10 around with me." Let's just concentrate on that.
11 A. [11:56:29] Okay.
12 Q. [11:56:29] These are not the typical remarks and behaviour of a man suffering
13 from major depressive disorder, are they?
14 A. [11:56:42] Sometimes individuals with severe major depressive disorders who
15 are suicidal write their wills, go say goodbye to people and their loved ones, make
16 peace with them and finally commit suicide. It is not remotely impossible for
17 individuals with severe forms of mental illnesses - to be precise, mood disorders like
18 depression - to joke. It would have been very interesting to see whether the
19 psychiatrist disputed that diagnosis of a major depressive disorder. I would have
20 loved to see that transcript.
21 Q. [11:57:44] Well, Doctor, you had the chance, didn't you? You were at the
22 prison, so was Dr Lefrandt. Did you ask to meet her to see if she disputed it?
23 A. [11:57:56] In the text I don't see it. I never met Dr Lefrandt.
24 Q. [11:57:57] No, but you --
25 A. [11:57:58] It was difficult to meet the people from the detention centre. We

1 made attempts, not once, not twice, not three times. We wanted to meet the
2 psychiatrist, we wanted to meet the medical officer. We met the psychologist once.
3 We made attempts, multiple attempts, Mr Gumpert.
4 Q. [11:58:18] But you were never successful?
5 A. [11:58:20] We met them once. We made multiple attempts.
6 Q. [11:58:23] Did you, one doctor to another, write to Dr Lefrandt and say "I'd
7 really like to discuss my client with you"? Did you ever do that?
8 A. [11:58:30] We tried to follow procedures as much as we could. What do I mean?
9 We would come to the Defence and tell them that, you know, the client says he's
10 taking pills X, Y, Z, the client says he's undergoing this, this is what's happening.
11 Then we would tell the Defence, okay, it would be good to know what exactly the
12 client is going through and what kind of treatment he is getting.
13 Q. [11:58:58] So the answer is no?
14 A. [11:59:00] Then the Defence teams would make attempts and then they would
15 get back to us, and then on one of those attempts we managed to see a clinical
16 psychologist who had been seeing the client.
17 Q. [11:59:13] Would you turn to tab 6, just the next page.
18 Are you there?
19 A. [11:59:26] Yes, sir.
20 Q. [11:59:28] This is the next month, we're in September of 2015 now. This is just,
21 what, five months before you first see him. And we can see that Dr Lefrandt reports
22 various symptoms of PTSD, flashbacks, dreaming, easily startled, yes?
23 A. [11:59:51] That's what's written in the text.
24 Q. [11:59:53] Yes. You were aware of this, weren't you, Doctor? It's referred to in
25 Dr Weierstall's report, which you must have read two years ago. Is all of this

1 coming as news to you?
2 A. [12:00:03] I think we came to some of these conclusions as well when we were
3 seeing the client, flashbacks, nightmares, easily startled. And I think I can see that
4 the psychiatrist at the detention centre also came across the signs and symptoms as
5 well.
6 Q. [12:00:19] Doctor, we will come to your observations and what Mr Ongwen told
7 you. Currently I am dealing with the medical records from the prison. Do you
8 understand? What other doctors observed. I'm bringing it again to your attention.
9 That's what I'm asking you about at the moment. Do you understand?
10 A. [12:00:40] It's clear from what I see that the doctors made observations that the
11 client had some forms of mental illness.
12 Q. [12:00:47] The client had some symptoms of PTSD, that's actually what the
13 doctor wrote, isn't it? PTSS, which is the Dutch acronym for PTSD, yes?
14 A. [12:00:59] Mm-hmm.
15 Q. [12:01:00] But at the same time the doctor - I think it's a lady, in fact - records
16 that Mr Ongwen is, and I quote, "A friendly man, able to joke. His perception is
17 clear, there are no cognitive disorders." The form and content of thoughts is normal.
18 Now a cognitive disorder is any type of condition that impairs the cognitive
19 functioning of a person, isn't it?
20 A. [12:01:30] Yes, it is, but if you go into details it's a bit more than that.
21 Q. [12:01:37] Cognition refers to mental functions such as memory, sustained
22 attention, processing information, yes?
23 A. [12:01:47] That's part of cognition.
24 Q. [12:01:48] All the diseases which you diagnosed, MDD, PTSD, dissociative
25 identity disorder, they are all conditions which impair the cognitive function of a

1 person, aren't they?

2 A. [12:02:03] To some extent they do.

3 Q. [12:02:06] You understand that if Mr Ongwen was suffering from any of those

4 conditions --

5 THE INTERPRETER: Your Honour, could we please get the parties to slow down

6 during the question and answers, please.

7 PRESIDING JUDGE SCHMITT: [12:02:18] I think we have heard it. And we had

8 this in the beginning yesterday.

9 THE WITNESS: [12:02:20] Thank you, sir. I will (Overlapping speakers)

10 PRESIDING JUDGE SCHMITT: [12:02:22] No, no, but -- no, no, it's not your fault

11 solely.

12 Also, Mr Gumpert, please wait a little bit with your next question. You may now

13 proceed. And also the tone was a little bit away for the moment so we didn't hear

14 what you said.

15 MR GUMPERT: [12:02:41]

16 Q. [12:02:42] If Mr Ongwen was suffering from the mental diseases or defects that

17 you have diagnosed, you understand that a key question is not just was he ill, but

18 how badly was it affecting him or, particularly, had it destroyed certain of his

19 capacities? You understand that that's a question which the Judges may need your

20 expert help with, yes?

21 A. [12:03:10] Yes. I think they will ask that question at a certain point in time.

22 Q. [12:03:17] These are issues of cognition, aren't they, whether you understand

23 what you're doing?

24 A. [12:03:28] Mr Gumpert, I don't think we can explain the cognitive deficits that

25 mentally ill patients have in simplistic terms. Let me just get this clear. Depression,

1 for example, is a disease for which many people will have, you know, some
2 psychomotor retardation, for example, cognitive slowing, but that does not in any
3 way mean that you cannot make a diagnosis of it.
4 When patients have mental illnesses they could be having some forms of anxiety, but
5 I don't make a diagnosis of an anxiety disorder. And you don't say because the
6 patient is anxious you couldn't make a diagnosis. I mean, the trade is such that these
7 things are assessed, but they don't stop you from coming to a conclusion. I think
8 that's important.
9 Maybe we just need to have this clarity that when we talk about cognitive disorders,
10 we talk about things like delirium and dementia. Anything else is just comorbid
11 with a mental illness and you can always find ways of going around it and making a
12 diagnosis.
13 Because I think we may get lost in this cognition situation and not get out of it.
14 I think the other people who are listening who are mental health experts would agree
15 with me that when psychiatrists and psychologists talk about cognitive deficits, they
16 are talking about dementia, they are talking about mental retardation, they are talking
17 about things like delirium.
18 I don't know whether that helps. Maybe it doesn't.
19 Q. [12:05:30] Let's move on to tab 7. Haven't got any problems with cognition
20 there. This is when Dr Lefrandt hands over his patient to the psychologist on
21 30 November, so this is just really a couple of months before you see your client for
22 the first time. And Dr Lefrandt summarises Mr Ongwen's condition down at the
23 bottom.
24 "The mood is neutral with modulating affect; there is no suicidality. Conclusion:
25 Stable, no mental health condition; some symptoms of PTSS." And again for clarity,

1 I think Mr Obhof has clarified this in the past, PTSS is the Dutch equivalent of PTSD.
2 So that's what Dr Lefrandt, who has been looking after Mr Ongwen as his treating
3 psychiatrist in the prison up until this point, has got to say. Weren't these findings a
4 matter of concern to you when you read this document?
5 A. [12:06:47] I've said this, but let me just say it again. Clinical notes are written
6 for clinical purposes. When somebody says "stable", when somebody says "no
7 mental health condition", what do they mean? What do they mean "stable"? Do
8 they mean that the mental illnesses have gone away? Do they mean the
9 participant -- sorry, the patient or the client is able to function well? Do they mean
10 everything is okay? Do they mean that the symptoms have reduced?
11 When a mental health care practitioner says "no mental health condition", does he
12 mean no mental health condition in the current, in the past? Because we talked
13 about diagnosis of mental illnesses yesterday. We said you make a diagnosis on the
14 current and the past. I am cautious in interpreting clinical notes in these kinds of
15 settings because the purposes for which they are written, they are not written for
16 forensic purposes, they are written for purposes of providing care.
17 So if somebody had a score of 15 on a certain instrument on day one, you saw them
18 again day 14 and they had a score of 8, they were no longer suicidal, they were no
19 longer hyperactive, you would say they were stable. You would say things are good.
20 I mean, the baseline from which you started and where you are, there is an
21 improvement.
22 So my colleagues who were writing notes and these notes were being used to provide
23 care to the client, the interpretation of that at the bottom of it all just indicates that
24 there is a problem that is being addressed and this problem is getting better.
25 I hope that helps to clarify some of the things. That clinical notes are written

1 differently. Notes for forensic purposes are written differently. Notes in research
2 settings are written differently. Notes by psychiatrists are written differently from
3 psychologists. Observations by nurses are written differently. Because I'm sure
4 there were some nurses who were observing the client and making their notes as well.
5 Maybe we don't have those notes here. I'm sure there were the social workers who
6 were doing this, the clinical psychologists. So we have a tonne of information that's
7 available and this information is the one that is useful to guide the health care
8 workers.
9 I'm just saying that it's possible that the client had a mental illness here or not, but
10 I think that's the bottom line.
11 Q. [12:09:56] So really the difficulty is that we're not sufficiently competent to
12 understand what no mental health condition actually means, is that a summary of
13 your last answer?
14 A. [12:10:08] If you provide clinical services in the world, then you are competent
15 to do that, if you're seeing the patient yourself.
16 Q. [12:10:17] No, there's a misunderstanding. I mean we, we the lawyers, we the
17 Judges, we don't understand what Dr Lefrandt meant, that's what you're telling us?
18 A. [12:10:25] You do, but you need to put it into the right context and I think I've
19 just clarified on that, that the notes that are written in a clinical setting are written in
20 exactly the manner that my colleague did at the detention centre and these notes were
21 meant to help the client. You have to interpret these based on maybe previous notes,
22 maybe other observations. It's, it's not that you don't understand it, it's just that you
23 need to put it in the right context. And it also has many different meanings as well.
24 Q. [12:11:00] Would you go back to the binder which Ms Lyons gave you and to tab
25 8, so that's the Defence binder. I'm looking at the third paragraph up from the

1 bottom of page 0005 which is the second page. And in that paragraph you say that
2 you had the opportunity to look at the clinical notes of the psychiatrist and the clinical
3 psychologist. So you were saying that you had looked at these documents that
4 we've just reviewed, weren't you?
5 A. [12:11:56] I think I remember saying that the documents looked familiar. Now
6 it makes sense. Yes, we did.
7 Q. [12:12:02] And you said this: "Our impression is that the information
8 translated to us was to a large extent similar to ours."
9 Now, Doctor, no mental health conditions just isn't similar to he's suffering from
10 major depressive disorder, PTSD and dissociative identity disorder, is it?
11 A. [12:12:25] Just ask the question again.
12 Q. [12:12:28] They're not similar. You thought he was gravely ill. Dr Lefrandt
13 thought he had no mental health conditions. That's right, isn't it? What you wrote
14 here was wrong?
15 A. [12:12:42] Haven't we just talked about the interpretation of no mental illness a
16 few seconds ago and what it means and what it doesn't mean? I think, Mr Gumpert,
17 it's important to put things in context most times. It helps. Because, you see, when
18 you read clinical notes the world over, you're going to see exactly what the
19 psychiatrist wrote and I've just told you what that means. I've just said when it says
20 no mental illness, what does it mean? I mean --
21 Q. [12:13:12] In what context does it mean grave mental illness? Tell us the
22 context.
23 A. [12:13:20] It would have been helpful, extremely helpful if these notes were
24 written for -- as a report by the detention centre to the Court. They would have
25 clearly highlighted a number of things that are not here. I'm sure they are competent

1 to do that. But if you're going to pick one page where a clinician wrote their notes, if
2 you pick one page of my notes for all the (Overlapping speakers) --
3 Q. [12:13:52] I may do that (Overlapping speakers)
4 A. [12:13:53] -- patients I see -- okay, if you interpret findings from one page, you
5 end up exactly in the, in the kind of cycle that we are in right now. I mean, my
6 colleague would do the same thing to me if he read my notes. He would exactly ask
7 the same questions. He would say, "Akena, what do you mean by no mental health?
8 What do you mean? Do you mean current? Past? What do you mean?"
9 Q. [12:14:18] And you would explain, "Well, I mean actually that he's very ill",
10 would you?
11 A. [12:14:23] No, that's what -- that's not what I would say.
12 Q. [12:14:25] I'll leave this, Doctor.
13 A. [12:14:27] Thank you.
14 Q. [12:14:27] You told us yesterday about Mr Ongwen's belief in spirits.
15 It's page 119 and page 120 of yesterday's transcript. You haven't got that, but it's so
16 that there can be a reference to it.
17 You described how another person you spoke to, one of the four, who had been in the
18 LRA, he talked about how Joseph Kony could read people's minds and how that
19 person believed that he was still able to do that even though the person you were
20 talking to was now out of the bush, yes? Do you remember that?
21 A. [12:15:02] Mm-hmm.
22 Q. [12:15:03] Yeah. And you went on to say that this is "not so different from
23 what our client [goes] through". So should we understand that Mr Ongwen has told
24 you that he too believes these kind of things about Mr Kony's, Joseph Kony's spiritual
25 powers, his enduring spiritual powers?

1 A. [12:15:24] It is written somewhere in our report about these kinds of beliefs that
2 the client has about his boss being able to tell what's going on, his boss being able to
3 tell the future, his boss being able to tell that he's talking to others and that the boss
4 still has some powers to do that up until we saw him.
5 Q. [12:15:54] Right up until when you last saw him, which I think is January of this
6 year?
7 A. [12:16:02] Mm.
8 Q. [12:16:03] Yeah, okay.
9 I want you to consider the evidence of another event which took place before you
10 became involved in the case. It's a telephone call on 3 June 2015 and it is at tab 8 of
11 the Prosecution binder. When you've got there, I'll explain what that is.
12 PRESIDING JUDGE SCHMITT: [12:16:27] Is this confidential or public?
13 MR GUMPERT: [12:16:30] Your Honour, it's been dealt with before. It was then
14 played in the original Acholi. I'm proposing that the doctor should simply read
15 silently to himself three relatively short passages and then I will ask him questions
16 based on a summary of what he's read.
17 PRESIDING JUDGE SCHMITT: [12:16:50] Yes, I think that, I think that's doable, yes.
18 MR GUMPERT: [12:16:51] And then we can proceed I think in public.
19 PRESIDING JUDGE SCHMITT: [12:16:54] Yes, please proceed.
20 MR GUMPERT: [12:16:56]
21 Q. [12:16:57] So I should identify the transcript, UGA-OTP-0286 --
22 A. [12:17:04] Give me a minute. Give me a minute. I'm still trying to get there.
23 Q. [12:17:07] Sorry. It's an absolutely standard characteristic of the person
24 standing in this seat, standing in this position that they go too fast, they speak too fast,
25 they rustle through the papers too fast, and I apologise to you.

1 PRESIDING JUDGE SCHMITT: [12:17:25] And the witness of course sees any
2 document for the first time and is not so versatile normally with the binders like we
3 are after all this time.
4 But it's tab 8. Do you have it? It's the small binder that Mr Gumpert gave you and
5 there we are at tab 8.
6 THE WITNESS: [12:17:45] Oh, the one that he gave me. Okay, fine.
7 PRESIDING JUDGE SCHMITT: [12:17:47] You know, the problem is that we're
8 constantly switching between these different binders, but it's --
9 THE WITNESS: [12:17:53] Sorry, I was looking at the big thing (Overlapping
10 speakers).
11 PRESIDING JUDGE SCHMITT: [12:17:54] It's absolutely no problem. It's not your
12 fault, so to speak.
13 THE WITNESS: [12:17:57] Sorry, tab 8.
14 MR GUMPERT: [12:17:59]
15 Q. [12:18:00] Tab 8.
16 A. [12:18:01] Yes, sir.
17 Q. [12:18:01] Okay. I've read the -- I don't think you need the ERN. It's got --
18 A. [12:18:04] It's Annex (Overlapping speakers).
19 Q. [12:18:07] "Annex II confidential - ex parte -" yes? We're on it?
20 A. [12:18:09] Yes, sir.
21 Q. [12:18:10] Okay. Now this is --
22 A. [12:18:14] Which lines?
23 Q. [12:18:15] I'll come to that. I'm going to explain what it is first. This is the
24 English transcript of the translation of a telephone call between Mr Ongwen and one
25 of the women whom he regarded as his wives in the bush. And I want to draw to

1 your attention three extracts from that conversation. The conversation itself goes on
2 for an hour and 27 minutes.
3 Can you turn to line 701. It's on page 25, going over onto 26. So 701 to 737.
4 Thirty-six lines. Could you read that silently to yourself, please, Doctor. And let us
5 know when you've done that.
6 PRESIDING JUDGE SCHMITT: [12:19:27] And Mr Gumpert, also we have to give a
7 little service to the witness. "DO" means Mr Ongwen I would say. So that he is
8 clear. Because he sees it for the first time.
9 MR GUMPERT: [12:19:41] Yes.
10 PRESIDING JUDGE SCHMITT: [12:19:42] We have to be fair here.
11 MR GUMPERT:
12 Q. [12:19:45] Yes. So "DO" Mr Ongwen. "FA" is the lady whom he regarded as
13 his wife.
14 A. [12:19:53] 701 to 706?
15 Q. [12:19:55] No. 701 to 737, 36 lines.
16 MS LYONS: [12:20:06] Your Honour, I think we should -- just to be fair, it's in
17 English, but we should make it clear to the witness that the original was in Acholi.
18 PRESIDING JUDGE SCHMITT: [12:20:14] Mr Gumpert has said that, has said that.
19 MS LYONS: [12:20:18] Okay. Thank you.
20 PRESIDING JUDGE SCHMITT: [12:20:21] It's okay. That's fine.
21 MR GUMPERT: [12:20:22] I wonder while that's being read whether we can have
22 the floor for the presentation of a document on evidence channel whatever it's going
23 to be.
24 PRESIDING JUDGE SCHMITT: [12:20:30] Why not.
25 MR GUMPERT: [12:20:32] Thank you.

1 PRESIDING JUDGE SCHMITT: [12:20:33] Time is precious.

2 MR GUMPERT: [12:20:35] Indeed.

3 THE COURT OFFICER: [12:21:00] You have evidence 2 channel. And could you

4 confirm whether the presentation is confidential or public.

5 MR GUMPERT: [12:21:07] Public.

6 PRESIDING JUDGE SCHMITT: [12:21:11] Excuse me but before we turn now to

7 evidence channel 2 we wait until the witness has read it to the end. It was simply to

8 have the technical matters, that they don't cost us too much additional time. Only

9 that.

10 Please tell us, Mr Akena, when you are through the --

11 THE WITNESS: [12:21:52] Yes, I think I'm through. I've --

12 PRESIDING JUDGE SCHMITT: [12:21:54] Thank you. Thank you for your quick

13 reading. Thank you for helping us.

14 Mr Gumpert.

15 MR GUMPERT: [12:22:00] Yes.

16 Q. [12:22:00] Now we read there Mr Ongwen is planning for the day that he's

17 leaving The Hague and going back to Africa, yes?

18 A. [12:22:08] Yes.

19 Q. [12:22:09] He's imagining how his children and wives will flock to him and how

20 he will persuade the European authorities to give him money, yes?

21 A. [12:22:17] Yes.

22 Q. [12:22:18] He's talking about how the other men in the prison compliment him

23 on his good looks and how he likes playing football with them, yes? And he's joking

24 about how their daughter, him and his wife's daughter, has inherited his strong

25 footballing calves; that's right, isn't it?

1 A. [12:22:40] Mm-hmm.
2 MR GUMPERT: [12:22:41] Now I'm going to ask that the diagnostic criteria of major
3 depressive disorder be put up on evidence 2.
4 PRESIDING JUDGE SCHMITT: [12:22:57] They are visible now.
5 MR GUMPERT: [12:22:58] I'm grateful.
6 Q. [12:23:01] And I hope that you can see them as well, although I'm sure you'll be
7 very familiar with them, Doctor.
8 A. [12:23:04] Yes, sir.
9 Q. [12:23:04] Yes. Do these remarks strike you as a man who feels sad, empty and
10 hopeless most of the time on most days?
11 A. [12:23:39] You want me to get the transcript of the conversation between him
12 and his wife and marry them here?
13 Q. [12:23:51] Do these remarks strike you as somebody who feels worthless or
14 inappropriately guilty, Doctor?
15 A. [12:23:59] So at times even when we are talking to patients who are severely
16 depressed, they will still tell us they have a life, they will still tell us they have to go
17 and do things. We tell them that. You can still have everything else that was in
18 that text happening in a depressed person.
19 Q. [12:24:22] Could you move on to lines 816 to 840, a slightly shorter excerpt.
20 A. [12:25:24] You said 816 to 8?
21 Q. [12:25:27] 840.
22 A. [12:25:29] Okay. Fine.
23 Q. [12:25:30] You've read that?
24 A. [12:25:32] It's long.
25 PRESIDING JUDGE SCHMITT: [12:25:33] Yes. It's a longer passage, yes.

1 THE WITNESS: [12:25:39] It's long.
2 PRESIDING JUDGE SCHMITT: [12:25:42] Mr Gumpert --
3 THE WITNESS: [12:25:45] It's long. You know, it's long. I need to process a lot of
4 information here (Overlapping speakers).
5 PRESIDING JUDGE SCHMITT: [12:25:46] That's correct.
6 THE WITNESS: [12:25:49] It's unfair.
7 PRESIDING JUDGE SCHMITT: [12:25:50] No, no. The witness is right here. We
8 should --
9 THE WITNESS: [12:25:52] Let's summarise whatever it is and then you ask the
10 question. It's easier.
11 PRESIDING JUDGE SCHMITT: [12:25:58] Yes. There are some -- he's correct here,
12 I think.
13 MR GUMPERT: [12:25:59] Very well.
14 PRESIDING JUDGE SCHMITT: [12:26:00] I agree with the witness.
15 MR GUMPERT: [12:26:01]
16 Q. [12:26:02] So Mr Ongwen is talking about his return to Uganda again, how he'll
17 deal with the fact that some of the women he regards as his wives now have other
18 partners, he claims to be able to read people's minds, he talks about how to tell the
19 difference between truth and lies, how to be mindful of people's welfare, and in his
20 opinion there's no one in Acholi who can do these things better than he can.
21 Now, if that's a fair summary of what's said, let's look at the characteristics of a person
22 suffering from PTSD and that's now on the screen.
23 This isn't a person with persistent, exaggerated negative beliefs about himself, is it,
24 Doctor?
25 A. [12:26:53] Are these diagnostic criteria pulled from the DSM-5?

1 Q. [12:27:00] They are indeed.
2 A. [12:27:01] There are qualifiers to this, sir. The qualifiers are something like
3 most of the times during the day for most of the days during a certain period of time.
4 We don't expect that people have all signs and symptoms of mental illnesses for
5 24 hours a day. They would die. The brain would just explode. There are lucid
6 intervals in between when people are okay. I mean, if we are to look at it that way,
7 then we wouldn't be practising mental illness -- we wouldn't be practising mental
8 health. Because when the patient comes to us and they are so sad, they can't even
9 say anything, they can't do anything. Or if manic patients come to us, they are so
10 excited, they don't have concentration, they can't think, they can't do anything.
11 I don't think we should interpret psychiatric text in this manner. It's unfair to the
12 client. And to the Court. There are qualifying statements to the symptomatology
13 of mental illness. It's a science. You need to do this in the proper manner in which
14 it's done. I'm happy to answer questions whether the client could have had a mental
15 illness at that time, but I don't think that putting diagnostic criteria not in totality and
16 then trying to get a text and merge it with it, it's fair to the practice of mental health, I
17 don't think it's fair to this Court. But I may be wrong. Who am I?
18 Q. [12:28:48] Thank you for your answer, Doctor.
19 A. [12:28:53] You're welcome, sir.
20 Q. [12:28:54] One last passage, it's shorter, 13 lines --
21 A. [12:28:55] Wow.
22 Q. [12:28:55] -- 1066 to 1079.
23 A. [12:29:01] 1066 --
24 Q. [12:29:15] Indeed.
25 A. [12:29:17] -- 1079. Okay.

1 Mr President, I request, sir, that Mr Gumpert has read these transcripts, he's
2 internalised them, he knows what they are about, and it would be easier if he just
3 simply asked the question (Overlapping speakers).
4 PRESIDING JUDGE SCHMITT: [12:29:36] We have, we have done this, but --
5 THE WITNESS: [12:29:38] Thank you.
6 PRESIDING JUDGE SCHMITT: [12:29:39] -- I think for you, because we have a
7 shorter one here, we give you the time, please read these couple of lines. The other
8 one was way too much to manage it, so to speak, to understand it, but I think this
9 would be perhaps possible and Mr Gumpert can even then try again to summarise it.
10 THE WITNESS: [12:30:00] Okay.
11 PRESIDING JUDGE SCHMITT: [12:30:01] And ask you the question. I think that's
12 best also for you now.
13 THE WITNESS: [12:30:05] Yeah, and it would save the Court more time, I think, but
14 (Overlapping speakers).
15 PRESIDING JUDGE SCHMITT: [12:30:10] No, no, but it's okay. Please take your
16 time and read these couple of lines. This is not too long and I think that's best to
17 proceed this way.
18 THE WITNESS: [12:31:04] Okay. 1066 to 1079, okay, fine.
19 MR GUMPERT: [12:31:09]
20 Q. [12:31:10] Mr Ongwen is talking really about how clever he thinks he is, isn't he?
21 He's boasting that he's so good at telling whether a person is telling the truth or not
22 that the leader, Joseph Kony, believed that he had psychic powers. So let's just get
23 this right. Mr Ongwen's account is that it was Mr Kony who thought Mr Ongwen
24 was a psychic, that's what he's saying. And he remembers how he'd indicate
25 disapproval of Kony's plans and how when Kony went ahead with those plans the

1 plans would fail.
2 Doctor, if we remember the question I asked you at the beginning, that Mr Ongwen
3 was telling you that still he feared Joseph Kony, this is a flat contradiction when he's
4 not talking to his doctors, isn't it?
5 A. [12:32:18] Does he actually confirm that he has psychic powers or he's just
6 intelligent and able to read the difference between right and wrong? I'm --
7 Q. [12:32:27] Doctor, I'm giving you a chance to answer the question. If you don't
8 want to take it, that's up to you, I'll move on. Have you got an answer?
9 A. [12:32:36] Well, I'm still thinking, sir.
10 Q. [12:32:39] Okay.
11 PRESIDING JUDGE SCHMITT: [12:32:59] The question --
12 THE WITNESS: [12:32:59] My interpretation -- okay, sorry.
13 PRESIDING JUDGE SCHMITT: [12:33:00] The question was if you see a
14 contradiction between what you have read and what Mr Gumpert has summarised
15 and what Mr Ongwen has told you.
16 THE WITNESS: [12:33:10] The text here talks about a gentleman who says he was
17 quite intelligent, able to tell the difference -- able to see into people's eyes and see
18 whether they are lying or not. That's what I read. There is something before, it's
19 1073, "... that I have some kind of psychic powers". I don't know whether that is
20 reference to -- I don't know what happens before that text. I don't know what text is
21 available before that, but maybe the boss thought he had some psychic powers,
22 maybe he didn't think he had some psychic powers. So I don't know whether this is
23 a contradiction or not, but --
24 PRESIDING JUDGE SCHMITT: [12:33:51] I think --
25 THE WITNESS: [12:33:52] I don't remember the -- I don't remember the patient

1 telling us that he had psychic powers.
2 PRESIDING JUDGE SCHMITT: [12:33:58] Please move on, Mr Gumpert.
3 MR GUMPERT: [12:34:00] I will, your Honour.
4 Q. [12:34:01] I want to move on to the report which is at tab 6 of the big bundle, the
5 Defence bundle, the first bundle. That's your report following your meeting with
6 Mr Ongwen for the first time in February 2016, isn't it?
7 A. [12:34:41] That's correct.
8 Q. [12:34:42] Yes. And I want to recall some of the things that you recorded.
9 Would you turn to UGA-D26-0015 and then the last four digits 0155, the second page,
10 in other words. The third paragraph down you wrote: "Important negative
11 findings". And the second sentence: "He didn't have overt episodes of hearing
12 voices of people he couldn't see, or seeing things others could not see during the day."
13 Now since that time his account has changed completely, hasn't it?
14 A. [12:35:41] Let me put that statement into context. When mental health care
15 workers talk about seeing things other people don't hear or hearing things others
16 don't hear, we are assessing for psychosis, we are assessing for perception disorders,
17 we are assessing for the fact that somebody could hear things that others couldn't
18 hear. That is psychosis.
19 When we are talking about spiritual possessions, people thinking they have been
20 captured by the spirit or whatever it was, we rarely consider that as psychotic
21 illnesses because these are things that are commonly shared by people in certain
22 situations. In the context of the LRA, the whole issue of the spirit was quite common.
23 You couldn't consider that as a delusion or hallucination. So indeed it was an
24 important negative that the client was not psychotic. He did not have a psychotic
25 illness at that, at that point in time.

1 Q. [12:36:55] Let's look at what he's told you subsequently. He's told you that he
2 sees dead friends screaming at him to kill himself, doesn't he? That's what he's told
3 you after this.
4 A. [12:37:12] In the context of PTSD, yes.
5 Q. [12:37:14] I'm really just concerned at the moment with the factual matters with
6 his account to you.
7 A. [12:37:20] Yes, it's okay. I'll respond to that, but please go ahead.
8 Q. [12:37:23] He has told you that he sees godly, merciful people dressed in white
9 robes with Bibles on the table speaking many different languages, yes?
10 A. [12:37:37] Again, Mr Gumpert --
11 Q. [12:37:40] I'm not asking you to interpret it, Doctor. These are selected from
12 your reports. I want to confirm that this is what he has told you. We can come to
13 the interpretation afterwards.
14 A. [12:37:50] It's important that we have context here. It's important that we have
15 context. Because, you see, in the field of mental health, yes, no, yes, no kind of
16 questions can be misleading at times. Sometimes they are helpful, sometimes they
17 are not. I think I need to provide context so that the individuals who are here are
18 able to appreciate some of these things. But it's okay.
19 PRESIDING JUDGE SCHMITT: [12:38:16] No, no, that is absolutely -- in principle
20 that is correct, but when it comes to establish, for example, here that everyone in the
21 courtroom might hear it and can also follow, the question was simply do you recall
22 that this has been told you? And from there we continue. I think that is the
23 purpose of this question.
24 THE WITNESS: [12:38:37] The answer is yes, but if they are going to use that answer
25 in the future, then (Overlapping speakers).

1 PRESIDING JUDGE SCHMITT: [12:38:40] Yes, yes. No, no. Yes, absolutely,
2 absolutely. I think Mr Gumpert in the course of his questioning will ask you
3 questions which allow you to put it into context.
4 Mr Gumpert.
5 THE WITNESS: [12:38:51] Thank you, sir.
6 PRESIDING JUDGE SCHMITT: [12:38:52] So yes would be the answer.
7 MR GUMPERT: [12:38:55] Thank you.
8 Q. [12:38:56] And he's experienced voices telling him to kill himself he's told you,
9 hasn't he, voices which he can hear but nobody else can hear, yes?
10 A. [12:39:07] Yeah.
11 Q. [12:39:08] So we got a contradiction between your report back when you first
12 saw him, he couldn't see or hear things other people couldn't, and now the reports to
13 you of these various phenomena. There is a contradiction, isn't there, in the way that
14 he has given his account to you of what he is experiencing?
15 A. [12:39:39] Maybe now it's important to put it into context.
16 Mr President, is that so?
17 PRESIDING JUDGE SCHMITT: [12:39:46] Absolutely. Now we are at the point for
18 explanation, so to speak.
19 THE WITNESS: [12:39:51] Thank you very much.
20 So when individuals are depressed, for example, they feel inadequate, they feel they
21 want to die, they may hear their ancestors calling them to go and die, they may see
22 their ancestors calling them, then they see angels. We don't interpret that as
23 psychosis per se. We interpret those as depressive symptoms that lead to whatever
24 it is that -- you can explain those experiences by the primary diagnosis that the patient
25 had.

1 If you have an individual who has post-traumatic stress disorder, they are going to
2 get flashbacks, they are going to get intrusive thoughts. I mean the PTSD things that
3 disturbs people the most are the intrusive thoughts. They are going to remember in
4 vivid quality whatever it is that happened when they were traumatised at that
5 particular point in time.
6 Mental health care workers don't go and say that the patient had visual hallucinations.
7 So when we report that the patient did not have visual and auditory hallucinations,
8 we are looking for psychosis as a disorder. We are looking for schizophrenia,
9 bipolar affective disorder. We rule them out. But when we make a diagnosis of
10 PTSD, we are aware that these experiences happen in the context of that. And the
11 DSM is very clear about it. Mr Gumpert has referred to the DSM a number of times.
12 Criteria C, D, usually around there, C, D and E, you come across disclaimers that say
13 that these experiences should not occur in the presence of another existing medical
14 illness. So when you have visual hallucinations, auditory hallucinations, cognitive
15 disturbances, negative cognitive distortions that we see in post-traumatic stress
16 disorder, we don't make a diagnosis of depression. I think somebody was
17 asking -- I think Beth was asking yesterday why -- how we could make a diagnosis of
18 PTSD and depression in the same patient, whether they could coexist, for example.
19 If you make a diagnosis of PTSD, sometimes you have to make -- one of the criteria is
20 what we call the negative -- I mean the cognitive distortions that we see. Those
21 things are very similar to what you see in depressed people, but you make a diagnosis
22 of PTSD, you don't make a diagnosis of depression.
23 So the context here really is important that the client did not have a psychotic illness,
24 but the client had experiences that were congruent with a post-traumatic stress
25 disorder and a depressive illness and he manifested those signs and symptoms that

1 we saw. We don't think those are contradictions. We just think those are things
2 that are helpful in the field of mental health to come up with a diagnosis.
3 Q. [12:43:00] Doctor, if he told you anything like the account of hearing voices,
4 confronting a group of lions, seeing people dressed in white robes, if he told you
5 anything like that back in February 2016, you would have recorded it, wouldn't you?
6 A. [12:43:19] No, I wouldn't because there was simply no way that he would have
7 told me those in the context in which I would have asked the question. The question
8 at that time would have been extremely clear: Did you ever see voices of people?
9 Again, we don't ask one question and stop there. So it's not enough to simply ask
10 the question that have you seen voices of people you don't see -- sorry, have you
11 heard voices of people you don't see and then stop there. You go ahead and figure
12 out in what context does it happen. Does it happen during the day? Does it
13 happen in the night? Is it an illusion? Is it a misinterpretation? Who else was
14 there? And things like that, so -- but it's unlikely. The answer is no.
15 PRESIDING JUDGE SCHMITT: [12:44:02] Mr Akena, would it be fair to conclude
16 when you have written in February 2016, "He didn't have overt episodes of hearing
17 voices of people he couldn't see, or seeing things others could not see during the day",
18 that at the time this was not part of the conversation with Mr Ongwen? Otherwise,
19 if it had been part of the conversation with Mr Ongwen and if it had appeared, you
20 would have worded it differently? I think this would be perhaps of interest.
21 THE WITNESS: [12:44:35] Yes, Mr President, and that's why in our next report those
22 experiences were there, but we didn't make a diagnosis of psychosis, we made a
23 diagnosis of dissociative disorder because the context in which this occurred put us
24 into the realm of making another diagnosis, not the other one. So even if he had told
25 us that those things were there at that point, chances are that we would have ended

1 up figuring out the other circumstances under which this was going on and it could
2 have led us to a different direction, yeah.
3 PRESIDING JUDGE SCHMITT: [12:45:09] Please.
4 MR GUMPERT: [12:45:10]
5 Q. [12:45:13] You also recorded that his -- forgive me -- he had a good, short and
6 long-term memory, good judgment, an intact executive function and concentrated
7 well throughout the interviews. That's on the next page, 0156, in the third -- fourth,
8 in fact, paragraph.
9 Now, currently you think that he suffers from dissociative amnesia, don't you?
10 A. [12:46:02] At times, dissociative disorder, yeah.
11 Q. [12:46:05] Which by -- no, forgive me. In your most recent report, amongst
12 other conditions, you diagnosed dissociative amnesia quite separately from DID, yes?
13 Yes?
14 A. [12:46:19] Yes, sir.
15 Q. [12:46:20] Yes. And the amnesia is the condition of having remarkable
16 forgetfulness, not just the average person forgetting to put in a reference number, but
17 forgetfulness of a really significant kind, isn't it?
18 A. [12:46:39] That's correct.
19 Q. [12:46:39] Yes. So again there's a contradiction here, isn't there? Back when
20 you first see him, you ask him questions designed to test his memory and you come
21 up with the conclusion that it's good, short and long-term it's good. Now you think
22 he's got such a bad memory that it's a disease. There's a contradiction there, isn't
23 there, Doctor?
24 A. [12:47:02] There are two ways of looking at that, Mr Gumpert. And the first
25 one, which takes me back to my earlier explanations about the occurrence of the signs

1 and symptoms of a mental illness, the whole day and the whole night. But we've
2 moved on from that.
3 There are episodes that the client described where he did have memory issues.
4 These episodes were often associated with some forms of severe psychological
5 distress. One of them was discussed in the morning hours here about the outburst
6 that happened in court here, where the patient actually -- well, the client says he had a
7 fuzzy memory after that. Two, three, four, five times, a number of occasions the
8 patient said he died and woke up. He died, he could remember what happened.
9 There was a time there was even a much longer memory lapse I think when he had a
10 splinter somewhere on his chest and was taken to hospital somewhere in South
11 Sudan.
12 When we are assessing for cognitive purposes in this situation, we want to know does
13 this gentleman have some form of dementia of some sort? Doesn't he have? It is
14 also possible that at the time that we saw him in 2016 maybe there wasn't just enough
15 time to figure this out in totality. When we see him again much, much later, we are
16 able to tell on two or three occasions that he wasn't, he wasn't himself. I think we
17 wrote it somewhere in the notes. He wasn't -- he was very distressed. He wasn't
18 concentrating. He looked like he hadn't slept the whole night. Actually, one time
19 he told us he had slept for two hours. His concentration was poor and everything
20 else.
21 I think whatever it is that we written down is consistent with, with what we have and
22 that these fluctuations in signs and symptoms are seen not just by us but by
23 colleagues in the detention -- I mean in the detention centre as well.
24 I hope that answers the question.
25 Q. [12:49:56] Well, that's for others to judge.

1 No contradictions you said a moment ago.
2 Please look at page 0155, the left-hand page. These are your words. It's the second
3 paragraph down: "He had a pessimistic outlook on life in the future. He had poor
4 concentration at some times when he experienced these thoughts," and then this "but
5 had no amnesia of the events that happened while in the LRA ranks."
6 Now on that score at least, Doctor, can you agree there is a contradiction between
7 what he told you then and what he is telling you now?
8 A. [12:50:46] On that score I think at that point we didn't have sufficient
9 information to make a diagnosis that we did later on.
10 Q. [12:50:54] Doctor, this isn't about a diagnosis. This is about the building blocks
11 which may enable you to come to a diagnosis, whether he was forgetting things or
12 not. He told you then or gave you answers which caused you to write down that he
13 had no amnesia. Now you've diagnosed him with a whole mental illness based on
14 amnesia. What's the explanation?
15 A. [12:51:19] The explanation is that you collect information over a long period of
16 time for you to be able to make a diagnosis. We have seen the client more than once
17 and we've been building our case slowly over that period of time. That's exactly
18 what happens in clinical practice, that you see the client today, the client tells you
19 something; you see the client again, you challenge the client, you collect more
20 information.
21 If they look at your notes on day one and they look at your notes on day six, some
22 things will change, some will not. Some will be consistent. And we're saying we
23 went and looked for more information. We went and looked for collateral
24 information. We were able to establish that there are points in time when the client
25 said he had died, when the client said he could not remember things that had

1 happened. We came back to the client and we put this back to the client and asked
2 him this same question that we had asked him again. It became apparent that some
3 of these things had actually happened in the past.
4 Q. [12:52:25] Doctor, you say you looked for more collateral information. Can you
5 detail what that information is. I don't mean anything Mr Ongwen told you.
6 Anything collateral. Tell us what it was.
7 A. [12:52:40] We interacted with four individuals who had to provide us
8 information about how we could come to a conclusion about his mental health. We
9 also asked the team whether they could provide us with some information regarding
10 whatever it is that he was getting at the detention centre. We managed to take a look
11 at one of the videos when he was being restrained, I think there was an attempt
12 somewhere. So that's what I mean by collateral information. And this information
13 was got after the first interaction. And the reasons we did that was we just needed
14 to be sure that whatever it is that we got the first time was reliable information.
15 Q. [12:53:40] And none of that information had anything to do with his memory or
16 amnesia, did it?
17 A. [12:53:47] That information had to do with a lot of things, Mr Gumpert.
18 Q. [12:53:52] Well, just concentrate on the one I'm asking you about.
19 A. [12:53:59] That information had to do with -- you know, the client had told us in
20 the beginning about something that seemed to indicate loss of consciousness. We
21 are not so sure whether this was epilepsy or something else, which of course you see
22 in such situations. So much as we may not have included this information at that
23 particular point in time, we really needed to get it and we finally came across it.
24 Q. [12:54:50] I think you understand the suggestion made by some of the
25 Prosecution experts that what's actually happened here is that rather than you

1 becoming better and better informed, Mr Ongwen has become better and better
2 informed about the nature of mental illnesses and he is, as Professor Mezey put it,
3 faking bad, he's malingering. You understand that that's the suggestion, don't you,
4 Doctor?
5 MS LYONS: [12:55:18] (Overlapping speakers) the basis of this question in
6 terms -- not in terms of the witness, that the first part is fine, but what is the factual
7 basis for the assertion in terms of Mr Ongwen? I mean, we've read the Mezey
8 testimony. I dealt with it yesterday. I dealt with these issues. But I think the
9 question should -- it's two parts. The first part is fine, he can ask Dr Akena. But in
10 terms of Mr Ongwen, we need an offer -- I don't know what he's basing it on.
11 PRESIDING JUDGE SCHMITT: [12:55:49] But you rightfully and correctly say that
12 you have brought the issue up yourself on your questioning and the question is
13 Mr Gumpert simply follows that, so to speak, as I understand it, and asks the witness
14 if this course of events, so to speak, would speak in favour of a malingering or not.
15 And I think if they put it this way, I think it's absolutely acceptable.
16 And you may answer. You have given an answer yesterday also, but I think in this
17 context because we have here new factual information -- of course it's not new, but it
18 has now been presented in the courtroom for the first time, so in light of this first
19 report and what follows, what would be your answer to this question that I have a
20 little bit rephrased and which follows - Ms Lyons is nodding - which follows what
21 Ms Lyons has asked you yesterday.
22 THE WITNESS: [12:56:57] So the issue of malingering and faking bad is interesting
23 because we really don't see why the client would do that. That's one.
24 The client is extremely distressed about what he goes through. We don't see that in
25 malingering. In clinical practice we don't see that kind of distress that people who

1 malinger get. People who malinger want to actually confirm that they have an
2 illness.
3 The client doesn't even know that what he's going through is a mental illness. The
4 client, if I could recall, told us "I don't understand why these two Dominics are
5 fighting in me. When they are done with their fighting, I am so tired. I'm so
6 exhausted. They are giving me conflicting information. I don't understand why
7 my brain is split into two. One brain is on the left, the other one is on the right.
8 And they keep on pulling me left, right, and centre. Why can't I be like normal
9 people?"
10 Individuals who malinger don't portray themselves like that. At least from my
11 clinical practice as a mental health care expert.
12 MR GUMPERT: [12:58:24]
13 Q. [12:58:24] Doctor, I was just asking whether you understood that that is the
14 suggestion. I understand that you don't agree with it, but you know that that is a
15 point of contention, don't you? You know that that's what lawyers call an issue, a
16 point where the two parties disagree; you understand that, don't you?
17 A. [12:58:48] I try to be as respectful as possible to my colleagues from the other
18 field. I understand that they had challenges and inability to see the client. I
19 understand their hands were tied. I fully appreciate that. I am not going to go into
20 the details of what they were thinking when they were making those conclusions and
21 assertions that the patient could have been malingering. I'm not going to say
22 whether this was good or bad or unfortunate. I'm just going to be respectful of the
23 fact that the psychiatrists, they thought about some of these things, they have asked it,
24 we have clarified, and that's what we have done as experts here.
25 It could have been suggested, it is an issue, yes, but that's what my colleague thought.

1 I'm not there when she's thinking like this. But I'm just telling you that in this
2 situation I don't disagree that in the field of forensic psychiatry people can malinger,
3 but I'm just saying in this situation that is very unlikely because the circumstances
4 under which we are operating, the clinical signs that the client manifested and
5 everything else that followed thereafter do not indicate that he was malingering
6 because there was no clear secondary gain out of that, not that we see at least.
7 Q. [13:00:21] When there is an issue about malingering or not, there are formal tests,
8 psychometric tests which forensic psychiatrists use to detect malingering, aren't
9 there?
10 A. [13:00:36] If you go to look out for them intentionally, yes.
11 Q. [13:00:39] So the answer is yes, there are.
12 Can you tell the Court about some of those psychometric tests. Which one would
13 you use if the Court specifically asked you to help it with the question of
14 malingering?
15 A. [13:00:57] We didn't assess for malingering, sir.
16 Q. [13:00:59] No. I'm asking you a different question. Which one would you use
17 if a Court asked you to do that?
18 A. [13:01:07] You may as well have asked me which test I would use to assess for
19 personality disorder cluster B.
20 Q. [13:01:11] Perhaps I will in a moment. Just answer the question I am asking
21 you now, if you would.
22 A. [13:01:20] Mr Gumpert, the clinical situations under which we operated did not
23 point towards malingering and we did not assess for that.
24 Q. [13:01:28] Not an answer. Can you answer it?
25 A. [13:01:31] Maybe this is not an exam, sir. You know, if I answer that question

1 about the test that is used for assessing malingering, the next question could be
2 personality disorder, anorexia nervosa, Tourette's, sexual disorder, sleep problems, it
3 could be endless.
4 PRESIDING JUDGE SCHMITT: [13:01:48] Why not -- why make it so complicated.
5 You said you didn't have indicia for it.
6 THE WITNESS: [13:01:56] We didn't have (Overlapping speakers).
7 PRESIDING JUDGE SCHMITT: [13:01:57] Now in the abstract. If there was any
8 other courtroom, any other client, if you had indicia for malingering, how would you
9 try to identify them or exclude them, excluded?
10 THE WITNESS: [13:02:10] Mr President, I would do everything within my means to
11 conduct a detailed clinical assessment which is far more superior than any
12 psychometric test in coming up with a diagnosis. That's what all mental health care
13 workers do.
14 PRESIDING JUDGE SCHMITT: [13:02:25] Mr Gumpert.
15 MR GUMPERT: [13:02:27]
16 Q. [13:02:28] Let's leave aside what you might use. Let's talk about other doctors.
17 Can you give the Court any example of the psychometric tests which are used when
18 the issue of malingering arises? Can you help the Court by naming just one of them?
19 A. [13:02:48] Mr Gumpert, I would do a clinical exam to assess for malingering.
20 That's what I would do. That's my preference. And as an expert that's what
21 I would do.
22 Other colleagues may use other tests. I used clinical exams to assess for depression.
23 Much as I have a visual scale that I developed personally in my own names, I didn't
24 use it on the client because I knew it wasn't appropriate.
25 So I'm just telling you what I would do. I know other colleagues would do other

1 things. That's fine with them. But that's what I would do. I'm sorry, but that's it.
2 That's what I would do. I would do a clinical exam. I don't think it replaces
3 anything like a psychometric test at all.
4 Q. [13:03:32] But you too have got your concerns with the accuracy of
5 Mr Ongwen's presentation. You say in your report this outward presentation that
6 Mr Ongwen is deceptive -- that Mr Ongwen exhibited is deceptive. It covers up the
7 intense internal emotional turmoil he experiences daily. So really on both sides
8 there's concern about Mr Ongwen not accurately reporting. The suggestion made as
9 a possibility by the Prosecution is that he is faking bad. The suggestion on your part
10 is, if it exists, he's faking good, he's actually pretending to be less depressed than he is.
11 So there's a vital point here, isn't there? Both of you are in agreement that
12 Mr Ongwen is not an accurate reporter of his symptoms. Wouldn't that make it
13 absolutely vital to use a psychometric test to try to shed some light on this? I mean,
14 I think you yourself have talked about the value of psychometric tests, haven't you?
15 A. [13:04:48] Mr Gumpert --
16 PRESIDING JUDGE SCHMITT: [13:04:51] Where is the problem now?
17 MS LYONS: [13:04:52] No, no, no. I'm just saying the question has been asked in
18 different forms and it's been answered and I'm just raising the issue of when enough
19 is enough because he's answered the same question, albeit in different forms,
20 Mr Gumpert, I'm listening carefully to you.
21 PRESIDING JUDGE SCHMITT: [13:05:05] Yes, yes, it is --
22 MS LYONS: [13:05:07] But it's been answered multiple times. It's an --
23 PRESIDING JUDGE SCHMITT: [13:05:10] Yes, when I --
24 MS LYONS: [13:05:10] -- asked and answered objection.
25 PRESIDING JUDGE SCHMITT: [13:05:12] Yes, but Ms Lyons, it's perfectly clear that

1 this is the last question in that regard, I would assume. It's simply giving it another
2 twitch, or however you would word it in English, I'm not absolutely sure here,
3 twist - twist, of course, thank you - and the new one, and because of that I did not
4 intervene. The new aspect was that in the reports, and you have reverted to it also
5 yesterday already, you say that he sometimes tries to hide also symptoms. So this,
6 as Mr Gumpert worded it, goes both ways.
7 So would this induce you to change what you said before or would you simply say,
8 okay, that is -- I simply answer the same way I have done.
9 THE WITNESS: [13:06:12] Maybe not. Maybe, maybe not. But I will ultimately
10 respond to the issue of psychometric because I think it's important.
11 The context in which the client presented was of showing strength and I think this
12 was a conditioning that they had undergone for many years. So we think that his
13 presentation as everything is okay, etc, etc, etc, was basically just what he had been
14 trained and conditioned to do his whole life.
15 And I think we were extremely clear that on the surface it all looks nice and good, but
16 when you start to engage with him, you start to observe challenges and weaknesses.
17 Which we did. But as mental health care workers, we challenged the clients, we
18 challenge the clients.
19 I think yesterday I talked at length about social desirability and how we used that to
20 make sure that the information that we get and what we see corroborates with the
21 evidence that we're interested in because it takes a bit of time for clients to actually
22 warm up to you and tell you exactly what it is that they are going through.
23 So I don't think it's a contradiction per se, it is just that when time went on it became
24 apparent that we were now able to get more information about some really
25 underlying troubles that the client had.

1 Mr Gumpert, we don't use psychometric tests like that. There are indications for
2 using psychometric tests. We don't fail to elicit a clinical interview or we don't end
3 up in the situation where we think the patient is not telling us the truth and then we
4 use the psychometric test. It's not a weighing scale. It's not a lab test.
5 Psychometric tests are used to either rate symptoms or severity or to get a score. If
6 you have failed at the clinical level to elicit signs and symptoms, those tests are of no
7 use to you. I think, I think we need this clarity because it's important. We are not
8 going to use psychometric tests in everybody. I have a psychometric test for
9 depression. My colleague has a psychometric test that he developed for suicide.
10 We didn't use them in the client. We would have had a lot of pride in using our own
11 instruments in the client, but we didn't do that because they were not appropriate in
12 that context at this time.
13 PRESIDING JUDGE SCHMITT: [13:09:07] I think you can move on now,
14 Mr Gumpert.
15 MR GUMPERT: [13:09:12] (Microphone not activated)
16 PRESIDING JUDGE SCHMITT: [13:09:17] Please microphone.
17 MR GUMPERT: [13:09:20]
18 Q. [13:09:20] The DSM-5 --
19 PRESIDING JUDGE SCHMITT: [13:09:23] No, no, no. We said that we have a
20 prolonged session.
21 MS LYONS: [13:09:27] (Microphone not activated)
22 PRESIDING JUDGE SCHMITT: [13:09:28] Yes. So we still have, although hunger
23 in some of us at least might now come, we have still to wait another 20 minutes.
24 MS LYONS: [13:09:37] (Microphone not activated)
25 PRESIDING JUDGE SCHMITT: [13:09:40] No problem.

1 Mr Gumpert.

2 MR GUMPERT: [13:09:46]

3 Q. [13:09:46] The DSM-5 provides diagnostic criteria for the three diseases we've

4 mentioned, MDD, DID, and PTSD, and you will find them at tabs 10, 11 and 12 of the

5 binder that I handed to you.

6 PRESIDING JUDGE SCHMITT: [13:10:18] I assume you will start with one of them.

7 MR GUMPERT: [13:10:21] Your Honour, no. I'm going (Overlapping speakers).

8 PRESIDING JUDGE SCHMITT: [13:10:22] No, you're not?

9 MR GUMPERT: [13:10:23] I'm going to start with all three.

10 PRESIDING JUDGE SCHMITT: [13:10:24] Okay, then please, you have an idea there

11 obviously.

12 MR GUMPERT: [13:10:26]

13 Q. [13:10:28] Because it's right, isn't it, Doctor, that all three of those diseases have

14 two common features. Firstly, the symptoms must cause clinically significant

15 distress or impairment in social, occupational or other important areas of functioning.

16 And secondly, the symptoms are not attributable to the physiological effects of a

17 substance or other medical condition. And we can, if we can have the control back,

18 put those two diagnostic criteria up on evidence 2.

19 That's right, isn't it, Doctor? In fact, there are lots of other conditions which have

20 these diagnostic criteria as well?

21 A. [13:11:23] Am I supposed to respond?

22 PRESIDING JUDGE SCHMITT: [13:11:34] Yes, the question was if you see this as

23 correct.

24 THE WITNESS: [13:11:37] No, no, he phrased it, he said that's right. Yes, it is.

25 PRESIDING JUDGE SCHMITT: [13:11:42] Yes, yes, exactly. That would be your --

1 THE WITNESS: [13:11:43] Okay. I will not argue with the DSM-5, it's clear.
2 PRESIDING JUDGE SCHMITT: [13:11:45] No, no. Yes, actually, we would have
3 been surprised. It was a little bit suggestive, this question.
4 THE WITNESS: [13:11:47] It was, but that's fine.
5 MR GUMPERT: [13:11:53] Wholly, wholly suggestive.
6 PRESIDING JUDGE SCHMITT: [13:11:58] I have learned over the years, so to speak,
7 that in these, at least in part, common law settings, that these are appropriate
8 questions and I accept it from every side here in the courtroom when it is the so-called
9 cross-examination.
10 But of course for the expert it is a little bit --
11 THE WITNESS: [13:12:17] It's strange, Mr President --
12 PRESIDING JUDGE SCHMITT: [13:12:20] It's a little bit (Overlapping speakers)
13 THE WITNESS: [13:12:18] -- but I've learned something.
14 PRESIDING JUDGE SCHMITT: [13:12:20] Yes, yes, yes, exactly.
15 Mr Gumpert, please continue.
16 MR GUMPERT: [13:12:24]
17 Q. [13:12:26] Now, Doctor, we can probably, I hope, dispose of the second one of
18 these quite quickly. Would you tell me, do you agree that it means that some of the
19 symptoms of some of these illnesses can be caused by alcohol or drugs or other
20 substances, and where that's the case, then doctors will, in a common sense way,
21 realise that a person is drunk or an alcoholic or a drug addict and they won't think
22 that that makes it more likely that they are suffering from one of these three diseases?
23 It's something you have to rule out, yes?
24 A. [13:12:57] Not as simple as that, actually.
25 Q. [13:13:01] Go on.

1 A. [13:13:02] You may actually make a diagnosis of a major depressive disorder
2 secondary to substance misuse if the last criteria is positive. So you can still do that.
3 You just don't dismiss it. You can, you can still do that.
4 Q. [13:13:18] Thank you for that. I'm going to move on to the other criterion:
5 Clinically significant distress or impairment in social, occupational or other important
6 areas of functioning.
7 This is a necessary criterion, isn't it? If this criterion is not satisfied, then according
8 to DSM-5 it can't be right to make the diagnosis; that's right, isn't it?
9 A. [13:13:54] We use the DSM-5 all the time, but again, we use it with caution
10 because it's a manual. I think we talked about that yesterday, that information for
11 diagnostic purposes in mental health and psychiatry is arrived at after fairly longer
12 conclusion. I don't want to disagree with you that that should be there, but I'm just
13 saying that there are times when your clinical judgment and information in a textbook,
14 not a manual, is used to come up with a diagnosis. But that's fine.
15 Q. [13:14:36] So you don't disagree?
16 A. [13:14:38] Not entirely. Not with the text, but --
17 Q. [13:14:40] Good.
18 A. [13:14:43] -- the issue of the diagnosis.
19 Q. [13:14:45] All right. We'll stick to the text.
20 Now, could you turn, please, to the table which you received on Friday. It's at tab 14
21 of the binder that I provided to you a little earlier.
22 Are you there?
23 A. [13:15:30] Tab 14, that's D-0026 or something?
24 Q. [13:15:33] Yes, exactly that.
25 A. [13:15:34] Okay.

1 Q. [13:15:35] Now the purpose of letting you have this on Friday was to enable you
2 to make yourself familiar with these extracts from the testimony. Have you done
3 that?
4 A. [13:15:48] Yeah. Yes, I have.
5 Q. [13:15:51] Thank you. Let's look at extract number 4 firstly, D-0075. This is a
6 man who served under Mr Ongwen for ten years in the LRA, according to his
7 testimony. He contrasted Mr Ongwen with other brutal commanders. Mr Ongwen
8 liked to play with junior soldiers and children, he would joke around. And the
9 witness had never seen him mistreating junior soldiers. On the contrary, the witness
10 said that Mr Ongwen would educate people about things they didn't know.
11 Mr Ongwen treated his wives well. And this friendly personality, which he
12 described on his oath to the Court, didn't change over the 10-year period that the
13 witness knew him and that included the charged period.
14 And the same witness was also able to speak about how, when there had been
15 wrongdoing in Mr Ongwen's unit of the LRA, the subordinate officers would conduct
16 an investigation and report back to Mr Ongwen. And if the case was proved, a
17 caution would be issued, or in the case of repeat offenders, corporal punishment.
18 That's a summary of what you and I have both read.
19 Now that really doesn't sound, over that 10-year period, like a person with significant,
20 clinically significant impairment in social or occupational functioning, does it?
21 A. [13:17:39] If we walked into a psychiatric ward the world over, we would
22 find -- okay, if we walked into a long-stay psychiatry ward, meaning a ward where
23 people are going to stay for a very long time, months, years, years, whatever, and an
24 external observer came and looked at what was going on, they would find
25 individuals who would be laughing, who would be organising themselves, who

1 would be taking a shower, who would be doing all sorts of things.
2 Actually, in the ward in which I practice at home, there are even administrative
3 structures that set up by the patients themselves. Patients are in charge of hygiene,
4 making sure staff members are not assaulted, making sure everybody is adhering to
5 their medication, making sure that, you know, people have eaten food, they are not
6 fighting over food, whatever it is. External observers are amazed at that level of
7 organisation.
8 Medical students are actually shocked when they come the first day. They tell us
9 "Doctor, why is this patient here? This patient speaks sense when they come here.
10 The patient said they don't have a mental illness." They all don't say that -- they all
11 say they don't have a mental illness. They say exactly that. They ask us "Why is
12 this gentleman here?" The patient comes and says, you know, "I'm a businessman
13 from town, I own all these buildings, I have all this money, I have a degree from
14 Oxford, I'm married to six wives, I'm doing all sorts of things." We tell the student,
15 go take a history from the patient and come and tell us. The students always come
16 back to us and say "I don't see why this patient is here." Then we sit down and we
17 elicit psychiatric symptoms in a manner that the students cannot. And they are
18 shocked.
19 If we look at text and observations from laypeople to come to the conclusion of
20 whether somebody has a mental illness or not and how well somebody is functioning
21 in a certain context or not, we may mislead ourselves. Not all the time, but
22 sometimes.
23 Indeed many people may have seen the client in that state. We did see the client in
24 that state the first time we came and saw him and we reported here. And in our
25 report we say again that initially it looked like all was well. When we sit down and

1 look for these kinds of information, we find a troubled person. The exact same
2 things that the medical students go through the world over. The exact same things
3 that bystanders go through the world over. The exact same things that loved ones of
4 patients come and tell us, they say, "They are not throwing stones anymore, they are
5 not stripping naked. Doctor, why are you keeping the patient here?" And we are
6 telling them "This person is still unwell. Give us more time."
7 PRESIDING JUDGE SCHMITT: [13:21:31] Mr Gumpert.
8 MR GUMPERT: [13:21:33]
9 Q. [13:21:35] I'd like you to look at extract number 3, D-56, a Defence witness. He
10 was in the same battalion as Mr Ongwen for about six months in 2002. He recalled
11 Mr Ongwen's ability to refuse impractical orders. He said that if he knew,
12 Mr Ongwen knew that someone was going to bring problems for his soldiers, he
13 wouldn't engage. That's why his soldiers loved him. D-56 said he wouldn't just
14 engage in something without being sure. If there's an order from the senior officer,
15 he'd sit down with his officers and they would obsess it -- sorry, assess it. And if
16 they felt that the order they had been given wasn't practical or feasible, Ongwen
17 would object -- Mr Ongwen, I should say, would object to doing that.
18 Now, here's another long-term subordinate, not a visitor to a psychiatric ward, but
19 somebody who is living with Mr Ongwen and functioning, working with him for
20 months on end. That's not clinically significant impairment in his occupational
21 functioning, is it? That's a man, this description at any rate, is a description of a man
22 who is functioning at a high level, refusing impractical orders, wouldn't you agree?
23 A. [13:23:13] Mr Gumpert, the reason "clinically" is the first in that sentence is
24 because that assessment needs to be made by somebody who is competent. If it was
25 just significant distress or impairment in social and occupational functioning, then

1 anybody could use the DSM-5 and make a diagnosis. Clinically, the word
2 "clinically" is very important.
3 I am not convinced that laypeople can successfully make a case for a diagnosis of a
4 mental illness until it is overt and a disturbance.
5 One of the reasons we insisted on assessing for psychosis was exactly that. So
6 assessment of mental health, without disrespecting anybody here, is something that
7 needs to be done by people who are qualified to do that. Simply observing
8 somebody for many years doesn't do that. We have situations where loved ones
9 bring patients to us, they have lived with this patient for 10, 15 years. You go back,
10 you find the patient has been depressed for six years nonstop. They didn't even
11 know that. But then we tell them and they are shocked.
12 I don't know whether this answers the question.
13 Q. [13:24:52] Doctor, yesterday you told us that the people around Mr Ongwen
14 would have been likely to notice, your words were, "something amiss". Do you
15 remember that?
16 A. [13:25:07] Yeah.
17 Q. [13:25:09] I'm not suggesting that the people around Mr Ongwen would have
18 diagnosed the nature of his illness, but these building blocks, these criteria, they are
19 everyday things, aren't they? If you get angry, if you can't sleep, if you can't do your
20 job, that's the way mental illness affects you in ways that ordinary people, your
21 colleagues, your friends, your lovers, they notice?
22 A. [13:25:43] That's true.
23 Q. [13:25:44] Is there anything in these documents from these 16 witnesses who
24 have given sworn testimony to suggest that there was that kind of everyday practical
25 dysfunction? Can you point to anything, apart from what Mr Ongwen himself has

1 gradually told you, to indicate some kind of objective confirmation of those
2 difficulties?
3 A. [13:26:12] When we assessed the individuals who had been with him ourselves,
4 we were able to elicit some symptoms. We were able to elicit symptoms of isolation.
5 We were able to elicit symptoms of sadness and unhappiness and being angry and
6 death wishes. We asked for these symptoms ourselves and were able to get it. If
7 we had been given the opportunity to ask these same individuals these questions,
8 I don't know, maybe the story would have been different. I'm just telling you, sir,
9 that you need to ask for these things and if you pick these interpretations from a
10 setting in which they have been elicited for another purpose and try to use it for a
11 mental health purpose, you are likely to go astray sometimes. Maybe not all the
12 time, but sometimes.
13 So if it were possible to indeed ask these individuals some of the questions that
14 mental health care workers ask about things. We don't ask suicide -- for example,
15 suicide, we don't ask for suicide directly. We don't ask patients whether you want to
16 kill yourself. That's not the way we ask for it. So simply asking somebody who has
17 lived with another whether the person was suicidal requires a certain amount of skill
18 that may be difficult until you've been trained to do that.
19 Q. [13:28:00] Doctor, one, two, three, four, five, six, seven, eight, nine, ten of the
20 individuals, of the 16 individuals in the table that we've been looking at are Defence
21 witnesses. Have you asked the Defence to have the opportunity to ask those persons
22 the kind of questions you've just been talking about?
23 A. [13:28:30] We asked the Defence to provide us with the witnesses that had been
24 as close to the client as possible. And they provided four witnesses and we asked
25 the four witnesses.

1 Q. [13:28:44] That was in 2016. You've been working on this case now for nearly
2 four more years. Have you asked whether you can ask your specialist, your
3 technical, your psychiatric questions of any other persons, the persons who have
4 actually come to the Court and testified? Have you asked that?
5 A. [13:29:08] When we asked for the information and received it, we used that
6 information to build our case and we built our case. We didn't ask for more
7 information. But that doesn't mean that we were not aware that more information is
8 useful. For example, we asked for information about what's going on at the
9 detention centre. We actually particularly asked for information about events that
10 happened in this courtroom because we were aware that at times there were some
11 little difficulties here and there. I think there was ultimately recommendation of two
12 days, a break, and two days. And that came from a recommendation about some
13 observations that we had made. This was a communication that we were having
14 with the team. And I think the reasons for having that break was also partly based
15 on our findings and our interaction with the client that the client needed a break.
16 PRESIDING JUDGE SCHMITT: [13:30:15] But you did not have this information
17 specifically that is in the binder and of these 16 witnesses. You have I think
18 elaborated that already.
19 Now I think it's really, it was a long session -- only a short question. But the
20 question, it's not important how short the question is, if -- okay, please proceed.
21 MR GUMPERT: [13:30:39] (Microphone not activated)
22 PRESIDING JUDGE SCHMITT: [13:30:43] Only with microphone --
23 MR GUMPERT: [13:30:44] Sorry.
24 PRESIDING JUDGE SCHMITT: [13:30:46] -- it goes quickly.
25 MR GUMPERT: [13:30:48]

1 Q. [13:30:50] Professor Mezey told the Judges, it's transcript 163, page 86 for those
2 who need a reference, "... if we're talking about serious mental illness ... which would
3 include an inability to function as a soldier ... I would expect his comrades to pick up
4 on that ... to have noticed it and commented on it ... yet there is no comment at all
5 about anything that causes them concern or ... is suggestive of mental illness."
6 Would you agree with Professor Mezey?
7 A. [13:31:28] The definitions of serious mental illness or severe mental illness again
8 varies the world over. The common one, the common definition for severe mental
9 illness is schizophrenia, bipolar affective disorder and psychotic depression.
10 If we had the opportunity to -- it's an operational definition, so it varies. Some
11 people would add in substance misuse, some people would add in neurological
12 disorders, but usually it's going to be schizophrenia and bipolar as a given to some
13 psychotic depression.
14 So the use of the words "severe mental illness" or "serious mental disorders" again is
15 something that I would interpret with caution. If the patient was psychotic, if the
16 patient has bipolar affective disorder in the manic phase, it would have been easier
17 for people to see. If the patient was dissociating in the context of being spiritually
18 possessed in the context where everybody was controlled by the spirits, I wouldn't
19 expect that his colleagues would have figured that out.
20 If the context -- if the patients -- if the client was feeling sad, angry, isolated, guilty,
21 and suicidal in the context in which he's losing his comrades, in the context in which
22 he has gunshots wounds and recovering without antibiotics or painkillers, for that
23 matter, gruesome stuff, and that individual isolates themself, I don't think his
24 colleagues would have considered that as a mental illness. They would consider that
25 as a normal reaction to the challenges that they were going through at that particular

1 point in time.
2 Brings me back to the issue of objective assessment of mental illnesses as an important
3 aspect of making a diagnosis that can inform practice. Thank you.
4 PRESIDING JUDGE SCHMITT: [13:33:47] We have now the break until 2.30.
5 THE COURT USHER: [13:33:54] all rise.
6 (Recess taken at 1.34 p.m.)
7 (Upon resuming in open session at 2.32 p.m.)
8 THE COURT USHER: [14:32:27] All rise.
9 Please be seated.
10 PRESIDING JUDGE SCHMITT: [14:32:47] Good afternoon, everyone.
11 Mr Gumpert still has the floor.
12 MR GUMPERT: [14:33:02] (Microphone not activated)
13 Q. [14:33:08] Dr Ovuga, I want to ask you some questions -- sorry, Dr Akena, my
14 apologies. I want to ask you some questions about dissociative identity disorder.
15 And again, we can put the diagnostic criteria up on the screen on evidence 2. Two
16 are omitted, those are the two which I considered in general terms because they span
17 all three of the diseases you have spoken of.
18 I want to concentrate on A, "Disruption of identity characterised by two or more
19 distinct personality states, which may be described in some cultures as an experience
20 of possession."
21 Now, Doctor, you concluded that in Mr Ongwen's case, and I quote from your report,
22 last four digits 0971:
23 "These personalities were obvious ... to his colleagues who interpreted his behaviour
24 as being possessed by the spirit."
25 Now that was what Mr Ongwen told you. Can you take us to a specific account

1 from any of the people who you spoke to who talked about his having two distinct
2 personality states or about him being possessed? Is there any corroboration,
3 triangulation from sources, apart from your client?
4 A. [14:35:24] Regarding this one, no.
5 Q. [14:35:27] (Microphone not activated) And if I can invite you to go back to our
6 tab 14, the Prosecution tab 14, the extracts, I'm just going to use two of them, the first
7 is extract number 2, and this, as I understand it, is new information to you.
8 D-0027 was abducted as a boy at about the same time as Mr Ongwen. He knew him,
9 both before and after he became one of the bigger commanders in the LRA. He
10 recalled how Mr Ongwen, in his experience, "didn't change", the witness mentioned
11 that twice.
12 And I move to extract number 3, just immediately below, D-0056, another Defence
13 witness. He was under Mr Ongwen's command in the Oka battalion. He thought
14 that Mr Ongwen was a normal person and he never observed any change in his
15 personality.
16 Now, Doctor, what those two witnesses say doesn't sound like a description of a man
17 who is dissociating three times a week, with his body being taken over by
18 a completely different personality, does it?
19 A. [14:37:05] In the context in which the questions and the answers were got, again,
20 it doesn't. But I am not so sure whether this information was got for purposes of
21 a mental health assessment.
22 Q. [14:37:20] Well, Doctor, it wasn't, this was the sworn testimony of these
23 witnesses when they were asked, as generally as possible, to describe the kind of
24 person that Mr Ongwen was. So the floor was wide open for them, they could say
25 anything from their extensive experience. And we are concentrating here on

1 whether he had, as he told you, two completely different personalities. You would
2 expect them to mention something if that was in fact the case, wouldn't you?
3 A. [14:37:53] If they were trained medical personnel, yes. If they were mental
4 health specialists I would expect that they would have a different perspective. I'm
5 not sure they were.
6 Q. [14:38:04] Well, Doctor, they certainly weren't, but I just want to try and explore
7 that for a moment. Is it really your testimony that ordinary people, a person's wife,
8 a person's friends, a person's work colleagues won't notice if they have got these two
9 personalities, violent, abusive, angry on the one hand, Dominic B; and kind,
10 well-organised, sensible, a good planner, Dominic A. You'd expect people, even if
11 they are not doctors, to notice that, wouldn't you?
12 A. [14:38:45] If I were given the chance to ask them I would have no trouble
13 whatsoever figuring that out. I didn't get the chance to ask them that question.
14 However, let's try and go back to yesterday and get back to mental health literacy and
15 what in Africa is considered mental illness, disturbance in behaviour or not, and then
16 we compare and contrast that with what we see in the western hemisphere, in Europe,
17 in the US, in the far east of the Asian countries.
18 Individuals in different parts of the world are likely to perceive behaviours as normal
19 or abnormal based on their knowledge of what they see, what they expect, what they
20 have been brought up to know. Somewhere along the way, we were able to figure
21 out that this gentleman was angry, isolating himself, and wished death on himself.
22 Somewhere along the way, healthcare personnel within the detention centre were
23 able to figure that out.
24 Q. [14:40:03] But they figured it out from what he said to them, and to you, 13 years
25 later. I want you to concentrate on the evidence of what happened between 2002

1 and 2005. Nobody figured it out then, did they? They simply didn't notice this
2 kind of behaviour, which is the essence of dissociative identity disorder.
3 A. [14:40:34] There was no way they were going to figure it out if they were not
4 trained. You can't figure it out unless you're trained. I think we've, we have talked
5 about this, but I'm happy to talk about it again.
6 Q. [14:40:51] Well, let's not, I'll go on to another topic.
7 PRESIDING JUDGE SCHMITT: [14:40:56] Indeed.
8 MR GUMPERT: [14:40:57]
9 Q. [14:40:57] Post-traumatic stress disorder. And again, that's going to appear on
10 the screen, and I'm just concentrating here on the first, indeed, part of the first
11 diagnostic criterion.
12 Now, I accept that Mr Ongwen satisfies criterion A. I accept that he had exposure to
13 threatened death, serious injury, sexual violence. So I want to go straight to B.
14 You'd be looking for, in making such a diagnosis, evidence that during the relevant
15 time he had, one, recurrent involuntary and intrusive memories of the traumatic
16 events, wouldn't you?
17 A. [14:41:45] Yes, I would.
18 Q. [14:41:46] And I suggest there's a bit of a contradiction here. Part of your
19 diagnoses, whether as part of dissociative identity disorder or as a standalone
20 condition, dissociative amnesia, Mr Ongwen will not be able to recall things, because
21 he's dissociating and affected by amnesia. But this is a characteristic which is
22 running in exactly the opposite direction, isn't it, rather than not being able to
23 remember things, he's been constantly unhappily, unwillingly reminded of them?
24 That's right, isn't it?
25 A. [14:42:29] That's the beauty of mental health. That's the beauty of psychiatry,

1 that things contradict, and then we are trained to sort out those contradiction.
2 Indeed these things contradict, because I think earlier you were talking about
3 cognitive problems, indeed if somebody has cognitive issues, which we see in these
4 disorders, how would they even recall that they have intrusive memories? This
5 brings us back to the training of mental health, that we don't interpret signs and
6 symptoms of mental disorders, mental illnesses in isolation. We interpret them in
7 context. We interpret them as a whole. We use a diagnostic manual like the DSM
8 to guide us in that assessment. Once we see recurrent distressing dreams related to
9 traumatic events, that's the base upon which the clinical exam evolves.
10 It looks paradoxical, but actually it isn't, because it would be practically impossible to
11 make a diagnosis of a mental illness if indeed people couldn't remember what
12 happened to them.
13 But somehow we must do that and I think that's what our training equips us to do.
14 Q. [14:44:00] Can you take us to any part of your reports where Mr Ongwen
15 himself describes to you suffering from involuntary and intrusive memories during
16 the charged period or while he was in the bush at all? Can you take us to that part?
17 A. [14:44:23] I think the client describes a situation where he has never forgotten
18 whatever it is that happened to him in the first month of his abduction. He says this
19 is something that he has never forgotten, this is something that lives with him, this is
20 something that he remembers, almost on a daily basis.
21 I laboured to describe that act yesterday here. It's not pleasant whatsoever, and
22 somebody is living with it. I think if you asked him now he would still say he has it,
23 if you ask him tomorrow he would say he has it.
24 So, if we were to go by the criteria listed above, B1 is positive. He doesn't dream
25 about going to parties or enjoying himself. These dreams that he gets are dreams of

1 battles, dreams of running water in his head, dreams of colleagues getting shot,
2 dreams of people getting starved to death, dreams of being beaten up.
3 Q. [14:45:27] Doctor, that's now. I'm asking you about the period between 2002
4 and 2005. Can you take us to any part of any of your reports where even from
5 Mr Ongwen himself you get such information?
6 A. [14:45:49] Between the day he was abducted until the last day we saw him, he
7 had recurring involuntary intrusive memories of multiple traumatic events.
8 Q. [14:46:03] My question is if you can help us by taking us to a part of your report
9 where you describe that?
10 A. [14:46:09] And that period I think caters for 2002 and 2005, I would think so.
11 We describe that somewhere in our report about, about -- I don't remember exactly
12 where, but we said that -- I mean, what happened to you the first times you were
13 abducted? He described to us that -- I described it yesterday -- maybe not as we
14 wrote it, but he was clear that these things had never left his mind. So they were
15 there in 1986, '87, whatever time it was that he was taken up, until the time we have
16 seen him in the detention centre. And I think that period also includes 2002 and
17 2005.
18 MS LYONS: [14:46:56] Your Honour, if I may? I'm not trying to disrupt the
19 questioning. We actually did a search, because we have the reports with us and our
20 case manager did a search of the word intrusive, that information is available if it will
21 help in terms of the, the answers that (Overlapping speakers)
22 PRESIDING JUDGE SCHMITT: [14:47:15] Why not? Yes, please tell us. It's okay.
23 MS LYONS: [14:47:18] Okay. First, on the first report, it talks about intrusive
24 images. It's at UGA-D26-0015-0013, page 10, and it's under the post-traumatic stress
25 disorder. That's the first report from 2016 and that's at our tab 7. So you can

1 double-check it, but that's -- you can look.
2 And in the second report -- all right, on the second report, which is at tab -- at tab 8, if
3 you turn to the page ending 097, which is page 27, the entry on 31/11/2016, so it's
4 a second entry from 2016, the last line, he was "concerned with 'bad thoughts', which
5 were intrusive and unacceptable to him."
6 I don't --
7 PRESIDING JUDGE SCHMITT: [14:48:28] Okay. Thank you. I think we -- it's
8 very good that we get this information. I am quite sure, since it is on the record and
9 since it is part of the evidence of this witness that we would have discovered it
10 ourselves, but for the moment it's okay.
11 And I think, Mr Gumpert, you can simply move on from there. We can figure it out
12 what we do it with, we have now the reference here. It's easier to find for us, thank
13 you.
14 MR GUMPERT: [14:48:59]
15 Q. [14:48:59] Doctor, recurrent distressing dreams, B2, wouldn't you expect that at
16 least some of the women Mr Ongwen was sleeping with night by night would notice
17 that he was suffering from recurrent distressing dreams? That's -- you don't need to
18 be a doctor to become aware of that, do you?
19 A. [14:49:30] How would they notice that?
20 Q. [14:49:32] Well, they're sleeping in the same bed as him, that's the way they
21 would.
22 PRESIDING JUDGE SCHMITT: [14:49:37] Mr Witness, simply, it is absolutely
23 acceptable if you say --
24 THE WITNESS: [14:49:40] Yeah.
25 PRESIDING JUDGE SCHMITT: [14:49:40] -- no, no, they wouldn't. And then it's

1 okay and then we can move on.
2 THE WITNESS: [14:49:44] It's a strange question, Mr President.
3 PRESIDING JUDGE SCHMITT: Okay, but --
4 THE WITNESS: [14:49:47] Because, because, because -- because of two reasons: We
5 didn't ask for that question because we didn't have access to the people he says were
6 sleeping with Mr Ongwen in the same bed.
7 The time we had access to that person, she was in such a terrible, terrible
8 psychological distress, state, that we couldn't continue with the interview, we actually
9 terminated it. But again, this brings us back to the same thing, that the ideal thing
10 would have been to find out from them and just ask them about these dreams.
11 I don't know whether anybody asked them about the dreams, people who had access
12 to them, yeah.
13 PRESIDING JUDGE SCHMITT: [14:50:48] Mr Gumpert.
14 MR GUMPERT:
15 Q. [14:50:52] Just before I move on from PTSD, can we look please at diagnostic
16 criterion C: Avoidance, in a word.
17 There's again, I suggest, a contradiction here, isn't here? You suggest that
18 Mr Ongwen was compulsively attracted to battle, fighting and danger as part of his
19 OCD.
20 A. [14:51:28] Yes.
21 Q. [14:51:30] But the characteristics of somebody suffering from PTSD is that they
22 persistently avoid the stimuli such as battle, which caused them trauma in the first
23 place. Can you help us with that?
24 A. [14:51:51] I think the trauma that the client described that he was subjected to in
25 the first place was not related to battle. The trauma was related to skinning of

1 people alive, being forced to carry the heads of severed persons and dumping them
2 into a pit. Having the intestines of people hung up on walls. The trauma was
3 related to bludgeoning of little children who had tried to escape and had been
4 brought back. The events were bad. That was the context in which the traumatic
5 events happened. Unfortunately, we are unable to expose the client to these kinds of
6 events now and see whether it happens or not. It's not possible.
7 But, avoidance of efforts, you know, things that trigger memories of his life in the
8 bush happened. I think he describes how he was bewildered by, by fireworks and
9 he ran to the guards, he ran to the guards and told the guards that "I thought I'd
10 survived. I thought I'd escaped. What's going on here?" He had never heard or
11 seen fireworks in his life. The guards were laughing at him. The guards were
12 saying, "Ah come on, you know, these are just fireworks," but he said, "Those are
13 gunshots."
14 And he had to basically be calmed down. So I think somewhere along the way
15 somebody figured out that, you know, this young man wasn't joking.
16 So those are cues that would take him back to, to that kind of event, and these are
17 reminders of traumatic events, and you could safely say that the client would avoid
18 situations where there were fireworks or gunshots.
19 Q. [14:54:23] So, as you see it, is he traumatised by battle, by gunshots, or not? I
20 thought a moment ago you said not, that it was to do with the gruesome skinning
21 which you spoke of. What's your evidence, Doctor?
22 A. [14:54:42] He is traumatised by many things. As long as -- you see, the
23 traumatic event in PTSD settings may not be limited to, to one setting, but it's like
24 a cascade of events that leads to, to the eliciting of these symptoms. So, for him, the
25 gunshots would naturally just remind him of his life that side. Now once he got that

1 memory, everything else, you know, would start to fall in place and that would,

2 would lead to those kinds of things, yes.

3 But I get, I get, I get the question, that maybe it's not very clear how this is happening,

4 but I hope the explanation can, can help to clarify this.

5 Q. [14:55:38] Doctor, I can't answer that question. It's not much good expressing

6 that hope. It's for the Judges to decide.

7 Now I want to turn, please, to your report, which is at tab 7 of the binder which

8 Ms Lyons gave you. The bigger binder. The Defence binder.

9 PRESIDING JUDGE SCHMITT: [14:56:01] Which report of them?

10 MR GUMPERT: [14:56:04] It's got UGA-D26-0015-0004, tab 7.

11 Q. [14:56:20] And if we turn to page 0010, he told you there --

12 A. [14:56:36] Just a minute sir, sorry --

13 Q. [14:56:38] No, no, not at all. It's all right.

14 A. [14:56:38] -- I lost that bit. The report has 0154 through 0157?

15 Q. [14:56:48] Tab 7 --

16 A. [14:56:49] Yes.

17 Q. [14:56:50] -- Doctor.

18 A. [14:56:54] Oh, tab 7. Okay. Which page?

19 PRESIDING JUDGE SCHMITT: [14:56:56] It's your first big report from 2016, I think.

20 I think this might help you.

21 THE WITNESS: [14:57:02] Okay.

22 MR GUMPERT: [14:57:10]

23 Q. [14:57:11] And under the heading "Mr Ongwen's life and roles within the LRA"

24 you reported that he told you that while still a child, shortly after his own abduction,

25 he witnessed the killing of four boys who attempted to escape, and that later he

1 himself had had to participate in a reprisal attack on a village. And the conclusion
2 he had drawn, he told you, was that the LRA were killers but that he had to follow
3 their orders, otherwise he himself would be killed.
4 So, at this stage, while still a child, Mr Ongwen's account to you was that he was
5 capable of understanding that what the LRA were doing was wrong, yes?
6 A. [14:58:03] Yes.
7 Q. [14:58:03] And a little later on the same page you record him saying one of the
8 things he liked least in the bush was the atrocities. Again, that's a person drawing
9 moral conclusions about evil deeds, isn't it?
10 A. [14:58:25] I don't know how I would interpret that.
11 Q. [14:58:29] Well, I suggest it is. I'm going to move on.
12 On the next page, that's 0011, you record him saying that:
13 "Following his attainment of the highest possibly rank in the LRA, [he] began openly
14 to question the moral basis of the LRA war ..."
15 So now, at the opposite end of his career, senior officer, rather than little boy, he has
16 retained the ability to form moral conclusions, hasn't he, but he is now finally senior
17 enough to express it openly, his word, yes?
18 A. [14:59:16] Yes, I think he was a bit more at ease to express this. But, again,
19 some of it was -- he tells us that one time he argued with his boss. He told him off.
20 I don't remember exactly what it was. Then the boss joked and laughed and said this
21 man is mentally, he actually said the word mad. He doesn't fear death, he doesn't
22 know what's going to happen.
23 And since the boss could not believe that his orders would be questioned, so, yeah, so
24 these, these kinds of questioning of, of the orders happened.
25 Q. [15:00:23] So he clearly did understand the nature of his conduct. What he was

1 telling you was that at first he made a calculation, something like I don't want to see
2 and participate in any of this stuff, but if I'm going to stay alive I'm going to have to
3 go along with it. Yes?
4 A. [15:00:45] I don't think that changed till he left.
5 Q. [15:00:48] Well, by the time he was openly questioning Joseph Kony it had
6 changed, hadn't it?
7 A. [15:00:54] He said at that time he really didn't care whether he would be alive or
8 dead.
9 Q. [15:00:59] That may be so, but by the time he is able to say to Joseph Kony --
10 THE INTERPRETER: [15:01:03] Your Honour, could the counsel give some space
11 between the questioning and the answers for the interpretation to complete.
12 PRESIDING JUDGE SCHMITT: [15:01:15] Carried away, so to speak.
13 MR GUMPERT: [15:01:20]
14 Q. [15:01:22] A person who continues to be able to make that calculation, this is bad
15 stuff, but I need to keep my mouth shut, hasn't been brainwashed, as you put it, has
16 he?
17 A. [15:01:44] I think almost all the time in the immediate somebody needed to
18 survive, in the immediate. Meaning there was an order and, in the immediate, if you
19 didn't execute it you would be killed. But also, there, there are things that we
20 elicited from the client, things like the stone bomb project, things like the boss being
21 able to tell you and read your mind and know that you can escape. Things like the
22 spirit leading back escapees, things like violent spirits attacking them on spirit days.
23 Things like if you committed a certain crime you would be shot in that particular part,
24 during, during the war, or during battle. Things that when you assemble them
25 together point towards a deeply ingrained belief system that is contrary to what most

1 people would, would have if they were not there. And things that we tried to elicit
2 from the other captives as well, and we were able to identify them. At least from
3 two of the four people, they were able to clearly tell us about this, this period and
4 then the stone bomb projects and everything else. And, yeah, stuff like that, like
5 somebody would stand and then they would, they would shoot them with multiple
6 bullets but the bullets wouldn't pierce them, they wouldn't die.
7 These kinds of things are a bit difficult to explain in the context in which we currently
8 are in, and if you challenge them as a mental health careworker you don't dismiss
9 them, you just challenge them to make sure that they are firmly held belief systems
10 that are not shakable by reasoning and the social and cultural context in which the
11 person is living, then you have all reasons to believe them. And if you get these
12 kinds of information from one than one source, chances are that it's valid.
13 Q. [15:04:29] That was rather a long answer. You mean the chances are that it's
14 valid, true, that Joseph Kony could turn stones into bombs or that people would be
15 shot in the private parts if they'd had inappropriate sexual relations?
16 A. [15:04:41] Mm-hmm.
17 Q. [15:04:42] Is that what you're saying, the chances are that that's true?
18 A. [15:04:46] The chances are that that kind of information is shared by more than
19 one person and that the person is simply not telling you in your face at that time.
20 That is something that everybody else seems to believe in. Everybody else who was
21 abducted within a certain time frame believed in them, and this is information that
22 was given.
23 So we give -- so we ask, so we were a bit astounded by the fact that a pebble could fly
24 out of somebody's hands and go and cause damage somewhere. So we asked the
25 client, "So what happened exactly?" He tells us, "The pebble flew and went and

1 destroyed the railway line." So we ask him, "Ah-huh. So did you really go and see
2 it?" He said, "Yes, we did." "You saw a railway line that had been destroyed by the
3 pebbles?" He said, "Yes, we did see it." "So how did you know that it was the
4 pebble that flew from your hands that did that?" He said, "You don't joke with the
5 spirit, the spirit knows these things."
6 I don't know whether that is helpful.
7 Q. [15:05:51] No.
8 A. [15:05:53] Okay.
9 Q. [15:05:53] On page 0010, same report, it's at the top, Mr Ongwen told you about
10 an occasion when he refused an order from Joseph Kony to kill religious leaders and
11 elders during peace negotiations at a place called Garamba.
12 He was clearly indicating that at that, at that period - and the Court has heard
13 evidence about when it was - at that period he understood that killing those people
14 would be wrong and he had the power to refuse the order and he stayed alive. All
15 those things are true, aren't they?
16 A. [15:06:47] Yes, they are. I don't know what else happened to him after he
17 refused the order, but he stayed alive. Although, somewhere along the line, he had
18 to get 285 strokes of the cane for disobeying orders. So I don't know whether this
19 was accumulation of the denial of orders or whatever it was, I don't know.
20 Q. [15:07:14] You understand, Doctor, I am asking you about the evidence, in this
21 case the evidence from Mr Ongwen's own mouth about his ability to understand
22 what was right and wrong?
23 A. [15:07:27] Yes, I do.
24 Q. [15:07:28] And his ability to refuse orders to do the wrong thing, yes?
25 A. [15:07:33] And know the consequences.

1 Q. [15:07:35] So that's -- I'm not asking about what punishment there may have
2 been, other people perhaps have or can give evidence about that. I'm asking you
3 about your specialism. It clearly indicates, does it not, that he understood something
4 was wrong and was able to resist an order to do it?
5 A. [15:07:56] Yes, it does. Yes, it does. But, again, there are many other instances
6 where he had to simply obey the orders, like he told us. And I think these changes
7 kept on happening during the period in which he was there. We don't see any point
8 in time before what he described as his adult life where he questioned that. The only
9 time we see whether he made any questions to this was when he told us, I think the
10 year 1996 or something when he got some suicidal ideas, when he started to question
11 this. But then thereafter he just continued questioning and questioning and
12 questioning. But again, he would question some of the things, maybe not all of
13 them.
14 Q. [15:09:06] I want to turn now to tab 8 in the same binder, in other words, to the
15 next tab, the third of your four reports.
16 PRESIDING JUDGE SCHMITT: [15:09:14] 2018 report.
17 MR GUMPERT: [15:09:17] 28 June 2018, last four digits of the ERN 0948, that's the
18 cover page.
19 THE WITNESS: [15:09:26] Yes.
20 MR GUMPERT:
21 Q. [15:09:28] Now, this report was intended to be your last word in writing, wasn't
22 it? It dealt with the issues the Prosecution experts had raised, spelt out the reasons
23 for your diagnosis of the mental health conditions which you'd identified. Yes?
24 A. [15:09:47] Yes.
25 Q. [15:09:49] I want to deal firstly with major depressive disorder and I want to

1 start with now, with the time when you've met him. It's fair to say, isn't it, that
2 Mr Ongwen has got reasons to be depressed, he's accused of atrocious crimes, kept in
3 captivity far from his home, forced to obey the directions of the detention staff,
4 separated from all the people who have been his companions since he has been
5 a child, unable to watch his children grow up, he's gone from being a man with
6 multiple sexual partners (Redacted); so he's got reasons to be
7 depressed right now, hasn't he?
8 A. [15:10:41] Usually that's not the way we look at the reasons as to why people
9 have mental illnesses. We don't rely squarely on social and psychological
10 circumstances, otherwise if we had used the same analogy, then maybe everybody in
11 prison would be depressed, but that's not usually correct. However, these kinds of
12 reasons, these kinds of circumstances could be precipitating factors to people who are
13 maybe genetically predisposed.
14 Q. [15:11:17] But they wouldn't have anything to do with the decision the Judges
15 have to make about whether he was depressed 15 years ago?
16 A. [15:11:27] That is for the Judges, I think, to decide. I wouldn't decide on that.
17 I would just simply tell the Judges that the person has been depressed from period X
18 to period Y, and in between here they were depressed. Between here and there they
19 would ask me questions, I would respond, and then they would decide.
20 Q. [15:11:54] Playing devil's advocate for a moment, let's suppose that he was
21 suffering from major depressive disorder between July 2002 and July 2005.
22 The Prosecution expert, Dr Abbo, told the Court that the only commonly observed
23 connection that depression has with violence towards other people is where the
24 sufferer becomes so hopeless about the future that they decide before taking their
25 own lives to end those of their dependent loved ones because they don't want to leave

1 them in the world behind to suffer. And for reference purposes that's transcript 166,
2 page 31.
3 Would you agree with Dr Abbo's observation?
4 A. [15:12:47] It's a common phenomena in people with postpartum depression, that
5 mothers who are severely depressed would kill people, their children, to be precise,
6 and then commit suicide. But it also happens in adults who don't want to leave their
7 loved ones behind.
8 Q. [15:13:14] But her proposition is that's the only commonly observed connection
9 between depression and violence towards others. That's my question. Do you
10 agree?
11 A. [15:13:28] In medical practice we usually try to steer away from statements like
12 it is the only explanation to something.
13 Q. [15:13:38] And she didn't say that, she said that it was the only commonly
14 observed connection, she didn't say it was the only connection. So one last time, do
15 you agree?
16 A. [15:13:51] Even that one we would be cautious about using it. Let me just give
17 you an example, sir, of when a depressed person could end up doing whatever it is
18 that he did. Some people can have depression with psychotic features and they may
19 be thinking they are totally inadequate and everybody else around them is
20 inadequate. It's hypothetically possible that individuals who are depressed could
21 kill other people as well and the reason is not that they don't want to leave them
22 behind.
23 I think we see these kinds of things in people with PTSD, veterans and stuff like that.
24 They don't only kill because they wouldn't want to leave these people behind, but
25 there are many other reasons as to why a combatant could involve himself in such

1 a situation. It is common, yes, but perhaps not the only connection.
2 Q. [15:15:03] I want to turn next to PTSD, as you deal with it in this same report.
3 And in particular I want to ask you to look at page 0950, so that's page 3 of 36 in this
4 tab 8.
5 MS LYONS: [15:15:30] Your Honour, I just -- I just -- may I go back to the last one,
6 because our case manager looked at the quote, she says "most of the time". I don't
7 know if that makes a difference in the question that Mr Gumpert was asking. I
8 just -- we are just looking at the transcript here, I know you are done with the
9 question, but it's "most of the time".
10 PRESIDING JUDGE SCHMITT: [15:15:48] I think we -- do we have exactly the --
11 MS LYONS: I'm reading it.
12 PRESIDING JUDGE SCHMITT: -- the reference and then we can, we can
13 (Overlapping speakers)
14 MS LYONS: [15:15:56] (Overlapping speakers)
15 PRESIDING JUDGE SCHMITT: [15:15:57] We will of course read it later on.
16 MS LYONS: [15:15:59] Yes. Thank you. Page, page 36, line, line 23, "most of the
17 time it is the loved ones, the people they love, the people they have connections to."
18 The question before that is how -- at 21, "How common is it for a clinically depressed
19 individual to direct violence at strangers rather than loved ones?"
20 I just want to call this to the attention for a complete picture based on the transcript.
21 PRESIDING JUDGE SCHMITT: [15:16:28] It is noted.
22 THE WITNESS: [15:16:38] Mr President, may I just get back to that statement, one
23 minute?
24 PRESIDING JUDGE SCHMITT: Yes.
25 MR GUMPERT: [15:16:42] Your Honours, can I just observe, I made my best

1 estimates in terms of time on a reasonable basis of how long things would take,
2 there's a risk of derailment here.
3 PRESIDING JUDGE SCHMITT: [15:16:53] But nevertheless, when the witness wants
4 to clarify something, I think we should give him the time.
5 And you said one minute, so please, please. Yes.
6 THE WITNESS: [15:17:01] Yes, so one minute. So you may have people with what
7 we call a typical depression, they wouldn't necessarily present with sadness, but
8 instability and anger. In such situations, you could expect a homicide to happen.
9 Thank you.
10 PRESIDING JUDGE SCHMITT: [15:17:15] Thank you.
11 Please proceed, Mr Gumpert.
12 MR GUMPERT: [15:17:18] (Microphone not activated)
13 PRESIDING JUDGE SCHMITT: [15:17:19] And of course without microphone it
14 would even be more difficult to cope with the time.
15 MR GUMPERT: [15:17:27]
16 Q. [15:17:28] Six lines up from the page I have taken you to, 0950 on the bottom,
17 you say this:
18 "Structured rating scales to assess for symptoms was not preferred due to its
19 association with poor variability in responses, and performance bias ..."
20 Now, Doctor, you told us when Ms Lyons was asking you questions that the use of
21 structured rating scales is something in which you're something of a specialist, yes?
22 A. [15:18:05] I am a specialist in that area, to be precise.
23 Q. [15:18:08] Yes.
24 A. [15:18:08] Not just somehow, I am, yes.
25 Q. [15:18:12] And your particular specialism, because these are useful tools, is

1 enabling them to be used on the non-literate population. That's right, isn't it?
2 A. [15:18:26] Absolutely.
3 Q. [15:18:28] Can Mr Ongwen read and write?
4 A. [15:18:32] The first time that we saw him he would struggle with that, but I'm
5 not so sure whether he can do it now.
6 PRESIDING JUDGE SCHMITT: [15:18:40] So, because I am interested now, does it
7 suggest that he made improvements during the period you, you observed him in that
8 regard, or is this a wrong perception?
9 THE WITNESS: [15:18:55] He was, he was able to speak English with us better, he
10 was able to, so. He was taking English lessons. So I, I really don't know how his
11 literacy went on and on (Overlapping speakers)
12 PRESIDING JUDGE SCHMITT: [15:19:07] Of course, the language issue is
13 something a little bit different from literacy.
14 THE WITNESS: [15:19:12] Yes.
15 PRESIDING JUDGE SCHMITT: [15:19:14] Please, Mr Gumpert.
16 MR GUMPERT:
17 Q. [15:19:19] CAPS, C-A-P-S, stands for Clinician-Administered PTSD Scale,
18 doesn't it?
19 A. [15:19:27] Developed by the VA of the United States for purposes of making
20 diagnosis and rating severity of PTSD symptoms.
21 Q. [15:19:36] It's often said, isn't it, that CAPS is regarded as the gold standard in
22 the diagnosis of PTSD?
23 A. [15:19:48] Other people would also say the LEADs, which is Longitudinal
24 Examination and Assessment of Disorders over a certain period of time, so the
25 diagnosis of mental illnesses, what a gold standard is and what a gold standard is not

1 may differ depending on context.

2 Q. [15:20:08] Well, what do you think, Doctor, is CAPS is useful tool?

3 A. [15:20:13] It is, sir.

4 Q. [15:20:13] Yes.

5 A. [15:20:13] It is a useful tool.

6 Q. [15:20:15] There's even an international version of that scale known as the CIDI

7 which has been designed by the World Health Organisation for what you might call

8 non-American contexts, yes?

9 A. [15:20:34] Designed for use in populations.

10 MS LYONS: [15:20:40] (Overlapping speakers)

11 MR GUMPERT: [15:20:40]

12 Q. [15:20:40] But you -- oh, please.

13 MS LYONS: [15:20:42] This is not about the questions. It's a Prosecution email

14 that's showing up on the evidence channel, I'm sorry. (Overlapping speakers)

15 PRESIDING JUDGE SCHMITT: [15:20:50] This might be the reason why I wanted

16 also to intervene now, because I hear strange noise in my ears.

17 MS LYONS: [15:20:59] I don't know, I can't read it. But that's what I'm told it. So I

18 just think -- I'm sorry (Overlapping speakers)

19 PRESIDING JUDGE SCHMITT: [15:21:02] No, no, no. No, you don't have to be

20 sorry. I also would prefer not to have additional noise in my ears, except of the

21 people speaking here in the courtroom.

22 MR GUMPERT: [15:21:20]

23 Q. [15:21:21] But you reject the use of this scale because you think the results are

24 not reliable, the questions too suggestive and the responses variable. Have you

25 actually done any formal research on that?

1 A. [15:21:35] Reject the use of the scales is a very strong word.
2 Q. [15:21:38] Well, you say --
3 A. [15:21:41] But we had, we had the opportunity, Mr Gumpert, we had the
4 opportunity to interact with the client on a face-to-face basis, which we did. We
5 insist that a clinical diagnostic exam between a mental healthcare worker and a client
6 is good enough to get the information that you need. We had the opportunities to
7 use the same instruments that you are talking about. We are pointing out that some
8 of those instruments have weaknesses.
9 Q. [15:22:18] The fact that some of them have weaknesses, when you know there is
10 a head-on dispute about whether your client is suffering from this disease or not, can't
11 be a reason, can it, for not using this scale?
12 A. [15:22:44] The use of instruments or scales in mental health is not independent
13 or made to substitute a clinical exam. We don't use scales because we have failed to
14 understand the context we -- or the diagnosis, or whatever it is. At the end of the
15 day, a scale is administered by somebody to a participant. Some of them are
16 self-administered, some of them are clinician administered, the CAPS is clinician
17 administered, trained clinician administered.
18 The question I would ask myself, if I can sit and talk to the client and ask questions
19 and interrogate these questions and get answers, what other benefit do I get from
20 using the scale in doing this? That's a question many, many healthcare workers ask
21 themselves.
22 Q. [15:23:47] Well let me suggest the answer so that you can comment upon it: It
23 is so that you can achieve something which Professor Mezey called triangulation, so
24 that to complement, to test the information which you are getting from the client, you
25 have some objective information alongside, perhaps, the corroborative material we've

1 spoken about earlier. That's the reason why you would want to do it, isn't it?
2 A. [15:24:20] Question number 1 on the PHQ-9, and question number 2, I think, go
3 like: Have you felt sad, lost interest in pleasurable things -- I mean, pleasurable
4 activities? Have you felt sad? Have you lost interest? I think that's 1 and 2.
5 Question number 1 and question number 2 in the DSM diagnostic criteria for
6 depression go along the same lines: Have you lost interest? Do you feel sad?
7 The diagnostic criteria for the DSM-5 for PTSD and the CAPS for the PTSD ask the
8 same questions. How one would ask those questions in a clinical exam with a client
9 and ask the same questions with a rating scale and get different answers defeats all
10 possible logic in mental health.
11 Q. [15:25:31] So your position is that provided you have got good access to a client
12 and can conduct a clinical examination, CAPS is effectively useless and you don't use
13 it; is that it?
14 A. [15:25:49] There are two types of instruments or scales that we use in
15 psychiatry -- three: There are screening instruments like -- so you give that to
16 members of the general population to find out whether they have your outcome of
17 interest, like the PTSDSC, which is actually part of the CAPS, five questions.
18 A person scores three, you administer the diagnostic criteria.
19 There are diagnostic instruments that we use in psychiatry, like the SCID, like the
20 MINI, like the scan, like the DSM-based diagnostic criteria. Then we have rating
21 scales to rate how severe a disorder is.
22 The use of rating scales or screening instruments or psychometrics varies according to
23 the context. We were looking for a diagnosis of a mental illness, which we did. We
24 could have administered the suicide scale that Professor Ovuga has, we could have
25 administered the visual scale that I have. They are screening instruments. We were

1 not screening for a mental disorder, we were making a diagnosis.
2 You use instrument based on whatever it is that you are looking for, the outcome of
3 interest. If you're in a research setting and you want to know whether medication X
4 or Y works better than placebo, you use a rating scale to see how severe the disorders
5 are and then you see what happens after a certain period of time.
6 If you are looking for mental illnesses in the population, you use screening
7 instruments to see how many people have this disorder.
8 If you are using instruments in a clinical setting, you use diagnostic instruments to
9 make sure that you confirm the diagnosis.
10 It is not entirely correct that the fact that you haven't used the scale means that it is
11 useless. That's not true. It is just that the context in which you need to use it needs
12 to be informed by science.
13 I hope this helps. You know, this issue about the scales keeps on coming up
14 repeatedly, but the three things need to be put into context; screening, diagnosis,
15 rating severity of symptoms. We were doing a diagnostic assessment for a mental
16 illness. We were not screening, we were not rating. Why? Why were we not
17 rating severity of symptoms? Because we were not the primary caregivers. The
18 individuals in the detention centre would have administered rating symptoms -- I
19 mean, rating scales to assess severity of symptoms and they would have used that to
20 know whether whatever it is that they were giving the client was working or not. So
21 they would have administered the Ham-D for example, and known what would have
22 happened to depression scores along the way.
23 PRESIDING JUDGE SCHMITT: [15:29:29] I think, Mr Gumpert, you can move to the
24 next point.
25 MR GUMPERT: [15:29:33] (Microphone not activated) I am going to ask one last

1 question.
2 Q. [15:29:41] Have you expressed what you have just said about how you think it's
3 perfectly proper clinical practice when dealing with a diagnosis of PTSD not to use
4 the CAPS, the gold standard, or some other similar psychometric test, rating scale?
5 Is that something you have written about?
6 A. [15:30:06] I thought we just talked about when we use rating scales, sir.
7 Q. [15:30:11] Yes. I am asking you about what you have written about, Doctor?
8 A. [15:30:14] I thought we just said that we were making a diagnosis.
9 PRESIDING JUDGE SCHMITT: [15:30:18] Please move on, Mr Gumpert.
10 THE WITNESS: [15:30:20] I think, I think, yeah, that's what we did. I'm just
11 reporting what we did.
12 MR GUMPERT: [15:30:25]
13 Q. [15:30:25] Yes. I'm not asking you about that, but I'll move on.
14 Can you turn to the page 0972; 0971 and 0972 are your multi-axial diagnosis table.
15 And if we look -- I am still on PTSD -- you can see that that starts at the bottom of the
16 left-hand page and goes on to the top of the right-hand page.
17 You can see that, can't you, Doctor?
18 A. [15:31:13] I can.
19 Q. [15:31:16] There are two diagnostic criteria which are missing here, aren't there?
20 Diagnostic criterion D, the criterion concerned with cognition, mental functions such
21 as memory, attention, processing information; and diagnostic criterion G, the element
22 which deals with how your PTSD affects your ability to do your job, socialise with
23 your friends and play a proper role in your family. Isn't the difficulty with not using
24 the commonly accepted rating scales that you tend not to cover all the bases?
25 A. [15:32:08] Again, to come up with this diagnosis, we used a clinical interview,

1 diagnostic clinical interview, not rating scales.
2 You can't use a rating scale to make a diagnosis, Mr Gumpert. I think this needs to
3 be clarified. You don't use rating scales to make a diagnosis, you don't use screening
4 instruments to make a diagnosis.
5 Q. [15:32:33] Doctor, I hear you. The question is: Why does your multi-axial
6 diagnosis concerning PTSD not deal with criteria D, cognition, and G, ability to
7 function? Why have you left those criteria out?
8 A. [15:32:51] I think we captured ability to function somewhere else. I don't
9 remember. And those disorders, those symptoms were sufficient to make a clinical
10 diagnosis at that point in time. This may have been an omission somewhere, but I
11 think if we look deep down our notes we should be able to find this out.
12 Q. [15:33:15] Doctor, I'm asking you about your report, your last word to this Court.
13 How is it that you have failed to address the very question of his ability to function,
14 which I suggest you must realise is at the heart of the evidence you're giving? How
15 is it you have just missed it out?
16 A. [15:33:46] I think that information is somewhere, I just am -- I am not sure where
17 it is, but the information of functioning is somewhere, either implied or stated. I
18 may not be able to find it here, but ...
19 PRESIDING JUDGE SCHMITT: [15:34:06] Let's put it we have it somewhere in the
20 report.
21 MS LYONS: [15:34:11] Yes.
22 PRESIDING JUDGE SCHMITT: [15:34:12] I simply, for the record -- let me do it,
23 Ms Lyons.
24 MS LYONS: [15:34:15] We have it.
25 PRESIDING JUDGE SCHMITT: [15:34:16] It's on page 4 of the report where it is

1 addressed in a more generic manner, so to speak, but nevertheless.
2 And be assured that the Chamber is aware of everything what is written down here
3 and what is being said yesterday and today in the courtroom.
4 So this would be, for the record, the same UGA number and the end number is 0951,
5 and there at the end it is addressed. And how it is addressed and how this has to be
6 put into perspective with everything else is, like I say hundreds of times in this
7 courtroom, is in the end to be assessed by the Chamber.
8 Mr Gumpert, you can move on.
9 MR GUMPERT: [15:35:05] (Microphone not activated)
10 PRESIDING JUDGE SCHMITT: [15:35:08] And again with the microphone.
11 I think now, like I have already done several time with Mr Bajnovic for Ms Lyons and
12 for the Defence, Ms Gilg is now mandated to observe the microphone for
13 Mr Gumpert.
14 MR GUMPERT: [15:35:32] She's on it.
15 Q. [15:35:34] As I said a moment ago, I don't dispute the possibility, perhaps even
16 the likelihood, that Mr Ongwen has been exposed to traumatic events. But the Court
17 heard evidence from Professor Mezey, that's at transcript 163, that only about
18 10 per cent of individuals who are exposed to such trauma develop the condition.
19 Would you agree with that, in broad terms?
20 A. [15:36:06] Ten per cent, is there a reference to that?
21 Q. [15:36:10] That was Professor Mezey's evidence. The question is --
22 PRESIDING JUDGE SCHMITT: [15:36:13] You can simply comment on that. What
23 do you think about it?
24 THE WITNESS: [15:36:17] I don't know. I need reference. I don't know,
25 10 per cent --

1 PRESIDING JUDGE SCHMITT: [15:36:23] No, would you -- no, from your
2 professional perspective, would you say does this sound adequate, okay to you, or
3 would you say this, from your professional expertise, this is something you would
4 not agree upon?
5 THE WITNESS: [15:36:39] I know that not everybody who gets traumatised
6 develops PTSD, I just don't know the percentage. But I don't know whether
7 10 per cent or 90 per cent is, is strange or adequate.
8 PRESIDING JUDGE SCHMITT: Fair enough.
9 MR GUMPERT:
10 Q. [15:36:53] Professor Wessells, and Ms Lyons referred you to the professor's
11 evidence, at transcript 176 told us that perhaps a third of formally abducted children
12 show symptoms of PTSD but not necessarily the full diagnosis. And
13 Professor Wessells suggested that's because they are not simply passive recipients of
14 violence and trauma but they're active agents who engage with their adversity and
15 find ways of coping with it. Would you agree with Professor Wessells?
16 A. [15:37:33] This statement has two constructs. The first one is that a certain
17 percentage of people have PTSD symptoms, and then the second construct is that the
18 reason for them not developing the PTSD is because they are perpetrators and not
19 victims. So I don't know which one to agree with, both or one.
20 Q. [15:37:54] That's not what the professor said?
21 A. [15:37:57] I am just paraphrasing because I couldn't recall everything
22 (Overlapping speakers)
23 Q. [15:38:01] All right. My apologies. My fault. I'll break it down. Number
24 one, perhaps a third of formally abducted children show symptoms of PTSD, not
25 necessarily the full diagnosis. Do you agree or disagree?

1 A. [15:38:17] Maybe more than that, because 10 per cent, generally about
2 10 per cent of the population has PTSD symptoms, normal general population,
3 population prevalence. So 30 per cent, which is a third is, I think that's good enough,
4 fair.
5 Q. [15:38:31] So broadly you agree. And the second proposition: The majority of
6 formally abducted children don't develop symptoms of PTSD because they're not
7 simply passive recipients of violence and trauma but they engage with their
8 adversity -- not they commit crimes, they engage with their adversity and find ways
9 of coping with it. Agree or disagree?
10 A. [15:38:58] There's a causation effect there. There's an association between
11 developing PTSD and interaction with the people described. I'm cautious in making
12 comments about things that cause mental illnesses, if that cause or prevent it, unless
13 they're in structured environments. But I'm a bit cautious about that second part of
14 the statement, not that I disagree or disagree, but I'm just cautious about it.
15 Q. [15:39:37] And lastly on the subject of PTSD I want to touch on appetitive
16 aggression. And I thread carefully here. As I understand it, this is an expression
17 coined in a paper written by two German researchers, Professor Elbert and, as he now
18 is, Professor Weierstall, who sits just to your right. And you refer to their paper in
19 your bibliography, don't you?
20 A. [15:40:08] Yes, we do.
21 Q. [15:40:09] I want to clear up any misunderstanding about what it is, and I will
22 use the expression which Professor Weierstall -- sorry, the explanation which
23 Professor Weierstall himself gave in his testimony back of April of last year.
24 Some people, he explained, react to traumatic events to which they have been
25 exposed or in which they have participated by developing symptoms of PTSD. They

1 have intrusive flashbacks, disturbed sleep, their memory is affected, they dissociate.
2 But other people process this violence, this trauma, by finding it appealing or
3 arousing, they gain an appetite for it, and those people suffer less or not at all from
4 the symptoms of PTSD.
5 Is that your understanding of appetitive aggression?
6 A. [15:41:16] That's what my colleague says. That's his research, that's his work,
7 that's his area of expertise. Yes, I do.
8 Q. [15:41:27] Thank you.
9 I want to turn now to dissociative identity disorder.
10 Now, when you interviewed him for this report in April 2018, and that's just a few
11 days after Professor Weierstall had testified, Mr Ongwen told you that in the bush he
12 was aware of two personalities within his body, Dominic A and Dominic B.
13 And he told you that he'd had many episodes of this phenomenon in a week,
14 although sometimes none at all for several weeks together. So it was a fluctuating
15 condition. That's a fair summary of what he told you, isn't it?
16 A. [15:42:15] Yes, it is.
17 Q. [15:42:17] And elsewhere in the report you recorded that he reported
18 dissociating two or three times a month, but there were sometimes breaks in these
19 episodes of between two or three months, yes?
20 A. [15:42:31] That's correct.
21 Q. [15:42:32] And he told you that his alter ego, Dominic B, first appeared in 1997,
22 but that by the charged period -- and you actually spelt it out in your report,
23 2002-2005, Dominic B was appearing two to three times a week, sometimes daily, yes?
24 A. [15:42:57] That's correct.
25 Q. [15:42:59] He also reported that on one occasion in the bush he'd actually seen

1 two versions of himself, one with "Dominic A" written on his uniform and one with
2 "Dominic B". That's what he told you, isn't it?
3 A. [15:43:17] Yes, that's what he told us.
4 Q. [15:43:18] And he told you, still in the bush, that Dominic A and Dominic B used
5 to fight over control of his body, yes?
6 A. [15:43:29] Mm-hmm.
7 Q. [15:43:32] Let's just contrast that with what he told you on previous occasions
8 two years earlier, in 2016. That's the report at tab 7.
9 PRESIDING JUDGE SCHMITT: [15:43:55] Can you please give us the exact
10 reference?
11 MR GUMPERT: [15:43:58] Yes. It's 0008. In other words, page 5 of 20.
12 Q. [15:44:11] And under the heading "Dissociative disorder" you summarised the
13 account he gave you at that time, two years earlier. His first experience of
14 dissociation, he told you, was in 1989, and between that time and 2014 he experienced
15 up to eight episodes of altered mental state. And there was no mention at all by him
16 at this stage of a second personality, no mention of Dominic B, no account of
17 occasions when he saw both personalities in the same place. It was a very different
18 account which he gave you on those two occasions, wasn't it?
19 A. [15:45:01] It was. And the reason was that this information became more
20 apparent and more clear with time. And that's why we had to report it the next time
21 around.
22 Q. [15:45:25] But what I'm having a little difficulty with, Dr Akena --
23 A. [15:45:30] Yes, sir.
24 Q. [15:45:33] -- is your report in 2018, it's at page 0974. It's about eight or nine
25 lines down from the top:

1 "... the narratives of Mr Ongwen have been consistent between the two visits we
2 jointly made to interview him in 2016 and 2018 ..."
3 We have just seen that that isn't true, haven't we, Doctor?
4 A. [15:46:13] I think we have seen that there is a narrative about depressive illness,
5 there is a narrative about suicide, there is a narrative about PTSD symptoms. We got
6 new information about dissociation later on. So you could say there is consistency
7 about the three, but there is new information that came up later.
8 Q. [15:46:43] So this doesn't strike you at all in retrospect, this assertion of
9 consistency, as being something you'd want to revisit or something which was wrong.
10 Doesn't strike you that way at all as you read it now?
11 A. [15:46:58] No normal clinical practice it wouldn't, because that would be what
12 people actually get. In normal clinical practice, in normal interactions with
13 individuals who have mental illnesses, you keep on building on to information, you
14 keep on getting new information. You keep on refining your diagnosis, you keep on
15 confirming the hypothesis or rejecting it. That's what happens in normal clinical
16 practice; symptoms fluctuate, patients get better, sometimes they get worse,
17 medicines work, they don't. You revisit your notes, you read some of the things that
18 the patients told you, and then you realise you should have asked it differently. You
19 go back and ask that question.
20 That's why doctors ask us to come back for review, and then they interview us again,
21 and it seems they are asking the same questions. But you get information based on
22 that. And we did exactly that, we looked at our information and we said we needed
23 to ask more information along these lines. And that's what we did.
24 Q. [15:48:23] You knew that there had been extensive discussion concerning
25 dissociative identity disorder during the testimony of the Prosecution experts which

1 had concluded just a few days before your visit, didn't you?
2 A. [15:48:40] We knew there were many discussions, yes. I don't know whether
3 we knew particularly that that was one of the things that was talked about, but we
4 knew that the issue of the client's mental health had been extensively discussed in this,
5 in this, in this setting.
6 Q. [15:48:58] Doctor, didn't you read the transcripts of that evidence of
7 the Prosecution experts?
8 A. [15:49:07] Before the interview with the client?
9 Q. [15:49:10] Well, have you ever read it?
10 A. [15:49:16] Yes, but I think it was much, much later.
11 Q. [15:49:20] So --
12 PRESIDING JUDGE SCHMITT: [15:49:21] Have you read it before you made the
13 second report?
14 THE WITNESS: [15:49:25] No, I don't think so. I don't think we had that
15 information (Overlapping speakers).
16 PRESIDING JUDGE SCHMITT: [15:49:30] Okay. Please proceed.
17 MR GUMPERT:
18 Q. [15:49:33] I'm sorry, I want to pick up. You say "I don't think we had that
19 information" as though you were a sort of helpless person. Did you ask for it?
20 A. [15:49:45] You see, we, we kept on asking the team about information that
21 would help us to make a diagnosis from our side. We knew that when, when
22 sessions are going on there are many things that are happening. But we, we just
23 asked for collateral history, we asked for more time with the client. Those are the
24 things that we kept on asking for; we needed more time with the client. And I think
25 somewhere in our limitations we also stated clearly that much as we saw the client

1 over four times -- I mean, over four sessions, we still believe that it would have been
2 better if we had more time. But, again, the practicality of that doesn't, doesn't work
3 because we couldn't see him every day for a long time.
4 So the information, the consistent information we kept on asking for the team was we
5 need more time with the client and we need to, as much as possible, get collateral
6 history.
7 Q. [15:50:47] Did it occur to you that this change, this inconsistency in what
8 Mr Ongwen was telling you might be more to do with the evidence which he had
9 heard from the Prosecution witnesses and less to do with it being a truthful account?
10 A. [15:51:12] No, it did not occur to us that way. We had no reason to believe that
11 that was the case.
12 Q. [15:51:20] Well, let's just tackle that for a moment, Doctor. As a forensic
13 psychiatrist, when a man is on trial for dreadful crimes and he's putting up a mental
14 health defence, there's always a reason why somebody might be seeking to exaggerate
15 their symptoms, isn't there? That's just commonsense.
16 A. [15:51:44] Yes, it is.
17 Q. [15:51:45] But, in fact, I suggest that not only did you have a reason but you
18 actually did ask him about it.
19 Can we go to 0955 in this report which is at tab 8. It's page 8 of 36. You see the
20 second paragraph:
21 "We challenged Mr Ongwen multiple times to ensure that his experiences were not
22 simply fantasy."
23 So it did occur to you that what he was telling you might not be accurate, and you
24 asked him about it, yes?
25 A. [15:52:46] Usually when clients tell you something like that, you need to be sure

1 that what they are telling you is actually correct.
2 When the client brought to our attention two Dominics in him, the left side of the
3 brain and the right side of the brain, it was we just needed to be sure that we were
4 dealing with proper information.
5 And that's what happens in clinical practice all the time. We get these kinds of
6 things, people tell you all sorts of things. Bizarre delusions, for example, you must
7 prove that this is the case. And consistent probing, asking the same question in
8 different ways is one of the methods that we use to arrive at that conclusion, yes.
9 Q. [15:53:51] Well, let's just examine the nature of your challenge. You report
10 three different methods in that same paragraph. Firstly, you told Mr Ongwen that it
11 was dangerous and unhelpful for him not to pay attention during court sessions
12 because he wouldn't be able to instruct his lawyers.
13 Now, the problem you were dealing here with was the possibility that what he was
14 telling you was fantasy, to use your words. How was that, that warning about the
15 danger of not paying attention, any kind of challenge to the possibility that he was
16 telling you things which weren't right?
17 A. [15:54:44] I remember us telling the client very, very explicitly that, if you don't
18 pay attention in court and things are read out and charges are brought up against you,
19 and evidence is brought up against you and you can't tell your lawyers about that,
20 you're going to prison for a very long time. If you don't -- if you're unable to follow
21 proceedings in court, that's dangerous to yourself because you're not in control
22 anymore, and if you're not in control then you're in trouble.
23 Indeed, if this was a fantasy, the thought would have quickly dissipated because the
24 client would have quickly realised, that, "Oh, my goodness, I'm in trouble here." So
25 we put it to him very, very clearly that if you don't understand what is going on in

1 the court, the trouble that results from that can be gross and severe.
2 PRESIDING JUDGE SCHMITT: [15:55:50] Please, please move on, Mr Gumpert.
3 MR GUMPERT: [15:55:53]
4 Q. [15:55:53] Your second challenge was to tell him that these acts of dissociation
5 could harm him. That wasn't a challenge at all, was it? That was a warning that if
6 what he was saying was right, it would be bad for him. But it wasn't a probe, as you
7 put it a moment ago, to see if he was telling you the truth, in any way, was it?
8 A. [15:56:23] The clients were supposed to be having meat, or something like that,
9 only when their visitors come or something, some special diets. One particular day
10 a certain client went and picked something from the fridge and the client told us he
11 was playing the piano and asked his fellow detainee why he was picking that thing
12 from the fridge. At that point he dissociated, there were two personalities. He
13 went up to this fellow detainee, grabbed him by the neck and I think pinned up
14 against the wall. It was a violent altercation. The guards were called in and they
15 were separated.
16 We told him that if this kind of activity goes on, you may end up harming yourself,
17 being harmed, or something terrible happening to you. Because if you are going to
18 be ending up in a physical fight, the chances are nobody knows what happens to you.
19 That is how we came up with that statement. The example was something that
20 happened in the detention centre and then he ended up like in that situation.
21 He also told us that he would have trouble knowing whether to eat or not when the
22 two personalities were conflicting. And once that happened, he goes without food.
23 That's a danger to self. When you bring up two of those examples to somebody and
24 that person is simply fantasising, you don't expect that fantasy to last long.
25 Q. [15:58:56] Not even if it's a fantasy that he hopes will get him found not guilty?

1 A. [15:59:04] He didn't indicate to us that. I'm not aware about that.
2 Q. [15:59:08] Well, if this was such a fantasy, of course he wouldn't indicate that to
3 you, would he, because then he'd have given the game away, Doctor?
4 A. [15:59:16] You see, the two personalities that we see now had been there for
5 a while, the possession by spirits and everything else that was associated with it.
6 Everything else -- well, there was evidence pointing towards that direction. Again,
7 I'm not aware, to the best of our knowledge, that we had alerted the client to that fact
8 in any way, because we were just simply interacting with him and getting
9 information that was going to be useful for his -- for coming up with a diagnosis.
10 Q. [15:59:58] And the third way in which you told the Court in your report that
11 you challenged this possibility of it being a fantasy was by telling him that he should
12 try to fight Dominic B. Well, that wasn't a challenge at all, was it, it was an
13 acceptance that Dominic B existed; isn't that right?
14 A. [16:00:19] When we are dealing with individuals with conversion disorders, we
15 know that such individuals are highly suggestible.
16 When you're treating somebody with a conversion disorder, somebody who says they
17 are blind, somebody who says they are lame, somebody who is having
18 pseudoseizures, we use the exact same technique. Usually it works in such
19 situations. It's a clinical skill that you get as a means of treating individuals with
20 such forms of psychogenic seizures and these kinds of things.
21 So if you put it to the client explicitly to try hard enough to challenge one of the two
22 personalities, and the client shot back at us and said, "I don't like these things. I also
23 want to be normal like you people. I don't like being tired. I don't like the fact that
24 I sleep two hours in the night. I don't like that I have to deal with two people who
25 I don't know fighting over my body. They make me weak. When they are fighting

1 I can't play football. I can't enjoy myself. I don't like this." I think that was
2 sufficient for us to be able to figure out that this was a core symptom of one of the
3 problems that the client was facing.
4 Q. [16:02:06] What about challenging him by asking him why he hadn't told you all
5 of this two years before?
6 A. [16:02:18] Ideally, he should have challenged us instead and asked us why we
7 had not asked this two years ago, because what's what my patients tell me. My
8 patients tell me, "Doctor, how come you did not figure out that I was depressed?
9 You just figured out that I have schizophrenia, what happened?"
10 We couldn't ask him that question. We didn't expect him. Ideally he should have
11 asked us that question himself, because in normal clinical practice that is the reverse
12 of what happens. The client instead and their loved one asks you, "How come you
13 didn't discover this in the beginning? How come you're discovering it now?"
14 That's how clinical practice works, that's how clinical exams work, that's how clinical
15 interviews work, you discover something down the line. Sometimes you actually
16 get blamed for that, by yourself, by your colleagues, they say "How could you have
17 missed this in the beginning?"
18 Q. [16:03:27] Well, if the answer is because the client isn't telling you something
19 two years previously, the answer you'd give is pretty obvious, isn't it, Doctor?
20 Because you've concealed information from us. Wouldn't that be the answer you'd
21 give?
22 A. [16:03:45] That's a hypothetical situation that really doesn't arise in clinical
23 practice.
24 Q. [16:03:49] Very well. Let me suggest another challenge: Did you ask him to
25 name anybody, perhaps one of the women in his household, so that you could talk to

1 them to get confirmation of these disassociations happening many times a week?
2 Did you do that?
3 A. [16:04:15] We didn't look for collateral history after 2018.
4 Q. [16:04:24] He himself --
5 A. [16:04:25] It would have been ideal to ask those questions, actually, in hindsight.
6 If it was logistically possible to identify individuals who had been with him and ask
7 the specific questions, in hindsight.
8 Q. [16:04:43] He himself actually named someone. And this is on 0953. For
9 safety's sake I won't give the name. Can you go down from the top, six lines. We'll
10 call him "Person X", "Mr X". Can you see that name there, Doctor?
11 A. [16:05:19] 05 what? 095?
12 Q. [16:05:22] 0953, six lines down, words two, three and four in the line. I am
13 going to call him Mr X.
14 A. [16:05:31] Yes.
15 Q. [16:05:31] Yes. All right. So he actually names someone that he said had
16 witnessed an episode of dissociation, yes?
17 A. [16:05:41] Yes, he does.
18 Q. [16:05:42] Yes. Did you make any enquiries with Mr Ongwen's lawyers to see
19 if you could speak to this person about this episode?
20 A. [16:05:54] We didn't. But the reason we put people's names in our reports is
21 actually meant to be able to get this information at the appropriate time. Again, we
22 were aware of someone of the logistical challenges in trying to identify these
23 individuals. For example, the people we saw first were not the people we had asked
24 to see, the people we had asked to see were nowhere to be seen.
25 Q. [16:06:31] Let's just concentrate on this person. Did you ask whether in fact he

1 was a witness in the case? Whether there was no logistical difficulty. Did you ask
2 that?
3 A. [16:06:45] There are some questions that doctors ask, there are some questions
4 that lawyers ask. I think if I were a lawyer I would have asked that question.
5 I didn't ask.
6 Q. [16:06:56] But, Doctor, your -- sorry, that was too fast.
7 A. [16:06:59] I didn't ask.
8 Q. [16:07:00] But, Doctor, I want to explore that, your duty here is to proceed
9 forensically, yes? You're trying to help the Court to establish whether there is
10 evidence of psychiatric illness which may have destroyed certain of Mr Ongwen's
11 functions. He's told you now, long and wide, that there is, that there was. As
12 a forensic practitioner, you needed to examine that critically, and one way you could
13 do it was by getting corroborative or non-corroborative evidence, wasn't it? That
14 was a duty on you as a forensic practitioner?
15 A. [16:07:43] The report has a number of names of people, a number of people --
16 Q. [16:07:49] Just concentrate on this one, please.
17 A. [16:07:51] That's true, that's true. I'm just coming back to that. It's obvious
18 that we didn't ask for these people, but I'm also putting this into context, that there is
19 also some other information in here that would have led us to other forms of
20 diagnosis, the other three diagnosis, for example, that we are making. And we
21 didn't get that information. The names are here. Why did we put the names? We
22 put the names exactly for that reason, that at the appropriate time would identify
23 these individuals if time allowed, if logistics allowed, and then would engage with
24 them. There would was been no need to put the names there, would have just had
25 anonymous things, and the story wouldn't add up.

1 MR GUMPERT: [16:08:45] Your Honours, I am coming to what I think Ms Lyons
2 called earlier her last -- my last section.
3 PRESIDING JUDGE SCHMITT: [16:08:53] I was -- yes, when you started that I had
4 hoped somehow --
5 MR GUMPERT: [16:09:00] That I was going to say my last question.
6 PRESIDING JUDGE SCHMITT: [16:09:02] Yes, yes, yes.
7 MR GUMPERT: [16:09:03] No, sorry.
8 PRESIDING JUDGE SCHMITT: [16:09:03] I have to be frank here, would have
9 hoped you would have said, but your last section, please.
10 MR GUMPERT: Yes.
11 MS LYONS: [16:09:10] Your Honour, may I just make one clarification, that I've just
12 received information that Mr X is not a witness in the case, just so that that's clear.
13 Okay. Mr X from the last conversation.
14 MR GUMPERT: [16:09:24] I'm sorry, that's an evidential assertion which can't come
15 from the Bar.
16 PRESIDING JUDGE SCHMITT: [16:09:37] I'm not sure -- okay, let me put it this way,
17 it's relatively easy. We have an evidentiary record, and that is the nice thing. For
18 example, in Germany we don't have any transcripts, but we have them here. So we
19 don't discuss this further, we figure it out, simply. No problem about that. And I
20 have the impression sometimes names are a little bit alike, they differ not too much,
21 but I have the impression that I have at least heard in the evidence of such a person.
22 But that doesn't matter, we figure it out. It's all on the record.
23 Mr Gumpert, please proceed to your last section.
24 THE WITNESS: [16:10:17] Mr President, sir, as we are going to the last section, I
25 have a request.

1 PRESIDING JUDGE SCHMITT: [16:10:21] Please, please, of course.
2 THE WITNESS: [16:10:23] To make through ....
3 PRESIDING JUDGE SCHMITT: [16:10:26] Mm-hmm.
4 Of course. Yes, I think we have really, we have now had a long time without a break,
5 we have five minutes' break. I think that's absolutely okay.
6 THE COURT USHER: [16:10:42] All rise.
7 (Recess taken at 4.10 p.m.)
8 (Upon resuming in open session at 4.17 p.m.)
9 THE COURT USHER: [16:17:48] All rise.
10 Please be seated.
11 PRESIDING JUDGE SCHMITT: [16:18:06] Mr Gumpert.
12 MR GUMPERT: [16:18:09] Thank you, your Honour.
13 Q. [16:18:13] Dr Akena, one of the things that Mr Ongwen told you when you
14 visited him in April 2018 was that, and I quote from page 0950:
15 "... he had contacted Salim Saleh ... so that the war in Northern Uganda could end
16 peacefully, and so that he could escape; instead he was arrested and jailed."
17 Now I want to be clear, this is something about which there is no dispute between the
18 parties, and the evidence which this Court has received establishes that this contact
19 was made during the charged period.
20 Now, we spoke earlier about occasions when Mr Ongwen had challenged
21 Joseph Kony. One good example was when he refused to murder the religious
22 leaders at Garamba or about his openly challenges the moral basis of the LRA, of
23 what the LRA was doing.
24 But I'm having difficulty in reconciling this information that he gave you about
25 contacting a senior UPDF man with a view to escaping with some of the things that

1 you wrote on page 0979 of this report, page 32 of 36.
2 I think I pick out six remarks which you made; your, as I understand it, professional
3 opinions:
4 A. Mr Ongwen's ability to form intent as an adult was destroyed by the social order of
5 the LRA.
6 B. Every activity Mr Ongwen participated in was under duress.
7 C. There was no room for dissent and disobedience.
8 D. Mr Ongwen lacked the concept of reality, moral choice, free will and intent.
9 E. Mr Ongwen had no options to choose from in relation to his own safety, welfare
10 and survival.
11 And lastly, F, every action in the bush was carried out in response to orders.
12 Doctor, are you really suggesting that when Dominic Ongwen made contact with a
13 general in the UPDF trying to escape, that he was acting in response to orders?
14 A. [16:21:26] From what he told us, he was, he was tired and he wanted -- he didn't
15 care whether he would die or not. He knew that that attempt would have led to
16 death, but somehow he thought, for once, that he should take the chance.
17 Unfortunately, it didn't work out as he thought.
18 I don't think there were orders from anywhere that forced him to move out or contact
19 somebody who he knew was -- he knew the consequences of making that contact.
20 Q. [16:22:10] So what you wrote unqualified every action in the bush was carried
21 out in response to orders. That's just wrong, isn't it, even on what he told you?
22 A. [16:22:34] I think this action was different. I think we meant the actions about
23 going to battle or dealing with people who are -- escaped, or whatever it was, within
24 there. This, this was clearly a deviation from, from what the norm - and the norm is
25 in quotes here - was in regards to life within, within the ranks of the LRA.

1 Q. [16:23:06] Well, let's look at another one of these unqualified statements.
2 Mr Ongwen lacked the concept of reality, moral choice, free will and intent.
3 When he refused to murder the religious leaders, he was demonstrating that he had
4 all of those things, wasn't he? And that's what he told you, you knew that. How
5 did you come to write this?
6 A. [16:23:33] Actually, by that time, according to what he tells us, he was defiant.
7 He was defiant. He had decided that he would die whatever the case may be, so he
8 started going against whatever it is that the establishment was putting in place. So
9 in the bigger context, in the bigger scheme of things, it was difficult for him to make
10 those decisions in the beginning, in the early days. But I think as he grew older, as
11 he looked at life and gave up on it, he started to make decisions that even his boss
12 considered reckless at one point in time.
13 Q. [16:24:29] Well, Doctor, I'm not really asking you about what he told you
14 Joseph Kony thought about what he was doing. The account which he gave to you
15 was that, from start to finish, he knew that what the LRA was doing was wrong, was
16 atrocious. That at first he couldn't do anything about it, he had to keep his mouth
17 shut, but when he got more senior he got more, as you said a moment ago, defiant
18 and uncaring about the possible consequences. That's a fair summary of his account
19 of the matter to you, isn't it?
20 A. [16:25:06] Yes, it is.
21 MS LYONS: [16:25:12] Your Honour, may we have a time frame on some of this,
22 because I think, so that we're clear -- I think that the time that Mr Gumpert is referring
23 to is not the charged period but is post-2006. So it may make a difference in
24 accuracy --
25 PRESIDING JUDGE SCHMITT: [16:25:30] We have, again, the Chamber knows

1 about what time Mr Gumpert is talking and we have, Mr Gumpert has been going
2 with the witness through also the statements about earlier times, and there is also
3 a time reference; we can put this into perspective.
4 Mr Gumpert.
5 MR GUMPERT: [16:25:54] I am done, your Honour.
6 PRESIDING JUDGE SCHMITT: [16:25:55] Thank you very much. And I don't
7 assume that the Legal Representatives for the Victims have any questions.
8 MS MASSIDDA: [16:26:00] No, your Honour.
9 PRESIDING JUDGE SCHMITT: [16:26:02] Okay.
10 Ms Sehmi?
11 MS SEHMI: [16:26:04] No questions, your Honour.
12 PRESIDING JUDGE SCHMITT: [16:26:06] Thank you very much. So this
13 concludes the testimony.
14 MS LYONS: (Microphone not activated)
15 PRESIDING JUDGE SCHMITT: [16:26:13] Okay. Thank you. So no further
16 questions.
17 MS LYONS: [16:26:15] (Microphone not activated)
18 PRESIDING JUDGE SCHMITT: [16:26:16] Yes. And, of course, Mr -- I will say
19 something to Mr Ovuga.
20 This concludes your testimony, Mr Akena. Thank you very much for having really
21 two long days here in the courtroom, and this is very strenuous, stressful, I can
22 imagine. And thank you for coming here and helping us establish the truth. And
23 have a safe -- I think you will not stay, I assume, or will you?
24 THE WITNESS: [16:26:45] I will.
25 PRESIDING JUDGE SCHMITT: [16:26:45] Okay, then I would not say you have

1 a safe trip back home, simply have a relaxing time afterwards now.
2 (The witness is excused)
3 PRESIDING JUDGE SCHMITT: [16:26:51] We continue on Thursday, 9.30, with
4 Mr -- Professor Ovuga.
5 And, Professor Ovuga, I think you are going to be provided with a video of your
6 colleague from yesterday because you could not have been here the whole day. I
7 assume that, so that you have the possibility to fully understand what has been going
8 on yesterday.
9 And a special thank you to the interpreters today and to all the staff that helped us on
10 this very long day, and also to all the parties and participants for their resilience and
11 patience. Thank you very much.
12 MS LYONS: [16:27:34] May the Defence -- may the Defence thank Dr Akena? Can
13 we talk to him now?
14 PRESIDING JUDGE SCHMITT: [16:27:40] (Overlapping speakers)
15 MS LYONS: [16:27:40] I'm just unclear on the protocol.
16 PRESIDING JUDGE SCHMITT: [16:27:42] I think there is no -- no, or what?
17 MR GUMPERT: [16:27:46] (Microphone not activated)
18 MS LYONS: [16:27:49] Oh, if you ruled, then we can't. Okay. That's fine. Okay.
19 PRESIDING JUDGE SCHMITT: [16:27:52] (Overlapping speakers) I have ruled upon
20 it and I think only, only after Mr Ovuga --
21 MS LYONS: Oh, okay. Fine.
22 PRESIDING JUDGE SCHMITT: -- I think that that was my, that was my decision.
23 MS LYONS: [16:27:56] Oh, okay. Fine. I just want to be clear. Okay, that's fine.
24 PRESIDING JUDGE SCHMITT: No, no, should be clear.
25 MS LYONS: Thank you. Thank you.

1 PRESIDING JUDGE SCHMITT: [16:27:59] So thank you everyone, a nice rest of the
2 day. And we see each other, all, nearly all of us, at 9.30 on Thursday.
3 THE WITNESS: [16:28:13] Thank you, Mr President.
4 THE COURT USHER: [16:28:17] All rise.
5 (The hearing ends in open session at 4.28 p.m.)