00746532

BEFORE THE TRIAL CHAMBER
EXTRAORDINARY CHAMBERS IN THE COURTS OF CAMBODIA

~~សម្ងាត់បំផុត / Strictly Confidential~~
~~/ Strictement Confidentiel~~

FILING DETAILS

Case No: 002/19-09-2007/ECCC/TC

Filed to: Trial Chamber

Date of Document: 9 October 2011

Original Language: English

ឯកសារដើម
ORIGINAL DOCUMENT/DOCUMENT ORIGINAL
ថ្ងៃ ខែ ឆ្នាំ ទទួល (Date of receipt/date de reception): 10 / 10 / 2011
ម៉ោង (Time/Heure) : 14:30
មន្ត្រីទទួលបន្ទុកសំណុំរឿង /Case File Officer/L'agent chargé du dossier: Ratanak

---

EXPERTISE REPORT PREPARED IN RESPONSE TO THE TRIAL CHAMBER'S EXPERTISE ORDER DOCUMENT NUMBER E111, DATED 23 AUGUST 2011

Filed By:

Dr Seena Fazel
Clinical Senior Lecturer in Forensic Psychiatry and Honorary Consultant Forensic Psychiatrist, University of Oxford, UK

Dr Koeut Chhunly
Psychiatrist (Norway), Psychiatric Department, Khmer-Soviet Friendship Hospital, Phnom Penh and Assistant Professor of Psychiatry, University of Health Science, Phnom Penh, Cambodia

Dr Lina Huot
Psychiatrist (Norway), Master of Psychological Medicine (MPM) (Australia).
Head of Psychiatric Department, Khmer-Soviet Friendship Hospital, Phnom Penh and Assistant Professor of Psychiatry, International University, Phnom Penh, Cambodia

Dr Calvin Fones
Consultant Psychiatrist, Gleneagles Medical Centre and Associate Professor, Yong Loo Lin School of Medicine, National University of Singapore, Singapore

Introduction

1. We, Doctors Fazel, Chhunly, Huot, and Fones, swear to assist the Chambers honestly, confidentially and to the best of our ability.

2. We provide this report in accordance to the Trial Chamber's Order Appointing Experts.[1]

3. We have presented our findings in the following order: background history, mental state examination, cognitive examination, responses to the questions of Co-Prosecutors,[2] and fitness to stand trial.

4. This report is strictly confidential and for the sole use of the Trial Chamber. We do not consent for it to be made publicly available at any point or for any reason without the express permission of all the authors.

Documents Reviewed

Among the documents we reviewed were:

E62/3/6	23 June 2011
E62/3/12	26 August 2011
C18	14 November 2007
E1/8	29 August 2011
E1/9	30 August 2011
B5	25 February 2008
B29/1	1 July 2009
B37/9/8	9 February 2010
E17.1	27 January 2011
E17/1/2.5	1 March 2011
E17/1/2.6	1 March 2011
E17/1/2.4	7 March 2011
E62/3/6/5.1	09 August 2011
E62/3/6.1	11 August 2011
E62/3/6.3	18 August 2011
E62/3/6.4	19 August 2011
E62/3/6.5	19 August 2011
E62/3/12.1	26 August 2011
E62/3/12.2	26 August 2011
E110/4/2.3.1	26 August 2011

[1] Document number E111, 00727083-00727087, dated 23 August 2011.
[2] Document number E111/2, 00738201-00738210, dated 2 September 2011.

E110/4/2.3.2	26 August 2011
E110/4/2.3.3	26 August 2011
E110/4/2.3.4	26 August 2011
E110/4/2.3.5	26 August 2011
E110/4/2.3.6	26 August 2011
E110/4/2.3.7	26 August 2011
E110/4/2.3.8	26 August 2011
E110/4/2.3.9	26 August 2011
E52	22 February 2011
E62/2	21 March 2011
E62/3/6/1	18 July 2011
E62/3/6/2	25 July 2011

Evaluation

5. We interviewed Mrs. IENG Thirith on three occasions on 12 and 13 September 2011 in the presence of at least one translator.

6. We also interviewed Dr Chamroeun on 12 September, one of the general physicians employed by Calmette Hospital, who works at the Detention Facility, and is one of a team providing medical care to Ieng Thirith.

7. We held a conference with Dr Hey Leang, a specialist radiologist based at Calmette Hospital, and reviewed Ieng Thirith's three most recent CT brain scans with him.

8. In addition, we interviewed Mr Mao Sopherom, Chief of the Detention Facility, who has known Ieng Thirith since her reception into detention in 2007.

9. We were unable to gather much background information directly from Ieng Thirith as she had a poor recollection of many events of her life. At the second interview, she recalled the name of her secondary school (Sisowath High School) where she said that she had been an 'excellent student', and remembered that she subsequently studied in France. She mostly denied being a Minister during the Khmer Rouge regime saying that she was too young at the time. Towards the end of our third interview, she seemed to accept that she had been a Minister but could not provide any details of her role. She could not remember how many children she had, where they lived or what they did, but did recall that she had a daughter. She named her husband (IENG Sary) on one occasion, while at other times referred to him by name as her brother. On direct questioning, she said that she had known Pol Pot, and

that he was her 'uncle' and was 'very friendly'. She thought that Pol Pot had died some years ago. We note that Professor John Campbell, in his interview from May 2011, found that she was unable to name her school, and provided details of her early life that he understood were incorrect.[3]

10. We note that Ieng Thirith was diagnosed with an 'organic mental disorder' after a hip replacement operation on 7 January 2006 at Bumrungrad International Hospital in Bangkok, for which she was treated with oral anti-psychotic medication (quetiapine).[4] Her medical records from this admission note cardiovascular abnormalities (including left ventricular hypertrophy and electrocardiographical changes) consistent with cardiac ischaemia. In relation to psychiatric symptoms, her medical notes at the time report 'hallucinations' and sleep disturbance.

11. We note that Ieng Thirith was given a 'complete medical check-up' on 13 November 2007 at Calmette Hospital, where she was diagnosed with 'high blood pressure, functional digestion trouble, anaemic [*sic*] and chronic kidney failure, lumbar osteochondritis, right ethmoid sinusitis, psychic/mental disorder [*sic*]'.[5] She was maintained on quetiapine (an oral anti-psychotic medication at a dose of 100mg). She had been previously prescribed clonazepam (an oral sedative), which was increased at this review.

12. We note that Ieng Thirith was reviewed again on 28 February 2008 by Dr Cheang Ra and Professor Nhem Sophoeun of Calmette Hospital.[6] She was diagnosed with a mild collapse of one of her lungs, 'high blood pressure and dyslipidemia [high blood lipid levels], chronic renal insufficiency, arthritis in lower back and both knees = osteoporosis, mental disorder, chronic gastro-enteropathy'. Her clonazepam was increased further. She was re-assessed medically on 18 July 2008, and her complaint of insomnia was noted.[7]

13. The medical records state that there were '24 occasions when IT's [Ieng Thirith's] behaviour has been inappropriate' from November 2008 to March 2009, and '26 incidents of irregular and immoral behaviour [*sic*]' from March 2009 to July 2009.[8] The records maintain that her

[3] Document number E62/3/6, 00708257-00708269, dated 23 June 2011, paragraph 19 and 20.
[4] Document number E111/3.2, 00738558-00738562.
[5] Document number E111/3.3, 00738563-00738565.
[6] Document number B5_EN, 00686653-00686655, dated 25 February 2008.
[7] Document number E111/3.3, 00738563-00738565.
[8] Document number E111/3.3, 00738563-00738565.

behaviour 'deteriorated further in 2010. She is described as insulting, aggressive and confused at times' (entry dated 19 May 2010).[9]

14. We were provided with three CT brain scans for Ieng Thirith. The first is dated 13/11/07 and reported as normal apart from a right frontal sinusitis.[10] The second is dated 22/10/09 and reported as 'generalized cerebral atrophy'.[11] The third one is dated 2/6/11 is reported as 'age consistent generalized cerebral atrophy' with no intracranial tumours.[12]

15. We note that Ieng Thirith's blood levels for vitamin B12, folate, and thyroid stimulating hormone (or TSH) were all normal on 10 May 2011, and her syphilis serology was negative.[13] We note that a detailed neurological examination conducted by Professor John Campbell, a geriatrician, in May 2011 was normal.[14]

16. We note in a letter dated 27/07/11[15] from Dr Chheang Ra of Calmette Hospital that Ieng Thirith was on the following medication (trade name first): nexium or esomeprazole 20mg (for dyspepsia), lasilix or furosemide 40mg (a diuretic), paracetamol 1g (for pain relief; that has increased to 1.5g more recently), Duphalac as required for constipation, Euphytose (a herbal remedy for anxiety and sleep disorders), lipitor or atorvastatin 10mg (a lipid lowering tablet), tardyferon (a folic acid supplement), cozaar or losartan 50mg (for high blood pressure), Osteocare (a calcium supplement), zyloric or allopurinol 100mg (for gout), rivotril or clonazepam 0.5mg (which has now stopped), and seroquel or quetiapine 100mg (an antipsychotic).

17. Dr Chamroeun of Calmette Hospital explained that a medical doctor from Calmette Hospital visits the Detention Facility every morning, and that he attends once weekly. He felt that, over the last two years, Ieng Thirith's memory had worsened, and he remarked that she has started to complain about forgetting. He stated that her physical health is currently stable, and a number of recent blood investigations were normal (including thyroid function tests, vitamin B12 levels, her liver enzymes and kidney function tests, and syphilis serology). He was under the impression that her appetite was normal and her weight was unchanged

---

[9] Ibid.
[10] Document number E17.1, 00680883-00680883.
[11] Document number E17.1/2.6, 00655124, dated 21 March 2011.
[12] Document number E62/3/12.1_FR, 00728016, dated 26 August 2011.
[13] Document number E62/3/12.2_FR, 00728017, dated 26 August 2011.
[14] Document number E62/3/6, 00708257-00708269, dated 23 June 2011, paragraph 26.
[15] Document number E62/3/6/5.1, 00723863-00723864.

recently. He reported that she often complains of knee and back pain, and that they have increased her paracetamol dosage recently. He explained that her psychotropic medication has been recently reduced, and that she was currently on quetiapine 50mg (half the previous dose) and that the bromazepam (another oral sedative) and clonazepam had now been discontinued. Dr Chamroeun said that he had not detected any change to her memory after these changes, and no obvious alteration in her mood. However, he reported that her sleep has reduced in duration to about 6 hours per night (previously it was 8 or 9 hours). On a general level, he said that she often repeats herself, and often talks about her sister and that both of them studied in Paris. He recalled that Ieng Thirith occasionally has mentioned what she had read in the newspapers.

18. Mr Sopherom recalled that Ieng Thirith had memory problems when she first arrived, and was irritable in mood and would curse detention staff on occasion. He reported that she was angry at times, but not consistently low in mood. He could not recall any time that she expressed suicidal ideas. He said that she sometimes needed assistance with dressing, and on occasion forgot that her clothes were drying and where they were located within her cell. Also he reported that she has, on a few occasions, been found naked on her bed having apparently forgotten to get dressed or unable to recall where to find her clothes. Mr Sopherom said that Ieng Thirith has had no reported problems putting her clothes on. In relation to self-care, he felt that this has generally not been a problem, although on a few occasions she has apparently sat on the toilet for a long time and needed reminding to get up. He said that she recognises familiar individuals who work there but cannot recall their names. He recalled that she would occasionally not remember the names of her son and daughter in conversation with guards. He did not think she was paranoid towards staff, although he stated that she has referred to one of the co-defendants (Nuon Chea) as a traitor (who also resides in the Detention Facility). He thought that she was not disoriented in person, and not obviously in place, but was often uncertain about the time of day. However, he noted that she occasionally misplaced things and accused staff of stealing these items. When she was in a good mood, he said that he could converse normally with her, and she had no obvious problems with word finding. Mr Sopherom said that, for the first year of detention or so, she talked about never having done anything wrong or killing anyone, and how she should not have been detained. However, she has not discussed this with him or his staff over the last year to his knowledge. He thought that she looked at her legal files in her room once or twice per month for a short time. He reported that she has never complained

about her lawyers. He stated that Ieng Thirith read the *Cambodia Daily* newspaper but rarely watched television. He recalled that she became angry when reading about the trial in this newspaper around 6 months ago. She had needed help operating the television initially when it was put in her cell and he is unsure if she knows how to operate the television independently. She receives family visits around once weekly and sometimes more often.

19. We note that Professor John Campbell, Professor of Geriatric Medicine, University of Otago, New Zealand, as part of a medical examination, spoke with Mr. Ieng Sary, Ieng Thirith's husband, and a co-accused.[16] We note that Professor Campbell reported that Mr. Ieng Sary stated that he had noticed a 'great change – she keeps forgetting things', and gave various examples of this, including the fact that her elder sister and parents have died, and that she had been a Minister. In addition, Ieng Sary said that she sometimes did not know where she was. He reported that the memory had becoming gradual worse. Detention staff told Professor Campbell that Ieng Thirith can become disoriented and lost in the Detention centre, and that she only remembers the names of her husband and immediate family.

20. We interviewed Ieng Thirith three times over two days. Two of these interviews were conducted in her cell, and one in a meeting room in the Detention Facility. She was generally cooperative and pleasant, and attempted to answer most questions. She occasionally winced with pain if she moved, but mostly appeared comfortable and happy to be interviewed. She did not appear to become tired even after two hours of questioning. She appeared to think that one of the interviewing Cambodian doctors was a family member, and maintained this assertion despite our explanations to the contrary. Her replies were evasive and tangential at times, but there was no abnormality in the rate or rhythm of her speech. Sometimes she spoke brief sentences in English and French, which were comprehensible. She also could read in English without obvious problems. Her mood appeared reactive, and she did not complain of any problems with her mood, sleep, or appetite. She described herself as 'happy' and denied any suicidal thoughts. Her thought possession and form were normal. There was no evidence of delusions, and she did not complain of any paranoid thoughts. There was no evidence of any abnormal perceptions during our interviews, and she did not complain of any hallucinations. She explained that she would agree to take medication prescribed by her doctors for pain and memory problems.

[16] Document number E62/3/6, 00708257-00708269, dated 23 June 2011, paragraph 14 and 13.

21. We conducted a number of brief cognitive tests. On consecutive days, we administered the Mini-Mental Screening Examination (MMSE), one of the most commonly used screening instruments for cognitive impairment. She scored 15/30 on the first day, and 18/30 on the second. She was unable to answer most of the orientation questions and was able to recall any of three objects on both occasions. Normally, a score of 23 or less is indicative of cognitive impairment, and would warrant further assessment. We note that Professor Campbell administered the elements of the MMSE in May 2011, and we estimated a score of 14/30 (assuming that she knew she was in Phnom Penh).[17]

22. On further examination of orientation, Ieng Thirith appeared to know that it was daytime but no other time or date details (such as the time of day, day of the week, month, season or year). In addition, her orientation in place was impaired and she believed that she was currently on the first floor of a hospital in Phnom Penh (although we were on the ground floor). She was able to count back in 2's from 20, but not in 7's from 100 beyond 93 (which are both simple tests of attention and concentration).

23. Ieng Thirith demonstrated some preservation of long-term memory, although there were notable gaps. She remembered her date of birth (which she said in French was 10 March 1932) but was unable to tell us how old she was. She could not name her last address, but said it was on 'the biggest street' in Phnom Penh (which we understand is broadly correct). She named the current King on her second interview (but not in the first interview), but had trouble recalling the name of her mother. She named her father as KHIEU Un in the second interview (which we understand is correct). She remembered the name of her secondary school in the second interview after one mistake (but not in the first interview), but could not recall the name of her primary school. She could not recall how many children she had or name them. She said that she had one brother who had been taking care of her when she was ill, and some sisters who were alive.

24. Ieng Thirith's short-term memory was poor. As reported above, she was not able to recall any of three objects after a few minutes on two occasions. She could not remember any of our names nor our roles, apart from one translator that she recognised from previous interviews. She was unable to name her lawyers, or any of the prison guards. She was unable

[17] Document number E62/3/6, 00708257-00708269, dated 23 June 2011, paragraphs 17 and 25.

to describe to us anything about recent news locally or internationally. She said that she had come to this location 'recently'.

25. We administered some tests of Ieng Thirith's executive function (cognitive abilities relating to planning, judgement, and reasoning).[18] She responded concretely to one out of three verbal similarities (where she was asked how an apple and orange were similar, she replied that they both have peel when a more obvious answer is that they are fruit), but gave appropriate responses to the other two similarities presented. She was unable to interpret one Khmer proverb. Her verbal fluency was poor – she managed one word starting with the letter 'S' in one minute, and four animals (where around 10 would be expected in an older adult). She had some difficulties with Luria's three-step test (a measure of motor sequencing) being able to copy the task once. She was unable to complete a Reciprocal Motor Programme Test (where you are asked to react in an opposing way to a simple hand tapping task). She was able to draw a diagram of alternating sequences. In summary, her executive functioning was impaired, but not to a severe degree.

Conclusions[19]

26. We have been asked to comment on Ieng Thirith's medical treatment from February to August 2006, when she was treated in hospital in Bangkok. On the basis of reviewing her medical records and her subsequent progress, we agree with previous experts that she was likely to have experienced an episode of post-operative delirium (that is categorised by the International Classification of Diseases 10th edition [ICD-10] as 'Delirium, not induced by alcohol and other psychoactive substances', code F05). There is no evidence, on the basis of the information available, that she was suffering from a clinical dementia or other severe mental illness (such as schizophrenia) at the time. At the time, she may have had some cognitive impairment that may or may not have been age-related, and we note that individuals with cognitive impairment are at higher risk of delirium. However, without a record of a full mental state examination at the time, we cannot be more precise on the extent, if any, of cognitive impairment.

[18] See Chan et al, *Archives of Clinical Neuropsychology* 2008 for a review of tests of executive function including evidence in support of the Luria and Reciprocal Programme tests: http://www.sciencedirect.com/science/article/pii/S0887617707001928#sec2.1.1

[19] This section comments sequentially on questions posed by the Co-Prosecutors, Document number E111/2, 00738201-00738210, dated 2 September 2011.

27. We have been asked to comment on Ieng Thirith's current diagnosis, and in so doing, take into account the conclusions of other medical experts over the last two years. Our view is that she does have a clinical diagnosis of dementia. We do not believe that she currently suffers from another serious mental illness, such as depression or a psychotic illness. Specifically, she meets the ICD-10 criteria for dementia. These are:

(i) A decline in memory, which is most evident in the learning of new information although in more severe cases the recall of previously learned information may also be affected. In our examination, this decline was verified by informants and by simple tests that we performed on two occasions. We would describe this memory impairment as 'moderate' in that it is 'a serious handicap' to independent living.

(ii) A decline in other cognitive abilities characterised by deterioration in judgement and thinking, such as planning and organizing, and general processing of information. Our assessment was that there was evidence of this decline from informants and also our examination of her cognitive functioning (especially in tests of executive function). This particular decline is mild to moderate in that it impairs performance in daily living, and may restrict her activities to undertaking simple household chores rather than shopping and handling money (which we were not able to assess).

(iii) Awareness of the environment is preserved (i.e. absence of clouding of consciousness). There has been no evidence since 2006 of any fluctuation in her state of consciousness.

(iv) There is a decline in emotional control or motivation, or a change in social behaviour manifest in at least one of the following: emotional lability; irritability; apathy; coarsening of social behaviour. Our assessment was that there was evidence of irritability, in particular, and a restriction in her social interactions with prison staff over time which may amount to a coarsening in social behaviour. Furthermore, her medical records identify a number of episodes of irritability in 2008 and 2009 (see paragraph 13 above), which would amount, in our view, to a decline in emotional control.

(v) For a confident clinical diagnosis, the memory decline symptoms need to be present for at least 6 months. We felt that her symptoms had been present for over one year.

We note that Dr Philip Brinded (Associate Professor of Forensic Psychiatry, Christchurch School of Medicine, New Zealand) and Professor Sunbaunat Ka (Professor of Psychiatry, University of Health Sciences, Phnom Penh), in their report dated 22 November 2009,[20] concluded that Ieng Thirith did have a 'age related dementing process that is mild in nature' (page 8) and a 'mild dementing process' (ibid). Professor Ka, in a later report from June 2011, stated that her cognitive impairment was 'within the extreme limit of mild and the lowest limit of moderate [*sic*]', although does not use the term dementia.[21] We note that Professor Campbell, in his report dated 23 June 2011,[22] concluded that Ieng Thirith had a dementia, and that this was 'moderately severe' (page 11), and described the impairment as 'moderate' and also as 'moderately, severely cognitively impaired' during the hearings in August 2011.[23] Overall, it is our view that these conclusions of previous experts are consistent with our diagnosis. First, all previous medical experts have stated that Ieng Thirith has a diagnosis of dementia. Second, it would be consistent with the clinical course of dementia that there would be progression from a mild illness to a moderate one from 2009 to 2011. Finally, the reports have made use of the terms 'cognitive impairment' and 'dementia' that are not interchangeable. The former is present as part of normal ageing, while the latter assumes a disease process that accelerates the rate and extent of memory decline. Furthermore, what experts describe as mild, moderate, and severe may differ, and we note that previous medical reports have provided no criteria by which they rated the degree of severity. We have used the International Classification of Diseases guidelines, which we understand to differentiate between mild and moderate severity on the basis of the degree of handicap to independent living.

We note that there is one report that apparently contrasts from the others, without explicitly saying so. A joint one page medical report of Professor Nhem Sophouen (whom we understand is not a psychiatrist) and Dr Chak Thida (a psychiatrist) dated 16 February 2011[24] does not seem to be consistent with a diagnosis of dementia. This report states, in relation to Ieng Thirith's orientation, that she is 'knowing people close to her (her female warden), time and the place she stays', that her memory is 'good' and 'concentration and attention are a bit poor' without any details of how these abilities were tested. Our view is that without more details about his particular examination, it is difficult to comment further on

[20] Document number B37/9/8, 00407278-00407286, dated 2 December 2009.
[21] Document number E62/3/6.1, 00715510-00715514.
[22] Document number E62/3/6, 00708257-00708269, dated 23 June 2011.
[23] Cited in Document number E111/2, 00738201-00738210, dated 2 September 2011, paragraph 5d.
[24] Document number E17/1/2.4, 00649547, dated 7 March 2011.

this report. However, we agree that, at a superficial level, Ieng Thirith is able to converse and has some ability to mask her memory problems by changing the topic and providing tangential answers. This is not an uncommon presentation in individuals with dementia.

28. We have been asked to comment on Ieng Thirith's ability to comprehend the purpose of our interviews. We found that she had a limited understanding. On explanation, she agreed to be interviewed but was not able to recall our explanation of its purpose on the second day of interviews. We note that this is consistent with Professor Campbell's conclusion.[25] Dr Brinded and Professor Ka reported that she was 'happy to be interviewed',[26] which we understand to be different from actually fully understanding the purpose of the interviews.

29. We have been asked to comment on Ieng Thirith's ability to maintain concentration and engage in interviews. Our impression that she demonstrated some ability to do so, and managed to answer questions without any obvious problems for over two hours on two consecutive days. We note that Professor Campbell notes that Ieng Thirith had 'difficulty concentrating and maintaining focus' and 'would frequently go off on tangents'.[27] We do not think that this is inconsistent with our findings. We also found that she would not answer questions directly, and would often repeat herself without directly addressing the question posed. In addition, we did not find any evidence of hallucinations, thought disorder, or delusions, symptoms that would interfere with concentration. In this respect, we understand that this has been a consistent finding over the last two years in medical reports.

30. We have been asked to comment on Ieng Thirith's long term memory. We found it to be impaired but there were pockets of long term memory that were preserved. For example, she did not remember the name of her school during the first interview but did remember it (after one mistake) in the second interview. She could not remember the name of her primary school in either interview. She did not recall the name of the King in her first interview but did so in the second. She could not remember her last address although we asked her a few times. She appeared not to recall how many children she had. However, we note some variation in her ability to recall significant events from her past in previous medical examinations. The variation in her memory is consistent with a diagnosis of dementia, and we found it when asking Ieng Thirith the same question over two days.

[25] Document number E62/3/6, 00708257-00708269, dated 23 June 2011, paragraph 15.
[26] Document number B37/9/8, 00407278-00407286, dated 2 December 2009, page 6 (1st paragraph).
[27] Document number E62/3/6, 00708257-00708269, dated 23 June 2011, paragraph 16.

31. We have asked to comment on Ieng Thirith's recognition of family members and others. We found that she had a poor recollection of who her family members were and their names. In our first interview, she was unable to remember the name of her mother, her siblings, or her children. She recalled her family's name correctly. On the second interview, she did remember her mother's name but thought she was still alive (which we understand is not the case). She was unable to recall her children's names or whether she had a son. She remembered her husband's name, although she referred to him as her brother initially. On the second day of interviews, she recognised us, and correctly identified what she described as the translator, but not our roles. We note that Professor Ka stated previously that 'she....could write their name[s] [of the expatriates] appropriately', and we also found that she was able to write down names correctly. In fact, she took special efforts to write down our names and where we came from for her own records, ostensibly as an aid to her memory. However, recording of names is, of course, not the same thing as having a complete memory for individuals and their purpose.

32. We have been asked to comment on Ieng Thirith's ability to communicate. In this respect, we are of the view that she can communicate clearly in the sense that she has no obvious word finding difficulties, and the form and structure of her sentences appeared normal. The rate, volume and rhythm of her speech were normal. However, she presented with little initiation of conversation. She was able to respond to questions, with the caveats stated above, which may be why there is an apparent difference in medical evidence on this matter over the last two years. Thus, although she was able to respond to questions over many hours, her ability to make spontaneous conversation was restricted to mostly pleasantries. She was, however, able at times to demonstrate appropriate humour and candour in conversation.

33. We have been asked to comment on Ieng Thirith's orientation. We found her to be oriented in person throughout our interviews, by which we mean the ability to recall her name. However, there were clear deficits in her orientation in time – she was able to correctly state that it was daytime (rather than night-time) but unable to identify the day of the week, the month, season, or year. In relation to orientation to place, we found that she was unable to identify the name and function of the building in which she was residing, although she knew that she was in Phnom Penh and in Cambodia. Therefore, it is difficult to interpret previous

medical evidence from Dr Thida and Professor Nhem, who stated in their report that her orientation to place and time was intact,[28] without specifically knowing what they asked. Furthermore, it would be normal that there would be some variation in this ability, and likely some worsening since 2009 as part of her progressive dementing illness.

34. We have been asked whether Ieng Thirith could have altered her cognitive performance in light of her understanding of the purposes of the interviews. Our view is that this is possible, and we agree with Professor Campbell that it 'may have affected her responses'.[29] However, a principal issue for us was whether she could feign dementia and her answers in relation to questions regarding fitness to stand trial. On these matters, we were of the view that it was very unlikely that she could do so, particularly as we partly relied on informant history and interviewed her with the possibility of her feigning in mind. In relation to the latter, this meant that we asked the same questions in different ways, asked her about hypothetical scenarios, and repeated the same questions in three separate interviews over two days. Our assessment was consistent with Professor Campbell in that we do not think that she gave us false answers, but that that her overall performance and attention might be improved under certain conditions and with rehearsal.

35. We have been asked to comment on Ieng Thirith's CT head scans, and we reviewed the three aforementioned CT scans from 2007, 2009, and 2011. We should clarify that none of us are trained radiologists, and hence our interpretation of these scans is qualified by this limitation. Therefore, we held a conference with a medical radiologist, Dr Hey Leang, who explained that he thought that in the 2007 scan, there was evidence of generalized brain atrophy which he felt was age-consistent with no evidence of infarcts or a tumour. He felt that in the 2009 scan, there was evidence of some progression in brain atrophy since 2007, and again evidence of generalized atrophy. He said that this atrophy was more prominent in the temporal lobes of the brain. Again, he saw no evidence of infarcts on the CT. In the 2011 scan, he stated that there was further progression of the atrophy of the brain, and no evidence of infarcts or a tumour. Dr Leang said it was difficult to compare the 2007 and later scans as the resolutions were different, but overall he felt there was evidence of progression, particularly from 2009 to 2011. We are of the opinion that the scans show generalized cerebral atrophy with progression of changes from 2007, through 2009, to 2011. We thought that there was no evidence of infarction or hydrocephalus. There is some

[28] Document number E17/1/2.4, 00649547, dated 7 March 2011.
[29] Cited in Document number E111/2, 00738201-00738210, dated 2 September 2011, paragraph 7.

evidence of periventricular ischaemia that is seen in 2009 and has remained stable in the 2011 scan. Our view was that these scans are consistent with dementia but not confirmatory one way or the other as they may be indicative of age-related changes (the latter is how the scans have been officially reported by the radiologists). The diagnosis remains a clinically informed one, and evidence from CT scans and other tests have supported our diagnostic opinion. We have no additional comments to make on these scans and their implications in response to the Defence Questions 13(i-v).[30]

36. We have been asked to comment on whether Ieng Thirith suffers from Alzheimer's disease, one of the common forms of dementia. We note that, in addition to the general criteria for dementia cited above, for a clinical diagnosis of Alzheimer's disease to be made according to the International Classification of Diseases, there must be no evidence from the history, physical examination or special investigations for any other possible cause of dementia, or alcohol or drug abuse. Furthermore, we note that this diagnosis is confirmed on post-mortem examination of the brain. An alternative diagnosis, in our view, is that of vascular dementia. We note a medical history of high blood pressure, and high blood lipid levels (that are independent risk factors for vascular dementia[31] but as they predispose individuals to atherosclerosis, they are associated with all dementias, including Alzheimer's disease[32]) but we note no recorded medical history or CT scan evidence of any stroke (infarction). Furthermore, the clinical picture is one of a gradual insidious decline, which is more consistent with Alzheimer's disease rather than vascular dementia. However, in practice, we note that the two causes of dementia can co-exist in the same person, and a diagnosis of Alzheimer's disease can only be confirmed by pathological evidence from brain tissue by biopsy or autopsy. On balance, we would agree with a clinical diagnosis of Alzheimer's disease ('Dementia in Alzheimer's Disease' according to ICD-10, code F00).[33] On the 7-point FAST (Functional Assessment Staging) scale, we estimated Ieng Thirith to be at stage 5 ('early dementia: moderately severe cognitive decline'). In terms of disease progression, we find it difficult to comment on this due to the lack of previous detailed examinations of her

[30] Document number E111/3, 00738537-00738545, dated 2 September 2011.
[31] Cf. Defence Question 13(vi), Document number E111/3, 00738537-00738545, dated 2 September 2011.
[32] We were not aware of any other risk factors that increased the risk of dementia in Ieng Thirith, although we did not have information on any possible family history of dementia. It should be noted that a higher level of educational attainment and a higher pre-morbid IQ is thought to exert a protective effect on the risk of developing dementia in different cultures.
[33] Another recommended set of criteria for diagnosing Alzheimer's disease are known as the NINCDS-ADRDA criteria (McKhann et al, *Neurology* 1984). For a diagnosis of probable Alzheimer's, individuals need deficits in two or more domains of cognition, a progressive decline or memory and other cognitive functions, preserved consciousness, an onset between ages 40 and 90, and absence of systemic or other brain disease that could account for symptoms. We believe that Ieng Thirith meets all these criteria. Specifically, she has memory and orientation (and possibly language) deficits in relation to the first criteria, and we have presented evidence of the other criteria.

cognitive state, and hence the relative lack of information on how fast she has progressed to date. Her living conditions in the detention centre also mean that the range of activities she participates in daily are limited and restricted, e.g. she does not have the opportunity to travel independently or handle money. In addition, she receives a high degree of supervision over many activities of daily living. Her restricted environment limits our clinical assessment of the degree of her disease progression and its future course over time.[34] However, the disease will lead to a gradual decline over time in her memory and function.

37. We have been asked to comment on medication options that were recommended by Professor Campbell, some of which have been implemented. These included a withdrawal of two oral sedatives, clonazepam (which was stopped in August 2011) and bromazepam (which was discontinued on 21 July 2011). We understand from a transcript of a discussion between Professor Campbell and doctors of Calmette Hospital dated 2 August 2011 that the discontinuation of her clonazepam led to some reduction in her sleep but caused no other obvious problems.[35] Dr Chamroeun confirmed that the quetiapine has been reduced from 100mg to 50mg. He noted that Ieng Thirith does sleep less now, but that this has not been associated with any obvious change in her cognitive function or mood. We would anticipate that any benefits from a reduction would have already been seen. Our view is that the continued reduction in quetiapine is good practice, as it reduces the likelihood of its possible adverse effect of cognitive slowing associated with its use in older adults. Further reduction and eventual discontinuation, however, is unlikely to lead to any marked improvement in her cognitive function, particularly as the reduction to date does not appear to have done so. Furthermore, it is our opinion that any further reduction in medication is unlikely to materially change our view on fitness to plead and stand trial (see below). Professor Campbell raised the possibility of a three month trial of donepezil. We would not disagree with the recommendation of a trial, but note that the evidence for cognitive improvement following treatment with acetylcholinesterase inhibitors, such as donepezil, suggests that improvement is small in magnitude and limited to a minority of individuals who take it. Furthermore, we are not aware of the local availability and experience with this medication or other acetylcholinesterase inhibitors, which we believe would complicate its use. We should point out that, as general and forensic psychiatrists, we have experience of prescribing clonazepam, bromazepam, and quetiapine, but very limited experience of donepezil.

[34] Cf. Defence Question 13(x), Document number E111/3, 00738537-00738545, dated 2 September 2011.
[35] Document number E62/3/6/4-4, 00725241-00725250, dated 2 September 2011, see page 5.

38. We have been asked to advise on whether there are any other treatments or measures that would be beneficial to Ieng Thirith's mental state and cognitive functioning. The following may be beneficial: consistent and stable staffing; retaining a familiar environment; flexibility to accommodate her fluctuating abilities; physical exercise, with assessment and advice from a physiotherapist when needed; and support for participation in activities she enjoys.[36] In addition, a structured cognitive stimulation programme may be helpful (but needs to be undertaken with those who are trained and supervised).[37] Furthermore, the treatment of her knee and back pain and the regular monitoring of her physical health would be important to maintain. The continued treatment of co-existent medical conditions will improve her prognosis. We note that there are no occupational therapists currently in Cambodia, but if there were, an assessment of her activities of daily living would be helpful and advice on any environmental modifications to her living conditions could be sought. However, we do not believe that such intervention is urgent as Ieng Thirith maintains a reasonable level of independent living, and appears to receive appropriate help as and when it is required from detention staff.[38]

Fitness to plead and stand trial

39. We note that the various criteria for fitness to plead and stand trial have been clarified in previous cases before various United Nations Courts. The *Prosecutor v. Strugar* case[39] identified seven capacities of the Accused, which are to:
   - (i) plead;
   - (ii) understand the nature of the charges;
   - (iii) understand the course of the proceedings;
   - (iv) understand the details of the evidence;
   - (v) instruct counsel;
   - (vi) understand the consequences of the proceedings; and

[36] This is based on 2011 clinical guidelines published by the UK's National Institute for Health and Clinical Excellence: http://www.nice.org.uk/nicemedia/live/10998/30318/30318.pdf

[37] 'People with mild-to-moderate dementia of all types should be given the opportunity to participate in a structured group cognitive stimulation programme. This should be commissioned and provided by a range of health and social care staff with appropriate training and supervision, and offered irrespective of any drug prescribed for the treatment of cognitive symptoms of dementia' (ibid.).

[38] More detailed neuropsychological assessments by a Khmer speaking clinical psychologist could document more accurately any changes in her cognitive functioning, but this is primarily for assessment and we would not recommend it for therapeutic purposes. However, we are not aware of any trained clinical psychologists currently working in Cambodia.

[39] *Prosecutor v Pavle Strugar*, Case No. IT-01-42-T, 26 May 2004. Document number E111/3.1.1, paragraph 41.

(vii) testify.

We note that the case of *Deputy General Prosecutor v. Nahak* outlined a 'minimum standard of competence [that] requires a defendant be able to cooperate with counsel, to inform his attorney concerning the facts of his case and to assist in the preparation of his own defense'.[40] Furthermore, we note that the Order Appointing Experts from the Trial Chamber used the wording, 'Does she have an adequate level of understanding of court procedures?', and asked specifically whether she has the ability to understand the 'consequences of a *conviction'* (our emphasis).[41] Below, we will take each of the Strugar capabilities and related criteria outlined above in turn.

40. As part of our assessment, we used the broad outlines of a semi-structured instrument called the 'Competency to Stand Trial Assessment Instrument',[42] a commonly used instrument with the highest correlations with competency status according to a 2011 review of the field,[43] which, although written with US law in mind and includes a limited range of capacities, was helpful in structuring our questioning. In addition, we noted the judge's directions in the case of *Regina v. M (John)* from England and Wales,[44] which provided some elaboration of items (iii) and (v) cited in paragraph 39 above.

41. Initially, Ieng Thirith stated that she had not been charged with anything. On reading her the indictment, Ieng Thirith explained that she 'never killed anyone', and 'I never done it' and repeated 'I never done that'. She stated that, 'they are my people, how could I mistreat them? How can a Cambodian woman kill?' She also said that she 'never mistreated anyone'. When we asked her about the meaning of the word 'guilty', she stated that she has 'never done anything wrong to feel like that'. She also said that she understood 'very well' the difference between guilty and not guilty at another point during the interviews. We concluded, on the basis of these responses, that she did have the capacity to enter a plea.

[40] *Deputy General Prosecutor for Serious Crimes v. Josep Nahak*, Case No 01A/2004, 1 March 2005. Document number E111/3.1.1, paragraph 131.
[41] Document number E111, 00727083-00727087, dated 23 August 2011, paragraph 2.
[42] McGarry, A. L., & Curran, W. J. *Competency to stand trial and mental illness*. Rockville, MD: National Institute of Mental Health, 1973. This instrument has no standardised scoring schedule and no norms. This instrument examines 13 functions: appraisal of legal defences; unmanageable behaviour; quality of relating to attorney; planning of legal strategy including pleading; appraising the role of defence counsel, prosecutor, judge, jury, defendant, witnesses; understanding of court procedure; appreciation of charges; appreciation of the range of possible penalties; appraisal of likely outcome; capacity to disclose pertinent facts to attorney; capacity to realistically challenge prosecution witnesses; capacity to testify relevantly; self-defeating vs. self-serving motivation (legal sense).
[43] Pirelli et al, *Psychology, Public Policy, and Law* 2011; http://www.apa.org/pubs/journals/releases/law-17-1-1.pdf
[44] *Regina v M (John)* [2003] EWCA Crim 3452 in the Court of Appeal Criminal Division (England and Wales).

42. There are four charges that we understand have been made towards Ieng Thirith. It was difficult to ask her about her charges as she mostly refused to discuss what they meant. However, with repeated questioning over the three interviews, she stated the following at different points. On asking her about crimes against humanity, she said that it was 'really severe' and meant that 'the whole population of a country vanished'. As cited above, she explained that she had never 'killed' anyone and also said that murder meant 'a man killing another human being'. She explained that genocide referred to 'the whole population'. On asking her about torture, she stated that 'no one inflicted such harm'. On asking her about religious persecution, she stated that she 'never encountered it' and that 'Cambodians were not ambitious' (which we thought was possible to interpret as her saying say that Cambodians were not the type to harm other ethnic groups). Taken together, we felt that she did have the capacity to understand the charges.

43. We have taken the criteria of understanding the course of the proceedings as including an understanding of court procedures, the speeches of witnesses and lawyers to the judge, and the ability to communicate intelligibly on anything that is said by witness and counsel. In relation to court procedures, Ieng Thirith appeared to understand the role of the judge, but had difficulty in comprehending the adversarial nature of legal process, even after explanation. In addition, we felt that Ieng Thirith's cognitive impairment would compromise the ability to understand what was said in court, reason and weigh the information, and comment intelligibly on it. Specifically, it was our view that she would not be able to retain information from any statements made in court long enough to be able to comment on them intelligibly. In addition, we were of the opinion that her taking notes would not improve her capacity to a level that would be sufficient for the purposes of understanding the course of the proceedings.

44. We have taken the criteria of understanding the details of the evidence as including the ability to point out statements to which she disagrees, and the ability to inform counsel of her version of events and any factors that should be brought forward in defence. On these factors, Ieng Thirith appeared to have some capacity. She clearly disagreed when we read the indictment to her, and she put forward a number of defences when we asked her directly. Although these defences were mostly not credible in our view, she nevertheless had the ability to bring them forward. The defences varied but included stating that she was too

young at the time of the alleged atrocities, that her mother had brought her up well, and that a Cambodian woman could never do harm to others. Her memory of the late 1970s and her activities during this period are compromised, and this does complicate any assessment of this capacity. However, we note that many defendants for serious crimes claim to suffer from amnesia for the alleged offence, but this does not preclude their participation in the trial process as long as they have the ability to understand the details of the evidence.

45. We have taken to mean the related capacity of instructing counsel as including the ability to cooperate with Counsel, informing Counsel of the facts of the case, and assisting in the preparation of one's own defence. Our impression was that she was able to cooperate with her lawyers, and she stated that her 'defence lawyers' were trying to 'help me'. There is overlap in the second of the abilities with paragraph 44 above. In relation to the third of these factors, we are of the view that Ieng Thirith would have considerable difficulty in assisting in the preparation of her defence due to her memory impairment, not only in relation to her involvement at the time of the alleged offences, but memories for the wider context of her life at the time.

46. Ieng Thirith refused to answer questions relating to the consequences of any conviction. However, she did demonstrate some ability to see the consequences of being found 'mad'. When we showed her the press coverage of her last appearance in court on a laptop computer, she recognised herself in the photo and she read out in English the caption accompanying her photograph that mentioned her name. She said, 'they dare not call me again [to court] as many people support me'. We showed her another article and she pointed at the word 'dementia' mentioned in the article.[45] She reacted somewhat indignantly and stated in Khmer, 'You see, they accused me of being mad [*cchkuot*], so no one can do anything to the mad person [*monous chhkuot*].'

47. In relation to the ability to testify, we have taken this to mean that she could understand the questions put to her in court, apply her mind to answering them, and convey intelligibly her position. We felt that, on the basis of these, she did have sufficient capacity to testify. Our impression was that there was no difficulty in comprehending questions, and was able to respond to questions as described above.

[45] AFP report entitled, 'KRouge court told defendant has dementia– Aug 29, 2011' at http://www.google.com/hostednews/afp/article/ALeqM5i1Hw3req77Db1Lm_LgLuA7IzbRUw?docId=CNG.f17dd620575edb02954a7f8f0971f63b.13c1

48. We note that the case of *Prosecutor v. Kovacevic* added the 'identification and examination of witnesses' as part of the criteria for instructing counsel.[46] This case also added that medical experts considering fitness to stand trial should assess whether the defendant be able 'to take, with full awareness, the decision of whether or not to testify at trial and offer relevant answers to questions posed to him by his counsel, the prosecution and the Trial Chamber'. We are not aware that the identification and examination of witnesses is part of criteria to plead and stand trial in national jurisdictions with which we are familiar (the UK and US). Furthermore, we are not aware that this is included in research criteria.[47] With these caveats, Ieng Thirith recognises persons with whom she is familiar, although she may not be able to name them or correctly remember their roles. In relation to offering 'relevant' answers to questions, Ieng Thirith provided answers that were relevant in the sense that she understood the meaning of the questions posed and her answers provided some defence, although they were not internally consistent in the sense they sometimes contradicted other evidence she gave. For example, she stated on a number of occasions in her interviews with us that she was a young girl at the time of the alleged crimes.

49. In relation to Defence Question 13 (xiv),[48] we are of the view that Ieng Thirith would be able to follow proceedings from a different part of the court building though audio-visual techniques, and this may be helpful to her to some extent in conjunction with the assistance of counsel and support staff as outlined in paragraph 11 of the Co-Prosecutors Questions.[49] We are not aware of any research evidence that would inform Defence Questions 13 (xv-xvi) on audio-visual measures that may enhance competence to stand trial for those with cognitive impairment. We reviewed the research literature on restoring competence. The programmes that we identified primarily use a psycho-educational approach.[50] The last of these has been used in relation to individuals with a learning disability (also known as 'mental retardation' in US jurisdictions), but this approach would be less appropriate in our

[46] *Prosecutor v. Vladimir Kovacevic*, Case No. IT-01-42/2-I, 12 April 2006. Document number E111/3.1.2.
[47] Cf. a comprehensive review of item content of competency instruments by Rogers et al, *Journal of Forensic Psychiatry and Psychology* 2008; http://www.tandfonline.com/doi/abs/10.1080/14789940801947909.
[48] Document number E111/3, 00738537-00738545, dated 2 September 2011.
[49] Document number E111/2, 00738201-00738210, dated 2 September 2011.
[50] See, for example, the following journal abstracts: Pendleton, *American Journal of Psychiatry* 1980; http://ajp.psychiatryonline.org/cgi/content/abstract/137/9/1098
Davis, *Hospital and Community Psychiatry* 1985 ; http://psychservices.psychiatryonline.org/cgi/content/abstract/36/3/268
Brown, *Hospital and Community Psychiatry* 1992; http://psychservices.psychiatryonline.org/cgi/content/abstract/43/7/732
Wall et al, *Journal of the American Academy of Psychiatry and Law* 2003, http://www.jaapl.org/cgi/content/abstract/31/2/189.

view with individuals with dementia as it would be dependent on a reasonable level of memory for recently learned information and skills.[51]

50. There is little research evidence on the association between dementia and fitness to stand trial. One study that compared older adults who were and were not competent found that incompetence was associated with a diagnosis of dementia.[52] In addition, deficits in orientation and memory were most highly correlated with dementia. Nevertheless, these were statistical associations, and, of those deemed competent, one fifth had dementia, 8% were disoriented and 22% had memory impairment. This research evidence concurs with the statement in the Kovacevic case that 'the issue of fitness is not determined merely by the diagnosis of the mental or somatic disorder from which the Accused suffers, or by identifying which of those conditions *can* affect the functioning of the Accused's mind' (page 18).[53] A further study of restoration of competence in defendants with dementia found that a proportion of individuals with dementia were successfully restored to competence, but the population with dementia in this study were aged 50 years on average and hence not typical of those with Alzheimer's disease.[54] Factors that predicted lack of restoration to competence included a diagnosis of dementia and advancing age.

[51] This is known as the Slater Method, which can be summarized as follows: 'This method presents material to the defendant in a manner which differentiates between the individual's knowledge of the information and his or her understanding of the information. The first phase of training is knowledge-based. It serves to educate the defendant about the courtroom process, but does not attempt to ascertain concept comprehension. By contrast, phase two, or understanding-based training, "... addresses the more complicated concepts of understanding, appreciation, and reasoning" so that the defendant can "begin to grasp the effect of the charge on his or her life." Following the completion of both phases, the individual participates in role-playing sessions to further examine the defendant's tolerance of stress from the courtroom proceedings. Photographs of simulated courtroom environments, including personnel, are also used to encourage discussion about what occurs in the courtroom. This also offers a visual representation of the experience and reinforces knowledge-based concepts used during training. The training tool is organized into five different modules, consisting of the following content areas: purpose of training, courtroom personnel, courtroom proceedings, communication, and tolerating stress. It is recommended that the material in the modules be presented in systematic order over a varying period of time. Defendants meet with their trainers from one to five days each week, with training sessions ranging from a few minutes to one hour. Training sessions are held in a one-to-one format, which seems to work more favorably with individuals with intellectual disabilities. The trainer reviews each module at least three times, as the authors note that this serves as a minimum guideline for information retention' (Stoops et al, *Mental Health Aspects of Developmental Disabilities*, April-June, 2007).

[52] Frierson et al, *Journal of the American Academy of Psychiatry and the Law* 2002; http://jaapl.org/cgi/content/abstract/30/2/252 (attached).

[53] This is further underlined in a study conducted by one of the writers of the current report, which found that a fifth of patients with a clinical diagnosis of dementia were deemed competent to complete advance directives (Fazel et al, Lancet 1999: http://www.sciencedirect.com/science/article/pii/S014067369901911X). Dementia is also a significant independent predictor of legal insanity in older defendants (Fazel et al, International Journal of Geriatric Psychiatry 2002; http://onlinelibrary.wiley.com/doi/10.1002/gps.715/abstract).

[54] Morris & Parker, *International Journal of Law and Psychiatry* 2009; http://www.sciencedirect.com/science/article/pii/S0160252709000272

51. We are cognizant that it is the Court that makes the decision on Ieng Thirith's fitness to stand trial. Our own professional opinion is that this will be a finely balanced decision, and will depend, in part, on the threshold set for the ability of understanding the course of the proceedings (and the related ability of understanding court procedures). Our view is that, on the balance of probabilities, she did not have sufficient understanding on the basis of our examination. This is partly influenced by the fact that Ieng Thirith's abilities will fluctuate, which is to be expected considering her dementia. Our concerns over her understanding remained even though we interviewed her in her own surroundings and on three separate occasions. It was also our view that the compensations suggested in paragraph 11 of the Co-Prosecutors' Questions, namely oral summaries, regular and continuous contact throughout the trial, having Khmer-speaking lawyers engaged in all consultations,[55] will not provide the necessary improvements such that she would gain a sufficient level of understanding to follow the course of the proceedings. We have commented on other possible options to improve her fitness in paragraph 38 above, and take the same view that they are unlikely to improve her cognitive ability to the extent that she would have a sufficient understanding of the course of legal proceedings.

Signed

Date	Name	Place	Signature
9/10/11	Seena Fazel	Oxford, UK	S. Fazel
10/10/11	Koeut Chhunly	Phnom Penh	[signature]
10/10/11	Lina Huot	Phnom Penh	[signature]
10/10/11	Calvin Fones	Singapore	C Fones

[55] Document number E111/2, 00738201-00738210, dated 2 September 2011.