IN THE GENERAL DIVISION OF
THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2022] SGHC 150

Criminal Case No 28 of 2018

Between

Public Prosecutor

And

Saridewi Binte Djamani

FINDINGS ON REMITTAL

[Criminal Law — Statutory offences — Misuse of Drugs Act]
[Criminal Procedure and Sentencing — Appeal — Adducing fresh evidence]
[Criminal Procedure and Sentencing — Trials — Whether accused person suffered from methamphetamine withdrawal]

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Public Prosecutor
v
Saridewi bte Djamani

[2022] SGHC 150

General Division of the High Court — Criminal Case No 28 of 2018
See Kee Oon J
7–11, 17–18 February, 8 March 2022

28 June 2022 Judgment reserved.

See Kee Oon J:

1 This remitted hearing arises out of an appeal against my original decision convicting two co-accused persons after trial, namely: Saridewi Binte Djamani ("Saridewi"), who is the individual solely concerned in this remitted hearing, and one Muhammad Haikal Bin Abdullah. My grounds of decision in respect of the trial are contained in *Public Prosecutor v Saridewi Bte Djamani and another* [2018] SGHC 204 ("GD").

2 Only Saridewi filed an appeal against her conviction and sentence in CA/CCA 30/2018 ("CCA 30/2018"). Saridewi also filed CA/CM 15/2019 ("CM 15/2019"), seeking leave to rely on a further ground in her appeal, namely, that she was suffering from methamphetamine withdrawal symptoms during the identified statement-taking period, *ie*, 18 to 24 June 2016 ("the statement-taking period"). Specifically, the first of the four statements in question was recorded on 21 June 2016 under s 23 of the Criminal Procedure

Code (Cap 68, 2012 Rev Ed) ("CPC"). The remaining three statements were recorded on 22 and 23 June 2016 under s 22 of the CPC.

3 In response to new psychiatric reports pertaining to Saridewi's methamphetamine withdrawal that were tendered at the appeal stage, the Court of Appeal remitted the case for me to take additional evidence relating to whether Saridewi had suffered from methamphetamine withdrawal during the statement-taking period. This was done pursuant to s 392 of the CPC. In the meantime, the Court of Appeal reserved its decisions on both CCA 30/2018 and CM 15/2019.

4 The Court of Appeal directed me to inquire and make appropriate findings in relation to the following questions as framed, and thereafter to remit the additional evidence for its assessment:[1]

> 1. Do the experts agree that the appellant was suffering from methamphetamine withdrawal between 18 and 24 June 2016?
> 2. What are the symptoms of methamphetamine withdrawal?
> 3. What was the extent of her condition?
>
> a. A range between mild and severe has been offered. It is possible to be more specific?
>
> b. If not, why not?
>
> c. What are the implications for the appellant's ability to give a reliable statement depending on whether her state of methamphetamine withdrawal was mild, moderate or severe?
>
> d. What particular and specific symptoms would have impeded her ability to provide such a statement?

[1] Minute sheet dated 16 September 2020 in CM 15/2019 and CCA 30/2018 at timestamp 1529hrs.

> e. Is it plausible that such symptoms would not have been noticed by any of the physicians who actually examined her at the time? If so, please explain.
>
> 4. The trial judge may consider any other relevant issues that may arise from the additional evidence and is then to determine whether the totality of the new evidence affects his earlier rulings regarding the statements in any way, and if so, what effect that has on the outcome of the trial.

Facts

Procedural history

5 Saridewi was convicted after trial on one charge under s 5(1)(*a*) read with s 5(2) of the Misuse of Drugs Act (Cap 185, 2008 Rev Ed) ("MDA") for having in her possession six packets and seven straws containing a total of not less than 30.72 grams of diamorphine, which is a Class A controlled drug under the First Schedule to the MDA. She was sentenced to suffer the death penalty.

6 In convicting Saridewi, I rejected, *inter alia*, her allegation of being unable to give accurate accounts during the statement-taking process because of her alleged mental conditions. At the trial, Saridewi adduced evidence from one Dr Julia Lam ("Dr Lam"), who opined that she was suffering from persistent depressive disorder and substance abuse disorder.[2] I was not persuaded by Dr Lam's assessment of whether Saridewi suffered from persistent depressive disorder, as she had failed to apply the exclusionary criterion to exclude symptoms attributable to the physiological effects of methamphetamine abuse during the period that Saridewi was also abusing methamphetamine.[3] In respect of Saridewi's claims that she was suffering from drug withdrawal during the

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2 GD at [36]; Psychologist report by Dr Lam dated 12 April 2018 at [35].

3 GD at [39].

statement-taking process, I found that these were afterthoughts as she did not raise any complaints or exhibit symptoms of drug withdrawal in respect of any drugs she had allegedly consumed to the four doctors who assessed her.[4]

7 Saridewi appealed against both her conviction and sentence by way of CCA 30/2018. In the Court of Appeal, Saridewi sought to admit by way of CM 15/2019 an expert medical report dated 13 July 2019 which was prepared by Dr Jacob Rajesh ("Dr Rajesh"), who is a Senior Consultant Psychiatrist in Promises (Winslow) Clinic and the Singapore Prison Service ("SPS") and a Fellow of the Academy of Medical Sciences, Singapore. Two further reports were prepared by Dr Rajesh pursuant to queries raised by the Court of Appeal. The third report Dr Rajesh prepared was in direct response to the Court of Appeal's questions for the purpose of the remitted hearing before me. In response to Dr Rajesh's reports, the Prosecution adduced three expert medical reports by Dr Mohamed Zakir Karuvetil ("Dr Zakir"), a Consultant in the Department of Addiction Medicine at the Institute of Mental Health ("IMH").[5]

The further evidence at the remitted hearing

Saridewi's evidence

(1) Explanations for the falsehoods in her statements

8 At the remitted hearing, Saridewi gave further evidence. She admitted that she had lied on several matters in her statements which were recorded from 21 to 23 June 2016 to create an untruthful narrative about her drug trafficking

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4 GD at [42].

5 Appellant's supplemental submissions for motion to admit fresh evidence at [3].

activities in order to avoid her capital charge.[6] She testified that she had wanted to downplay her involvement in drug trafficking.[7]

9 However, Saridewi also testified that she had made untruthful statements as she had not been "able to think properly".[8] She claimed that her mind had "shut down"[9] which led her to answer the questions posed to her without thinking through her responses. She had also felt sleepy at the material time but testified that she "still [had been] able to listen and … just answer spontaneously whatever [had been] asked" [*sic*].[10]

(2) Impression that she could be granted bail

10 Saridewi further testified that she had informed Dr Jason Lee Kim Huat ("Dr Lee"), an IMH doctor who conducted her psychiatric assessment in July 2016, that she was not suffering from drug withdrawal as she had been "hoping to get bailed out".[11] She explained that she had wanted to make it seem as if she had not been consuming drugs so that she could be granted bail.[12] She had been under the impression that the matter of bail would be decided based on a recommendation from the psychiatrist to the relevant judge.[13]

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6 Notes of Evidence ("NE") 7 February 2022, p 18 lines 3–6; p 83 lines 6–9.

7 NE 7 February 2022, p 29 lines 3–5.

8 NE 7 February 2022, p 83 lines 20–22.

9 NE 8 February 2022, p 42 lines 7–10.

10 NE 8 February 2022, p 42 lines 18–20.

11 NE 7 February 2022, p 72 lines 5–11.

12 NE 7 February 2022, p 73 lines 1–4.

13 NE 7 February 2022, p 73 lines 26–30.

(3) Alleged methamphetamine withdrawal symptoms

11 Saridewi testified that she had experienced symptoms of methamphetamine withdrawal during the statement-taking period. In particular, she claimed that she had experienced feelings of sleepiness and/or lethargy, hypersomnia, depressed mood, anxiety, an increased appetite and psychomotor retardation, as well as agitation.

12 Saridewi testified that she had felt sleepy and lethargic during the relevant period and had also suffered from hypersomnia. She felt sleepy from 18 to 24 June 2016 "[b]ecause of the withdrawal"[14] and she would sleep "all [day] along" [*sic*].[15] Furthermore, she stated that she had wanted the statement-taking process to be concluded quickly so that she could continue to sleep.[16] When asked why she did not raise her feelings of sleepiness to the doctors who examined her during the relevant period, she explained that addicts rarely tell doctors of their withdrawal symptoms, as they "want to be bailed out".[17]

13 Saridewi further testified that she had felt depressed from 18 to 24 June 2016 as she had been thinking of her son. She also attributed her depressed mood to her cessation of the usage of "ice" (the street name for methamphetamine).[18] She stated that she had already been experiencing a depressed mood when she was arrested, but that she "definitely [was] getting more depressed" after her arrest.[19]

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14 NE 7 February 2022, p 6 lines 6–8.

15 NE 7 February 2022, p 6 line 13.

16 NE 7 February 2022, p 10 lines 11–12, p 11 lines 27–28.

17 NE 8 February 2022, p 41 lines 12–17.

18 NE 7 February 2022, p 7 lines 7–11, p 11 lines 16–17.

19 NE 7 February 2022, p 86 lines 7–14.

14 Saridewi also testified that she had been anxious and tense during the statement-taking period. She had felt breathless, her heart had been beating fast, her hands had been shaking,[20] and she experienced an increase in appetite. However, she did not mention her increased appetite to the physicians who examined her or to Dr Rajesh when he interviewed her on 12, 14 and 21 March 2019 in preparation for his first report.[21]

15 Lastly, Saridewi testified that she had experienced symptoms of psychomotor retardation during the statement-taking period. Saridewi stated that "everything coming out from [her had been] slow".[22] She had to think and take some time before she answered questions and she had been "stammering".[23] She however failed to mention this when she was first interviewed by Dr Rajesh in March 2019 as she had "overlooked" it.[24] She claimed that she had also felt agitated but she could not explain why she had given inconsistent accounts on this to Dr Rajesh.[25]

Dr Rajesh's reports

16 In total, Dr Rajesh prepared three reports. The first report dated 13 July 2019 ("Dr Rajesh's 1st Report") was prepared on request of Saridewi's trial defence counsel. In preparation for the report, he interviewed Saridewi on 12, 14 and 21 March 2019. Dr Rajesh's second report dated 23 November 2019 ("Dr Rajesh's 2nd Report") was prepared in response to queries that were raised

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20 NE 8 February 2022, p 10 lines 14–17.

21 NE 7 February 2022, p 89 line 28 to p 90 line 4.

22 NE 8 February 2022, p 17 lines 6–7, 27.

23 NE 8 February 2022, p 18 line 10.

24 NE 8 February 2022, p 18 lines 30–32.

25 NE 7 February 2022, p 91 lines 7–13.

by the Court of Appeal on 11 September 2019. Specifically, the Court of Appeal's query at this juncture was:[26]

> … The only question for us is: having regard to his professional training, whether looking at the evidence he is satisfied that Dr Lam made a mistake in the evidence she gave and in the concessions she made. If he looks at what she said and he accepts that, as far as he is concerned, the concessions were correct on the evidence and the conclusions she arrived at were correct on the evidence, then I do not think there is anything more to be said. … If Dr Rajesh is able to say that she was wrong, and that there are a whole lot of medical reasons why they shouldn't have been made, then he needs to back that up with the relevant material. …

In preparation for this report, Dr Rajesh interviewed Saridewi on 10 October 2019. Dr Rajesh's third report dated 14 December 2020 ("Dr Rajesh's 3rd Report") was prepared in response to the queries raised by the Court of Appeal for the purposes of the remitted hearing (at [4] above). In preparation for this report, he interviewed Saridewi on 14 and 22 October 2020.

(1) Saridewi's persistent depressive disorder

17 In Dr Rajesh's 1st Report, he set out an opinion that Saridewi was suffering from persistent depressive disorder and amphetamine-type substance use disorder "at the material time of the offence".[27] He explained that "comorbid substance abuse, depression and dysthymia are common" as individuals "with depression and dysthymia often resort to drug use as a means of coping with their negative emotional state".[28] Dr Rajesh opined that Dr Lam's opinion was disregarded by the court as "the link between drug use and mental disorders was

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26 Minute sheet dated 11 September 2019 in CM 15/2019 and CCA 30/2018 at timestamp 1108hrs.

27 1st Agreed Bundle ("1-ABR") at p 141 (Dr Rajesh's 1st Report at para 26).

28 1-ABR at p 142 (Dr Rajesh's 1st Report at para 30).

not properly explained in her report".[29] He further explained the possibility that comorbid mental disorders can coexist with drug use and can be diagnosed even in individuals using drugs. As such, he concluded that Saridewi had been suffering from an abnormality of mind at the material time of the offence, due to her mental disorders which had impaired her judgment and ability to make rational decisions.[30]

(2) Diagnostic criteria for methamphetamine withdrawal

18 Dr Rajesh noted that Saridewi's reported methamphetamine use was documented in a drug withdrawal assessment form used by the SPS on 18 June 2016.[31] However, the withdrawal symptoms and signs of methamphetamine withdrawal are very different from the items that are mentioned on the drug withdrawal assessment form that the prison medical officers used.[32] Dr Rajesh stated that the drug withdrawal assessment form used by the SPS is tailored predominantly to account for symptoms and signs of heroin (the street name for diamorphine) withdrawal. These include nausea, diarrhoea, vomiting, running nose, dilated pupils, yawning and piloerection.[33]

19 Dr Rajesh also outlined the diagnostic criteria for stimulant withdrawal as set out in the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association Publishing, 5th Ed, 2013) ("DSM-V").[34] This consists essentially of dysphoric mood and

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29 1-ABR at para 144 (Dr Rajesh's 1st Report at para 39).

30 1-ABR at p 143 (Dr Rajesh's 1st Report at para 33).

31 1-ABR at p 101.

32 1-ABR at p 185 (Dr Rajesh's 2nd Report at para 7).

33 1-ABR at p 189 (Dr Rajesh's 2nd Report at para 14).

34 1-ABR at p 188 (Dr Rajesh's 2nd Report at paras 10A–10D).

two (or more) of the following physiological changes developing within a few hours to several days after cessation of (or reduction in) prolonged amphetamine-type substance, cocaine or other stimulant use:

(a) fatigue;

(b) vivid, unpleasant dreams;

(c) insomnia or hypersomnia;

(d) increased appetite; and

(e) psychomotor retardation or agitation.

20 According to the DSM-V, the above signs or symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. The DSM-V also specifies that the signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.[35] The drug withdrawal assessment form used in prison settings did not include items related to methamphetamine withdrawal as mentioned in the DSM-V.

(3) Whether Saridewi was suffering from methamphetamine withdrawal

(A) SARIDEWI'S SELF-REPORTED ACCOUNT

21 Dr Rajesh opined that Saridewi had been suffering from amphetamine withdrawal during the statement-taking period.[36] In his interviews with Saridewi, she reported that she had experienced both the symptoms of a "crash"

35 1-ABR at p 188 (Dr Rajesh's 2nd Report at para 10D).

36 1-ABR at p 199 (Dr Rajesh's 3rd Report at para 15).

and the withdrawal symptoms which set in after a crash during her lock-up.[37] He explained that chronic methamphetamine users first experience a "crash" commencing 12 to 24 hours after the last use, which is characterised by exhaustion, fatigue and sleep disturbances (typically, excessive sleep). This subsides within two to four days and is followed by the withdrawal phase. The withdrawal phase sets in two to four days after last use, peaks in seven to ten days and subsides over two to four weeks.[38]

22 Dr Rajesh was of the view that Saridewi was experiencing methamphetamine withdrawal symptoms from 18 to 20 June 2016, during her observation at Changi Women's Prison ("CWP"), based on her reporting of excessive sleepiness, feelings of fatigue and sadness to Dr Lam and himself.[39] He stated that the prison medical officers' assessment that she was negative for non-opioid withdrawal was erroneous as the structured drug withdrawal assessment form used by the SPS was not specifically designed to pick up signs of methamphetamine withdrawal.[40]

23 Dr Rajesh further stated that it was plausible that symptoms of methamphetamine withdrawal would have been missed by the physicians who examined her at the time. The structured drug withdrawal assessment form used by the SPS to assess drug withdrawal is not designed to capture symptoms and signs of methamphetamine withdrawal, hence the relevant questions specific to methamphetamine withdrawal were not asked.[41] Furthermore, Dr Rajesh stated

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37 1-ABR at p 193 (Dr Rajesh's 2nd Report at para 27).

38 1-ABR at p 193 (Dr Rajesh's 2nd Report at para 26).

39 1-ABR at p 190 (Dr Rajesh's 2nd Report at para 20).

40 1-ABR at p 190 (Dr Rajesh's 2nd Report at para 21).

41 1-ABR at p 201 (Dr Rajesh's 3rd Report at para 18).

that the physicians and nurses only saw her "cross-sectionally" and there was no longitudinal assessment over several days which was necessary to observe withdrawal symptoms.[42] He opined in his 3rd Report that Saridewi was "probably" suffering from moderate withdrawal at the time her statements were taken.[43]

(B) AMPHETAMINE WITHDRAWAL QUESTIONNAIRE

24 Dr Rajesh further attached to his 3rd Report an amphetamine withdrawal questionnaire ("AWQ") which is used in addiction settings in New Zealand that "elucidates the withdrawal symptoms".[44] He administered the AWQ to Saridewi on 22 October 2020 and found that she had met several of the questionnaire criteria.[45] Accordingly, Dr Rajesh opined that Saridewi had been suffering from amphetamine withdrawal between 18 and 24 June 2016.[46]

25 As for the limitations of the AWQ, Dr Rajesh acknowledged that the AWQ is not used in clinical practice in Singapore and needs to be administered within the 24-hour period after a patient is admitted to an inpatient unit, so that the limitation of retrospective recall is minimised.[47] Nonetheless, the AWQ is routinely used in Australia and New Zealand and has been validated for clinical use.[48] He also explained that the reason that he had used the questionnaire was to respond to the Court of Appeal's queries on the extent of Saridewi's condition

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42 1-ABR at p 193 (Dr Rajesh's 2nd Report at para 27).

43 1-ABR at p 201 (Dr Rajesh's 3rd Report at para 16)

44 1-ABR at p 185 (Dr Rajesh's 2nd Report at para 6).

45 1-ABR at p 203 (Dr Rajesh's 3rd Report).

46 1-ABR at p 199 (Dr Rajesh's 3rd Report at para 8).

47 NE 8 February 2022, p 86 lines 9–18.

48 1-ABR at p 199 (Dr Rajesh's 3rd Report at para 8).

(at [4] above).[49] Dr Rajesh stated that the symptoms that Saridewi displayed included excessive sleepiness, fatigue, increased appetite and going into "shut down mode" (in her words) after her arrest due to methamphetamine withdrawal. This was corroborated by the entry of a nurse, Maria Rhodora Vinluan Isla ("Ms Maria") who documented that she "look[ed] lethargic" on 20 June 2016.[50] Another nurse, Zawiyah Bte Amat ("Ms Zawiyah") recorded her pulse rate to be 62 on 19 June 2016.[51] Dr Rajesh stated that "a slower heart rate (bradycardia) is also a sign of methamphetamine withdrawal", though "it is not one of the essential criteria in the DSM-V".[52]

(4) Severity of methamphetamine withdrawal and impact on reliability of Saridewi's statements

26 Dr Rajesh further stated that Saridewi had been suffering from "at least moderate withdrawal" based on her self-reports of excessive sleepiness, fatigue, increased appetite, psychomotor retardation and depressed mood. Her urine test also showed a high amount of amphetamine, much higher than the cut-off.[53] The reliability of her statements could be affected depending on the severity of withdrawal, as her cognitive processes could be affected by symptoms such as a lack of focus, poor concentration, and suggestibility.[54]

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49 NE 8 February 2022, p 87 lines 1–5.

50 1-ABR at p 200 (Dr Rajesh's 3rd Report at para 10).

51 1-ABR at pp 106–107.

52 1-ABR at p 200 (Dr Rajesh's 3rd Report at para 11).

53 1-ABR at p 201 (Dr Rajesh's 3rd Report at para 15).

54 1-ABR at p 201 (Dr Rajesh's 3rd Report at para 16).

Dr Zakir's reports

27 Dr Zakir prepared three reports providing his views on Dr Rajesh's reports. Dr Zakir did not personally examine or interview Saridewi. In preparing his reports, he relied on Dr Rajesh's medical reports, transcripts of Dr Lam's evidence at the trial in May 2018 and her medical report dated 12 April 2018, Dr Lee's medical report, transcripts of evidence by doctors who assessed Saridewi for drug withdrawal and Saridewi's investigation statements.

28 The first report dated 15 April 2020 was prepared for the purpose of providing Dr Zakir's general views on Dr Rajesh's 2nd Report ("Dr Zakir's 1st Report").[55] Dr Zakir prepared a second report dated 25 May 2020 ("Dr Zakir's 2nd Report") that further considered the Toxicology Reports from the Health Sciences Authority and Saridewi's Instant Urine Test ("IUT") result slip from a test done by the Central Narcotics Bureau ("CNB"). Dr Zakir prepared a third report dated 27 May 2021 ("Dr Zakir's 3rd Report") in response to the queries raised by the Court of Appeal for the purposes of the remitted hearing (at [4] above).

(1) Diagnostic criteria for methamphetamine withdrawal

29 Dr Zakir also relied on the diagnostic criteria in the DSM-V (at [19] above).[56] He highlighted that the most prominent signs and symptoms of methamphetamine withdrawal are disturbed sleep, depressed mood and anxiety, craving and cognitive impairment.[57]

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55 Appellant's supplemental submissions for motion to admit fresh evidence at [4].

56 1-ABR at pp 126–127 (Dr Zakir's 1st Report at paras 6.1–6.2).

57 1-ABR at p 126 (Dr Zakir's 1st Report at para 5.3).

(2) Whether Saridewi was suffering from methamphetamine withdrawal

30 At the outset, Dr Zakir noted that there were several contradictions in Saridewi's self-reports of the type, quantity and duration of methamphetamine and heroin consumption.[58] These details were vital in accurately diagnosing any substance use disorder, especially the substance withdrawal state. He subsequently detailed the different accounts that Saridewi had provided to various persons, highlighting that the varying accounts would result in the respective records indicating that she may have experienced different withdrawal symptoms (if any).[59]

31 However, given her history of methamphetamine use and the urine toxicology analysis that showed positive results for methamphetamine, Dr Zakir opined that it was likely that she may have suffered withdrawal symptoms after she was arrested due to abrupt cessation of methamphetamine use.[60]

(3) Severity of methamphetamine withdrawal and impact on reliability of Saridewi's statements

32 Dr Zakir stated that generally, the severity of Saridewi's withdrawal symptoms could vary from mild to severe,[61] though he was unable to comment on the exact degree of severity of Saridewi's withdrawal symptoms.[62] He noted that Saridewi's level of alertness, distress, orientation and cognition at the point a particular statement was recorded could impede her ability to give accurate

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58 1-ABR at p 121 (Dr Zakir's 1st Report at para 4.1).

59 1-ABR at pp 121–123, 125 (Dr Zakir's 1st Report at paras 4.2–4.5, 4.11).

60 1-ABR at p 131 (Dr Zakir's 2nd Report at para 3).

61 1-ABR at p 131 (Dr Zakir's 2nd Report at para 3).

62 1-ABR at p 133 (Dr Zakir's 3rd Report at question QC).

information.[63] However, Saridewi had not reported any major withdrawal symptoms nor exhibited any significant distress or impairment that would greatly impact her ability to give a coherent testimonial during the statement-taking period.[64] Most clinicians are capable of noticing moderate to severe withdrawal symptoms and in most cases of amphetamine use disorder, the withdrawal symptoms tend to be short, mild and self-limiting.[65]

33 Dr Zakir observed that Saridewi had the opportunity to report any withdrawal symptoms she had experienced during the initial period at Changi Medical Complex, but had failed to do so. This suggested that her symptoms had been neither prominent nor subjectively bothersome to her.[66] He stated that experienced clinicians are usually able to provide a reasonably accurate and consistent judgment as to the level of discomfort experienced by patients in methamphetamine withdrawal or in substance withdrawal (in general).[67] Since there were clear discrepancies in her description of the types, timeline and the quantity of the substances used, it was difficult to accurately diagnose her substance use disorder or substance use withdrawal.

Physicians' and nurses' evidence

34 During the remitted hearing, six doctors and four nurses who had observed Saridewi at the contemporaneous time testified on their observations and findings they had regarding Saridewi's alleged methamphetamine withdrawal during the relevant period. The four nurses were called as defence

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63 1-ABR at pp 133–134 (Dr Zakir's 3rd Report at question QE).

64 1-ABR at p 133 (Dr Zakir's 3rd Report at question QD).

65 1-ABR at p 134 (Dr Zakir's 3rd Report at [QF]).

66 NE 10 February 2022, p 51 lines 24–28.

67 1-ABR at p 127 (Dr Zakir's 1st Report at para 7.2).

witnesses while the doctors were called by the Prosecution. I will summarise the main aspects of their evidence below.

35 Notably, three of the doctors, Dr Tan Chong Hun ("Dr Tan"), Dr Edwin Lymen Vethamony ("Dr Vethamony") and Dr Rachel Chan ("Dr Chan") used the structured drug withdrawal assessment form issued by the SPS to assess Saridewi for drug withdrawal symptoms discussed at [18] above.[68]

(1) Dr Tan

36 Dr Tan examined Saridewi on 18 June 2016 at CWP. At the material time, Dr Tan was a Medical Officer attached to the Complex Medical Centre of the SPS. The clinical examination that he conducted at the material time included an assessment regarding whether Saridewi was experiencing withdrawal symptoms associated with the use of methamphetamine.[69]

37 At the remitted hearing, Dr Tan testified that he had looked out for withdrawal symptoms but conceded that it was possible that he may have missed symptoms that had not been specifically presented by the patient.[70] He testified that Saridewi had been coherent in answering questions and had not been so drowsy that she was unable to respond to his questions.[71] He further stated that Saridewi had not exhibited any suicidal tendencies and that she had not appeared teary or sad.[72]

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68 1-ABR at p 101.

69 1-ABR at p 117 (Statement of Dr Tan at para 5).

70 NE 17 February 2022, p 131 lines 22–25.

71 NE 17 February 2022, p 119 lines 4–6.

72 NE 17 February 2022, p 119 lines 15–21.

(2) Dr Vethamony

38 Dr Vethamony conducted a clinical examination of Saridewi on 19 June 2016 at CWP. At the material time, Dr Vethamony was a Medical Officer attached to the Complex Medical Centre of the SPS.[73] The examination that he conducted at the material time included an assessment of whether Saridewi was experiencing withdrawal symptoms associated with the use of methamphetamine.[74] Dr Vethamony testified that if a doctor were to solely rely on the structured drug withdrawal assessment form, which is a form to facilitate notetaking for doctors when they attend to patients in the police lock-up,[75] mild to moderate methamphetamine withdrawal could be missed.[76]

39 Dr Vethamony further stated that he did not specifically ask Saridewi about hypersomnia, but this should have been monitored by the prison, which has a CCTV system.[77] He also did not observe any "flat [a]ffect", which is sometimes presented by patients who are depressed.[78] Saridewi did not report any increased appetite to Dr Vethamony, and he did not ask about it.[79] During his examination of Saridewi, he also did not observe any restlessness or psychomotor retardation, but had in fact observed that she was quite alert.[80]

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73 1-ABR at p 114 (Statement of Dr Vethamony at para 1).

74 1-ABR at p 114 (Statement of Dr Vethamony at para 2).

75 NE 17 February 2022, p 61 lines 5–6.

76 NE 17 February 2022, p 105 lines 16–19.

77 NE 17 February 2022, p 87 lines 7–9.

78 NE 17 February 2022, p 88 lines 4–9.

79 NE 17 February 2022, p 87 lines 12–13.

80 NE 17 February 2022, p 87 lines 15–17.

(3) Dr Chan

40 Dr Chan examined Saridewi on 20 June 2016 at CWP. At the material time, Dr Chan was a Medical Officer attached to CWP.[81]

41 Dr Chan testified that she had relied on the symptoms and signs as listed in the structured drug withdrawal assessment form,[82] and conceded that she had not looked out for specific signs of methamphetamine withdrawal. She also testified that she had not been specifically looking out for any symptoms and signs of fatigue or exhaustion, and accepted the possibility that mild symptoms of fatigue will not be picked up on medical examination unless the patient actively complains and reports it.[83]

42 Dr Chan was questioned as to the discrepancies between Saridewi's weight recorded on the Inmate Admission Medical and Mental Health Screening Questionnaire administered on 18 June 2016, when it was recorded as 50kg,[84] and on 24 June 2016, when it was recorded as 55kg.[85] Dr Chan testified that a 5kg weight increase in a few days is quite impossible, even in someone with an increased appetite.[86] Dr Chan also noted that Saridewi had not exhibited any abnormalities with her compliance with instructions.[87]

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81 1-ABR at p 88 (Statement of Dr Chan at para 1).

82 NE 18 February 2022, p 26 lines 8–11.

83 NE 18 February 2022, p 37 lines 19–23.

84 2nd Agreed Bundle ("2-ABR") at pp 18–19.

85 2-ABR at pp 12–13.

86 NE 18 February 2022, p 33 lines 2–9.

87 NE 18 February 2022, p 13 lines 2–3.

(4) Dr Wong Kia Boon

43 Dr Wong Kia Boon ("Dr Wong") examined Saridewi on 21 June 2016, at about 2.05pm at the Central Police Divisional Lock-up for a pre-statement medical examination, and again at about 6.00pm for a post-statement medical examination.[88] At the material time, Dr Wong was attached to Healthway Medical Group Pte Ltd as an ambulatory physician.[89]

44 Dr Wong testified that the list of signs contained in the structured drug withdrawal assessment form are "more relevant for opioid withdrawal". For methamphetamine withdrawal, a lot of the withdrawal symptoms, including sleep disturbances and vivid dreams, are "dependent on subjective reporting".[90] Dr Wong also stated that the focus of his medical examination had not been specifically to "pick out withdrawal", but rather, to ensure that the subject had mental capacity to undergo interrogation.[91]

45 Dr Wong stated that Saridewi did not present symptoms of excessive sleepiness when he examined her.[92] She also did not present any symptoms of depression or symptoms relating to depression.[93] The content and rhythm of her speech had been normal. She had also not been obtunded and had been able to respond to instructions given to her.[94]

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88 1-ABR at p 90 (Statement of Dr Wong at paras 2–3).

89 1-ABR at p 112 (Statement of Dr Wong at para 1).

90 NE 17 February 2022, p 76 lines 2–6 and lines 26–31; NE 17 February 2022, p 78 lines 14–16.

91 NE 17 February 2022, p 66 lines 3–9; NE 17 February 2022, p 79 lines 1–7.

92 NE 17 February 2022, p 69 line 30 to p 70 line 1.

93 NE 17 February 2022, p 69 lines 27–28.

94 NE 17 February 2022, p 70 lines 6–11.

46 Although Dr Wong agreed that the list of signs and symptoms in the structured drug withdrawal assessment form was "more biased towards opioid withdrawal", which has more physical signs,[95] as opposed to methamphetamine withdrawal. Nonetheless, in his physical examination of his patients, he would not limit himself to just focusing on the symptoms listed in the structured drug withdrawal assessment form, and he would also consider his patients' general appearance and speech.[96]

(5) Dr Cheok Liangzhi

47 Dr Cheok Liangzhi ("Dr Cheok") examined Saridewi on 24 June 2016 at about 9.40pm at CWP. This was for the purpose of a medical assessment and to obtain her medical history, before she was remanded.[97] At the material time, Dr Cheok was a Medical Officer attached to the Complex Medical Centre of the SPS.

48 Dr Cheok conducted a "general cursory examination" to see if there were "obvious or gross signs of withdrawal".[98] He confirmed that Saridewi had not displayed any objective signs of lethargy, *eg* being slumped over her chair, dozing off in-between questions or being unable to follow instructions. She also did not subjectively report any concerns during her history-taking.[99] If Saridewi had been assessed to be lethargic at the material time, Dr Cheok would have documented that she was lethargic or confused.[100]

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95 NE 17 February 2022, p 78 lines 14–16.

96 NE 17 February 2022, p 78 lines 22–26.

97 2-ABR at p 7 (Statement of Dr Cheok at para 2).

98 NE 18 February 2022, p 51 lines 16–19.

99 NE 18 February 2022, p 54 lines 8–13.

100 NE 18 February 2022, p 53 lines 26–27.

(6) Dr Lee

49 Dr Lee interviewed and examined Saridewi on 7, 8 and 14 July 2016 at CWP. Dr Lee subsequently prepared a psychiatric report dated 15 July 2016. At the material time, Dr Lee was an Associate Consultant with the Department of General and Forensic Psychiatry of the IMH.[101]

50 Dr Lee testified that after questioning Saridewi on her drug history during the forensic psychiatric assessment, he had been satisfied that she was no longer having any drug withdrawals.[102] Saridewi also told him that she was not having any withdrawals when her statements were taken at the Police Cantonment Complex.[103] He was satisfied that Saridewi was aware of what drug withdrawal symptoms would be presented on abstinence, as she had provided details such as hunger, sleepiness, weakness and "no backbone", which he interpreted to refer to fatigue or tiredness.[104]

51 The Prosecution also asked Dr Lee if he had any personal knowledge of Saridewi's intentions to seek release on bail in 2016. Dr Lee testified that based on his notes, no such matter had been discussed between him and Saridewi.[105]

(7) Wu Cai Xia

52 Wu Cai Xia ("Ms Wu") was a staff nurse at CWP who had care of Saridewi on 18 June 2016. Her documentation did not indicate that Saridewi

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101 2-ABR at p 3 (Statement of Dr Lee).

102 NE 8 March 2022, p 4 lines 11–25.

103 NE 8 March 2022, p 4 lines 20–22.

104 NE 8 March 2022, p 4 lines 29–32.

105 NE 8 March 2022, p 14 lines 21–31.

had any symptoms of methamphetamine withdrawal.[106] According to Ms Wu, she would observe inmates via CCTV and during physical rounds. If an inmate was experiencing sleepiness, she would document that the "patient is sleepy".[107]

(8) Ms Zawiyah

53 Ms Zawiyah was a staff nurse at CWP who had care of Saridewi on 19 June 2016. Her documentation indicated that Saridewi had been "resting most of the time".[108] She testified that this meant that she had observed Saridewi lying down in her cell most of the time, without moving around or exercising.[109] She did not recall having any difficulty waking Saridewi up.[110]

(9) Ms Maria

54 Ms Maria was a staff nurse in CWP who had care of Saridewi on 20 June 2016. Her documentation indicated that Saridewi had "slept the whole night" and "look[ed] lethargic".[111] She testified that she would only document this if the patient lacked energy and was difficult to wake up.[112] As she had made this record at 6.37am in the morning, she also clarified that it was possible that Saridewi had appeared sleepy as she was in the process of waking up and not lethargic *per se*.[113]

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106 1-ABR at p 103.

107 NE 9 February 2022, p 107 line 30 to p 108 line 7.

108 1-ABR at p 107.

109 NE 9 February 2022, p 139 line 29 to p 140 line 7.

110 NE 9 February 2022, p 146 lines 11–13.

111 1-ABR at p 108.

112 NE 10 February 2022, p 7 lines 5–11 and lines 28–30.

113 NE 10 February 2022, p 15 lines 8–18.

55 It is unnecessary for me to outline the evidence of the fourth nurse, Ms Elvina Tai Yee Tsing, as no reliance was placed on her testimony by the parties. All four nurses confirmed that Saridewi did not raise any complaints to them.

Defence's submissions on the further evidence

56 Saridewi argues that where the opinions of the two doctors differ, Dr Rajesh's evidence should be preferred.[114] Dr Zakir did not personally interview Saridewi in arriving at his opinions, but relied on the documentation of other physicians who attended to her during the material period.[115] Dr Lee confirmed during the hearing that *if* he were providing expert opinion on a person's mental condition, it would be more prudent and effective to conduct a personal interview or assessment of the subject individual, which Dr Zakir chose not to do.[116]

57 Furthermore, Saridewi seeks to discredit Dr Zakir's reports, alleging that they were not substantiated and that they showed a clear bias in the presentation of his evidence. To illustrate this, Saridewi points out that Dr Zakir was selective in his reliance on scientific research and that he deleted words from the clinical conclusions in the articles he referred to in order to suit the Prosecution's case. Dr Zakir admitted that paragraph 5.2 of his 1st Report had been adapted from a specific paragraph referenced in Catherine McGregor *et al*, "The nature, time course and severity of methamphetamine withdrawal", *Addiction* (2005).[117] The words used in his report were reproduced from the said article, but Dr Zakir had

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114 Saridewi's Closing Submissions ("DCS") at para 5.

115 DCS at para 6.

116 DCS at para 7.

117 2-ABR at p 83.

selectively removed certain words, such as omitting to say that the subacute phase of methamphetamine withdrawal lasts "at least" two weeks,[118] thus giving an opinion in his report at odds with the medical conclusions of the referenced material.[119]

58 Saridewi submits that both experts agree on the symptoms of methamphetamine withdrawal, in that they refer to the same DSM-V criteria (at [19] above).[120] Saridewi further argues that both experts' views are not different. After Dr Zakir had sight of Saridewi's toxicology drug screen results, he confirmed that Saridewi may have "suffered withdrawal symptoms from Methamphetamine after she was arrested on 17th June 2016, due to abrupt cessation of the use" (at [31] above).[121] Dr Rajesh is of the same opinion, since he opined in his 3rd Report that Saridewi had been suffering from amphetamine withdrawal between 18 and 24 June 2016 (at [24] above).[122]

59 As to the extent of her condition, Saridewi relies on the AWQ administered by Dr Rajesh that suggests that she had been suffering from at least moderate withdrawal at the material time.[123] According to Dr Rajesh, the greater the severity of the withdrawal, the more one's cognitive processes can be affected.[124] Saridewi submits that symptoms that would have impeded her

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118 NE 11 February 2022, p 9 lines 11–20.

119 DCS at para 9.

120 DCS at para 22.

121 DCS at para 20.

122 DCS at para 21.

123 DCS at para 23.

124 DCS at para 26.

ability to give a reliable statement include her depressed mood and fatigue as her body was in "shut down mode" during the relevant period.[125]

60 Saridewi's symptoms during the relevant time could have been missed by the physicians who examined her as the structured drug withdrawal assessment form used by the SPS is not designed to capture symptoms and signs of methamphetamine withdrawal, but more those of opioid withdrawal, which entails a different set of symptoms and signs.[126] As the physicians used the template drug assessment form deployed at CWP, the relevant questions indicating the symptoms of methamphetamine withdrawal would not be asked of persons in remand such as Saridewi.[127] Furthermore, as suggested by Dr Rajesh, it is not reasonable to expect general practitioners to know of or be aware of all methamphetamine withdrawal symptoms.[128] Accordingly, if Saridewi did not volunteer her symptoms, it would be unlikely for the physicians to identify them.[129] This is further supported by the cross-examination of the doctors who examined Saridewi at CWP from 18 to 24 June 2016 – Dr Wong, Dr Vethamony and Dr Tan in particular stated that they could have missed mild symptoms of methamphetamine withdrawal.[130]

61 Lastly, Saridewi points out that she was labouring under the impression that she could be offered bail in spite of her capital charge.[131] As she testified

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125 DCS at para 29.

126 DCS at para 32.

127 DCS at para 33.

128 DCS at para 43(c).

129 DCS at para 47(c)(iii).

130 DCS at paras 47(c)(iii), 48(f), 49(c).

131 DCS at para 67.

during the remitted hearing, one of her motivations when giving her statements to Dr Lee had been to present a good impression to him in the hope that she could obtain bail.[132] As such, she did not mention that she was suffering from methamphetamine withdrawal and downplayed her "ice" consumption, when in reality, she had been consuming up to 5 grams of "ice" a day.[133]

Prosecution's submissions on the further evidence

62 The Prosecution submits that the totality of the evidence shows that Saridewi's statements are reliable.[134] First, the Prosecution submits that Saridewi's statements reflect her mental clarity at the time. Saridewi herself made several admissions that establish that she was lucid during her statement-recording.[135] She admitted that she had consciously and deliberately lied in her statements, which reflects goal-directed thinking. An individual undergoing withdrawal would not be able to lie continuously during the period of withdrawal.[136] Furthermore, she was able to recollect the events leading up to her arrest, providing details such as her feelings and actions of disposing the drugs, which show her alertness and active engagement during the course of her statement-recording.[137] The statements also disclosed information that only she knew about, such as the fact that she did not have a regular source of income.[138]

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132 DCS at para 68.

133 DCS at para 70.

134 Prosecution's Closing Submissions ("PCS") at para 4.

135 PCS at para 17.

136 PCS at para 21.

137 PCS at para 22.

138 PCS at para 26.

Saridewi herself also accepted that all the information was uniquely within her knowledge.[139]

63 The Prosecution further submits that Saridewi was not suffering from any methamphetamine withdrawal at the relevant time. Saridewi admitted to Dr Lee that she had not suffered from drug withdrawal during her statement-taking. Across the two statements recorded on 23 June 2016, Saridewi also made positive assertions that she was "*feeling fine and…can give [her] statement*" [emphasis added].[140] She also did not ask to postpone her statement-recording over the three-day period of 21 to 23 June 2016.[141] Even if Saridewi was suffering from methamphetamine withdrawal, her symptoms based on her claims were mild to moderate and they did not affect the reliability of her statements.[142]

64 The Prosecution urges the court to reject Dr Rajesh's evidence and opinion. To substantiate this, the Prosecution submits that Dr Rajesh relied heavily, if not *solely* on Saridewi's self-reports in formulating his opinion and that he accepted that these self-reports constituted a major part of his opinion.[143] The symptoms that Saridewi had self-reported to Dr Rajesh are inconsistent with her position during the 2018 trial – while she reported to Dr Rajesh that she had experienced symptoms of an increase in appetite and psychomotor retardation, this was not raised during the 2018 trial.[144] Dr Rajesh's assessment

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139 PCS at para 26.

140 PCS at para 32; 1-ABR at p 49 and p 53.

141 PCS at para 33.

142 PCS at para 42.

143 PCS at para 48(a).

144 PCS at para 63.

also arises from the results of the AWQ, which was administered four years after the event and was therefore not validly administered.[145] Dr Rajesh had also failed to set out Saridewi's account of the statement-taking process.[146] His reports fail to consider Saridewi's lies, her recollection of specific events, her ability to study photographs and identify exhibits, as well as to furnish details and to understand the contents of her statements.[147]

65 The Prosecution also submits that it is implausible that Saridewi's symptoms would have gone unnoticed by *all* her doctors and nurses given their experience and familiarity with withdrawal symptoms.[148] Dr Rajesh himself conceded that doctors who were aware of methamphetamine withdrawal symptoms and who worked regularly with such patients should be able to pick up on withdrawal symptoms.[149]

Findings arising from the further evidence in the remitted hearing

Questions 1 and 2: What are the symptoms of methamphetamine withdrawal and do the experts agree that Saridewi was suffering from methamphetamine withdrawal between 18 and 24 June 2016?

66 Dr Rajesh and Dr Zakir agree that the symptoms of methamphetamine withdrawal are as listed in the DSM-V, as set out above at [19].

67 Saridewi's case that she was suffering from methamphetamine withdrawal between 18 and 24 June 2016 centred mainly on her dysphoric mood

145 PCS at para 66.

146 PCS at para 51.

147 PCS at para 57.

148 PCS at para 96.

149 PCS at para 98.

and alleged withdrawal symptoms of fatigue, hypersomnia (or excessive sleepiness), increased appetite and psychomotor retardation. She did not claim to have experienced any vivid or unpleasant dreams.

68 From the experts' explanations at the remitted hearing, they agree that Saridewi was suffering from methamphetamine withdrawal based primarily on her self-reported account of drug use and her IUT result. It appears to be common ground that she did suffer from methamphetamine withdrawal in the immediate aftermath of her arrest on 17 June 2016 (see [22] and [31] above). However, they disagree on the degree of severity of her withdrawal and the extent to which she suffered from withdrawal during the statement-taking period.

69 The pivotal considerations therefore relate to Question 3 which is the primary point of contention in the remitted hearing. I shall elaborate on my reasons for my assessment of the severity of her withdrawal in due course in dealing with Question 3 below.

Question 3: What was the extent of Saridewi's condition?

The experts' assessment of her withdrawal symptoms

70 In relation to Question 3a as framed by the Court of Appeal, namely whether it is possible to be more specific as to the extent of Saridewi's methamphetamine withdrawal, both experts were clear that she did not suffer from severe withdrawal that was objectively observable during the relevant period.

71 It would appear that the experts broadly agree that it is not possible to be more specific as to the precise extent of her withdrawal. Dr Zakir suggested

at the remitted hearing that her withdrawal symptoms, if present, had likely been mild to moderate,[150] as she did not report or exhibit any major withdrawal symptoms (see [32]–[33] above), while Dr Rajesh opined that she "probably" had moderate withdrawal symptoms at the time of her statement-taking (see [26] above).[151] Dr Rajesh also accepted that it was difficult to comment on the severity of her withdrawal since no specific or structured assessment scale was used.[152] It must be borne in mind that they had both prepared their reports based substantially on Saridewi's self-reported accounts. Moreover, Dr Zakir did not examine Saridewi personally, as his remit was to respond to and comment on the reports prepared by Dr Rajesh and those of the other physicians who examined her at the material time. Pertinently, neither of them had the benefit of any contemporaneous observation or evaluation of her alleged symptoms.

72 As I shall explain in the analysis below, the critical and dispositive consideration in the remitted hearing is that the further evidence does not show that Saridewi suffered significant withdrawal symptoms (if any) *during the statement-taking period*. This turns primarily on the credibility of Saridewi's allegations, as well as my assessment of the cogency of the experts' views on the severity of her condition.

Credibility of Saridewi's account during the remitted hearing

73 At the remitted hearing, Saridewi maintained her claims to have felt very sleepy and lethargic, being in "shut down mode"[153] and wanting the statement-taking process to conclude quickly so that she could sleep. She maintained that

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150 NE 10 February 2022, p 44 lines 30–31.

151 1-ABR at p 201 (Dr Rajesh's 3rd Report at para 16).

152 1-ABR at p 200 (Dr Rajesh's 3rd Report at para 14).

153 NE 8 February 2022, p 42 lines 7–10.

she had "felt depressed"[154] during the relevant period and felt agitated,[155] though her evidence in support of the latter claim was inconsistent. Arising from the additional evidence, there were also a number of fresh allegations in Saridewi's account of her withdrawal. For example, she also reported feeling anxious, tense,[156] experiencing an increased appetite[157] and psychomotor retardation.[158] These were not disclosed previously at her trial.

74 It is pertinent to note that during the trial, Saridewi had already raised the issue of her allegedly suffering from *some* drug withdrawal symptoms, including lethargy and sleepiness.[159] There is no reason why she could not have surfaced the full extent of her alleged withdrawal symptoms earlier during the trial, if indeed they were genuine. As the Prosecution rightly points out, she was an experienced "ice" user and was familiar with the relevant withdrawal symptoms. For the very first time, she claimed at the remitted hearing that she had suffered anxiety during the statement-taking period to the extent that her hands would shake. She also claimed that her heart had been beating fast and she had been unable to breathe.[160] Not only were all these never previously raised at her trial, they were not even mentioned to Dr Rajesh in any of his six interviews with her from 12 March 2019 to 22 October 2020.

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154 NE 7 February 2022, p 7 lines 7–11, p 11 lines 16–17.

155 NE 7 February 2022, p 91 lines 7–9.

156 NE 8 February 2022, p 10 lines 13–21.

157 NE 7 February 2022, p 88 lines 10–17.

158 NE 8 February 2022, p 17 lines 6–7, 27; NE 8 February 2022, p 18 line 10.

159 NE 9 May 2018, p 73 lines 4–5, 8–11.

160 NE 8 February 2022, p 10 lines 13–21.

75 It is telling that Saridewi gave inconsistent accounts of having felt agitated, based on what she stated to the doctors (including Dr Rajesh) and her evidence at trial and the remitted hearing. She claimed during the trial that she had been agitated during the statement-taking process. However, her evidence in this regard was in a constant flux. In Dr Rajesh's clinical notes, she was first recorded as reporting that she had experienced agitation,[161] but she reversed her position a year later at a subsequent interview when the AWQ was administered.[162] This resulted in Dr Rajesh recording "[n]ot at all" in response to the AWQ question of whether she had felt agitated.[163] At the remitted hearing, she claimed that she had felt agitated from 21 to 23 June 2016.[164] She further claimed only at the remitted hearing, again for the very first time, that she had been "stammering" and that her hands had been shaking during the statement-taking process. These details were not surfaced to Dr Rajesh before, despite her having had six opportunities to do so when he interviewed her.

76 It should also be noted that psychomotor retardation and agitation are binary symptoms in the DSM-V, yet Saridewi claimed, quite incredibly, to have experienced both. The very first time she mentioned having experienced psychomotor retardation, which according to her was similar to being in "shut down mode", was during the 14 October 2020 interview with Dr Rajesh, more than four years after her arrest on 17 June 2016.[165] Pertinently, this was only after the Court of Appeal had raised its queries for the remitted hearing.

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161 2-ABR at p 29 (Dr Rajesh's clinical notes transcript on 10/10/2019).

162 2-ABR at p 30 (Dr Rajesh's clinical notes transcript on 14/10/2020).

163 1-ABR at p 203.

164 NE 7 February 2022, p 90 lines 9–15.

165 2-ABR at p 30 (Dr Rajesh's clinical notes transcript on 14/10/2020).

77 In another key area of contention, Saridewi claimed to have experienced an increased appetite among her methamphetamine withdrawal symptoms. She claimed that this was supported by a purported weight gain of 5kg across the few days during the statement-taking period. It is self-evident that there must have been an error in the recording of her weight since such rapid weight gain within such a brief duration is inherently incredible, a view echoed by Dr Chan (at [42] above). The very first time she mentioned having had increased appetite was during the 10 October 2019 interview with Dr Rajesh, more than three years after her arrest.[166]

78 In my view, it is highly likely that Saridewi strenuously sought to shore up her alleged withdrawal symptoms at the remitted hearing after Dr Rajesh had elicited her responses on the factors listed in the AWQ. Illustrations of such self-prompted additions include her mention of anxiety, increased appetite and psychomotor retardation, all of which were listed among the AWQ factors though not specifically in similar terms among the DSM-V criteria. She also maintained at the remitted hearing that she had felt agitated in spite of stating the exact opposite in response to the AWQ. By the time she testified during the remitted hearing, she would have seen Dr Rajesh's three reports and the list of DSM-V criteria for methamphetamine withdrawal which were outlined in Dr Rajesh's 2nd Report.

79 I am therefore of the view that the additional details of withdrawal symptoms furnished by Saridewi only emerged as afterthoughts. They were crafted in an attempt to bolster her allegations during the remitted hearing. They were plainly tailored to fit either the AWQ or the DSM-V criteria for methamphetamine withdrawal as outlined in Dr Rajesh's reports as fully as

166 2-ABR at p 28 (Dr Rajesh's clinical notes transcript on 10/10/2019).

possible. As such, I consider these to be material inconsistencies in her evidence as a whole which seriously affect her credibility.

The severity of Saridewi's condition

(1) Dr Rajesh's opinion

80 Dr Rajesh opined that Saridewi had been suffering from "at least moderate withdrawal" during the statement-taking period,[167] which affected the reliability of the statements that she gave (see [26] above). However, Dr Rajesh's heavy reliance on Saridewi's AWQ responses and her self-reported accounts poses several difficulties. To begin with, Dr Rajesh's use of the AWQ itself is controversial. It is not disputed that usage of the AWQ is not an accepted protocol in local clinical practice.[168] The research paper that accompanies the AWQ also acknowledges that one of its limitations is that the number of patients participating in the factor analysis conducted in Thailand only had a small sample size of 102 cases, and more studies with a larger number of patients, among other criteria, should be conducted.[169] In addition, as Dr Zakir testified, apart from the first and ninth question on the AWQ, the majority of the questions are not specific to methamphetamine withdrawal, and are instead general questions that could overlap with various other psychiatric diagnoses.[170] In my view, this calls into question the reliability of the AWQ.

81 More importantly, even if the AWQ is accepted to be a reliable diagnostic tool for methamphetamine withdrawal, such a questionnaire is meant

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167 1-ABR at p 201 (Dr Rajesh's 3rd Report at para 15).

168 1-ABR at p 199 (Dr Rajesh's 3rd Report at para 8).

169 2-ABR at p 74.

170 NE 10 February 2022, p 55 line 26 to p 56 line 5.

to be administered to assess withdrawal symptoms experienced within the past 24 hours. This is clearly stated at the top of the AWQ itself. In the present case, by the time the AWQ was administered to Saridewi, four years had elapsed since her alleged withdrawal symptoms. The self-reported responses must surely be prone to recall errors at the very least, and recollection bias at worse. While Dr Rajesh testified that he had only administered the AWQ in response to the Court of Appeal's queries on the extent of Saridewi's condition while bearing in mind its limitations (see [25] above), these caveats do not adequately address the concerns I have concerning the reliability and utility of the AWQ.

82 Where expert medical opinion is based almost entirely on an accused person's self-reported symptoms, the court also has to consider "the cogency and limits of the medical evidence complemented by, where appropriate, an understanding of human experience and common sense" (see *Ilechukwu Uchechukwu Chukwudi v Public Prosecutor* [2021] 1 SLR 67 at [95]). In this regard, the Court of Appeal in *Teo Ghim Heng v Public Prosecutor* [2022] SGCA 10 ("*Teo Ghim Heng*") at [39] also considered that an accused person's self-reported symptoms should be considered in light of the additional information from people who would ordinarily interact with the accused person, as it is not uncommon for accused persons to exaggerate or malinger symptoms. In *Teo Ghim Heng*, the Court of Appeal found that the appellant's evidence on his alleged depressed mood had been externally and internally inconsistent, which lent credence to the finding that his self-reported symptoms were unreliable as a whole (at [53]).

83 Reverting to the present case, I find that Saridewi's evidence was externally and internally inconsistent. Fundamentally, the further evidence of the physicians who examined Saridewi reinforced my principal findings at trial. They were consistent in affirming that they did not notice any signs or

symptoms of drug withdrawal, and specifically of methamphetamine withdrawal. Saridewi was able to respond and communicate with them in a lucid and coherent fashion at all relevant times. She was alert and oriented, and did not raise any complaints to them of drug withdrawal. In a similar vein, the recording officer, Investigating Officer Peh Zhen Hao ("IO Peh"), had confirmed that she was in a proper condition to give her statements during the statement-taking period.[171] Crucially, Saridewi herself acknowledged during the remitted hearing that she had "felt fine" during the statement-taking period, that she had been able to recall the preceding events, and that she had been able to give her statements in considerable detail.[172]

84 In the four days spanning Saridewi's arrest and admission to CWP for drug withdrawal observation from 17 June 2016 to 20 June 2016, just before she gave her first statement, Ms Maria's observation notes did record that Saridewi looked sleepy and lethargic on one occasion (*ie,* on 20 June 2016; see [54] above).[173] This observation should however be understood in its proper context, namely that it was documented in the early morning when Saridewi had just been roused from her sleep. Moreover, there were no other similar observations recorded by the nurses or any of the doctors at any point in time. It is far more likely that this was an isolated instance.

85 In my assessment, Saridewi's accounts were taken largely at face value by Dr Rajesh and simply assumed to be truthful and accurate. There was little or no accounting for the fact that she had given different accounts previously in

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171 NE 18 February 2022, p 64 lines 6–11.

172 NE 7 February 2022, p 16 lines 6–11; p 23 lines 11–22; p 23 line 31 to p 24 line 3; p 40 line 24 to p 41 line 10; p 47 lines 7–11.

173 1-ABR at p 108.

her statements and at her trial, long before Dr Rajesh first interviewed her. He was not even aware that Saridewi had previously told Dr Lee that she had not suffered any withdrawal symptoms at the relevant time.[174] Notwithstanding the documented observations from the doctors and nurses who had previously interacted with her, Dr Rajesh was quick to dismiss these observations as being tenuous or inadequate while glossing over the fact that they were consistent and contemporaneous observations. He also glossed over the fact that she had given intentional, detailed and coherent statements containing information which only she could have furnished. Within these statements, she had deliberately woven in false exculpatory accounts. This strongly suggests that she was well-oriented and in a fit and proper condition to give her statements.

86 In my view, there are fundamental defects in Dr Rajesh's reports which diminish the objectivity, credibility and reliability of his expert opinion. While I would not characterise Dr Rajesh as a partisan witness, his objectivity is questionable primarily because he had relied almost unquestioningly on Saridewi's self-reported account. The upshot is that even if Dr Rajesh had correctly assessed Saridewi to have suffered withdrawal symptoms up to and during the statement-taking period, he had in all likelihood made an overly generous assessment of the severity of her condition.

87 To further illustrate Dr Rajesh's lack of objectivity, he had plainly suggested in his 3rd Report that "a slow heart rate (bradycardia) is also a sign of amphetamine withdrawal",[175] and that this was ostensibly supported by Ms Zawiyah's record of Saridewi's pulse rate at 62 on 19 June 2016. However, when asked for clarification, he claimed quite disingenuously that he had not

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174 NE 9 February 2022, p 26 lines 1–13.

175 1-ABR at p 200 (Dr Rajesh's 3rd Report at para 11).

said it was bradycardia and conceded that a heart rate measured at above 60 did not amount to clinical evidence of bradycardia.[176] It would thus follow that his opinion (as contained in his 3rd Report) that Saridewi had an "objective sign of slower heart rate which can be caused by methamphetamine withdrawal"[177] was seriously flawed. To round off, I note that Saridewi in fact claimed when cross-examined that among her withdrawal symptoms, her heart had been beating fast due to her anxiety, rather than too slowly.

(2) Dr Zakir's opinion

88 Dr Zakir acknowledged that given Saridewi's self-reported history of methamphetamine usage, she could have experienced withdrawal symptoms after her arrest, but also opined that she was unlikely to have experienced anything beyond mild to moderate withdrawal[178] as there were no observable symptoms (see [32]–[33] above). At any rate, any symptoms she might have experienced did not prove bothersome to her, as she did not surface any complaints to the multiple physicians who examined her. Apart from the absence of complaints of withdrawal, he noted that Saridewi did not exhibit any significant distress or impairment that would greatly impact her ability to give her statements.[179]

89 Dr Zakir therefore opined, consistent with the extrinsic objective evidence, that her ability to give reliable statements during the statement-taking period had not been affected. He further opined that most clinicians are capable of noticing moderate to severe withdrawal symptoms and in the case of

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176 NE 9 February 2022, p 55 line 31 to p 56 line 11.

177 1-ABR at p 201 (Dr Rajesh's 3rd Report at para 15).

178 NE 10 February 2022, p 44 lines 30–31.

179 1-ABR at p 133 (Dr Zakir's 3rd Report at question QD).

amphetamine use disorder, the withdrawal symptoms tend to be short, mild and self-limiting, such that in most cases, they tend to resolve within a week. I find these opinions reasonable and persuasive.

90 In his references to the relevant scientific and academic literature, Dr Zakir has summarised and consolidated the salient points. I see no basis for the Defence's criticism at [57] above that Dr Zakir failed to digest these points, as Dr Zakir's consolidation of the points is consistent with the key components of the literature in question. In particular, Dr Zakir testified that his findings were a "combination" of his research,[180] considering the DSM-V, textbooks, the research literature which he extracted and his clinical experience. I agree with Dr Zakir that the research articles that he relies on, cumulatively, point justifiably to the finding that the severity of methamphetamine withdrawal has a high initial peak, but subsequently is mild and tends to resolve within a week.[181]

91 As a whole, I find Dr Zakir's opinion to be more measured and objective. In the circumstances, I accept Dr Zakir's opinion that Saridewi's state of methamphetamine withdrawal was mild to moderate at most.[182] This is more consistent with the totality of the evidence, including her own accounts and admissions, and having regard to the inconsistencies and constant shifts in her accounts. I find that the severity of her condition was exaggerated in her AWQ responses and her self-reported accounts to Dr Rajesh. I find that she was unlikely to have suffered from any significant withdrawal symptoms by the time her statements were actually recorded.

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180 NE 17 February 2022, p 39 lines 20–28.

181 2-ABR at p 75, p 83, p 93 and p 125.

182 NE 10 February 2022, p 44 lines 30–31.

92 I agree with the Prosecution that the fact that Dr Zakir did not personally interview Saridewi is immaterial. As stated in *Public Prosecutor v Irwan bin Ali* [2016] SGHC 191 at [59], an expert's evidence may be accepted even where he did not interview the accused. Moreover, as Saridewi herself admitted during the remitted hearing, she had not raised any complaints of her condition and had felt fine during the statement-recording process. She claimed that she had withheld mentioning her symptoms to Dr Lee, in an effort to bolster her purported request for bail (see [10] above). These points contradicted her claims of how serious her drug withdrawal had been.

93 Bail would not be granted for an accused charged with a capital offence: see s 95(1)(*a*) of the CPC. In any case, the District Court's notes of evidence pertaining to Saridewi's court mentions from 18 June 2016 to 23 May 2017[183] do not show that she made any specific request for bail during these sessions. In addition, Dr Lee's clinical notes indicate that Saridewi had not discussed with him her intention to request for bail (see [51] above). This casts serious doubt on her claims in relation to bail requests.

Implications on her ability to give reliable statements

94 Dr Lee was satisfied that Saridewi had been aware of what the relevant withdrawal symptoms were, and it is not disputed that she admitted to him that she was not in withdrawal during the statement-taking period. Her own admission at trial and at the remitted hearing was that she had "felt fine" and had been able to provide her statements. The contents of her statements also show that she gave detailed and coherent accounts with specific particulars which only she was in a position to elucidate to IO Peh, such as the events and

[183] 2-ABR at pp 153–162.

activities of the day before her arrest when she had placed an order for drugs from one "Bobby".[184] For instance, she was able to recount specific details leading up to her receipt of the heroin consignment from her co-accused, the specific floor on which the drug transaction took place ("17th floor"),[185] the time of the CNB raid ("not long before the officers came")[186] and her experiences of the raid ("I heard the sound of the tools and I saw the sparks from the door").[187] She was also able to review and engage with various exhibits and photographs that were shown to her, and to provide her position on them.[188]

95 In this connection, I accept Dr Zakir's evidence that Saridewi's ability to provide reliable statements was not compromised or affected in any way by any alleged drug withdrawal symptoms. She did not exhibit any significant distress or impairment that impacted her ability to give coherent testimony during the statement-taking period.[189] While Saridewi could have felt lethargic and sleepy as a result of her methamphetamine withdrawal during the statement-taking period, I find that this was not so debilitating that she was unable to provide reliable statements within which she had consciously interlaced various false exculpatory accounts. After all, she accepted that her withdrawal symptoms were not bothersome to her.[190] Even in re-examination on this issue, she confirmed that she had thought that she was "just sleepy", but that she had

184 1-ABR at p 10 (Saridewi's statement dated 22 June 2016 at paras 2–3).

185 1-ABR at p 50 (Saridewi's statement dated 23 June 2016 at para 15).

186 1-ABR at p 50 (Saridewi's statement dated 23 June 2016 at para 16).

187 1-ABR at p 50 (Saridewi's statement dated 23 June 2016 at para 16).

188 1-ABR at p 11 (Saridewi's statement dated 22 June 2016 at paras 4–6).

189 1-ABR at p 133 (Dr Zakir's 3rd Report at question QD).

190 NE 7 February 2022, p 81 lines 17–22.

still been "able to listen" and to "just answer spontaneously whatever that [had been] asked".[191]

Whether it is plausible that her withdrawal symptoms would have been missed by the doctors who examined her at the relevant time

96 In relation to Question 3e as framed by the Court of Appeal, a key contention among the Defence's submissions is that the doctors who examined Saridewi during the statement-taking period were not specifically trained to observe symptoms pertaining to methamphetamine withdrawal, or did not adopt appropriate methodology to specifically detect such symptoms. However, as the doctors explained at the remitted hearing, what was more crucial was that there had been no objectively observable or noticeable symptoms or signs of distress to begin with, and no subjective complaints from Saridewi herself. Although the structured drug withdrawal assessment form used by the SPS is generic, this does not in and of itself mean that the observations made by the doctors were unreliable or inaccurate.

97 Further, the fact that the doctors and nurses who observed Saridewi had conducted what Dr Rajesh described as "cross-sectional" assessments, rather than a longitudinal assessment, did not materially detract from the cogency of their observations.[192] These observations were consistent as a whole and were made separately and independently over the relevant time frame.

98 It was suggested that since at least one nurse, Ms Maria, had noted that Saridewi had slept the whole night and looked "lethargic" on 20 June 2016 (see [54] above), this would corroborate Saridewi's account. However, this was

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191 NE 8 February 2022, p 42 lines 14–20.

192 NE 9 February 2022, p 31 lines 10–16.

neither here nor there as it was an isolated instance. It would also not be appropriate to equate this observation of lethargy with Saridewi being so disoriented as to be in "shut down mode". There were no other consistent observations of a similar nature. Equally, while another nurse, Ms Zawiyah, had noted on 19 June 2016 that Saridewi was "resting most of the time" (see [53] above), this was a neutral observation given that Saridewi was undergoing remand in a prison environment and was not noted to be restless, agitated or aggressive.

99 Saridewi's IUT result provides a possible objective indicator that she likely suffered from methamphetamine withdrawal at least immediately upon arrest. Nevertheless, this would not necessarily compel the inference that she was unable to give accurate or reliable statements during the statement-taking period. The further evidence also shows that she did not exhibit clear or noticeable signs of such withdrawal up to the time of the statement-taking period. As mentioned above at [96], Saridewi also did not raise any complaints or issues to the doctors or nurses.

100 If Saridewi had indeed exhibited or experienced the plethora of symptoms as she alleged, I find that it is highly implausible that *all* the doctors who examined her would have failed to notice any of these symptoms. If she were capable of masking the symptoms, as she appeared to have suggested in respect of her interactions with Dr Lee in particular as she wanted to be bailed out and thus did not want to complain of having withdrawal symptoms (see [10] above), this would equally suggest that the symptoms (if any) were hardly as severe as she claimed.

101 For completeness, I should also add that I find no merit in the Defence's suggestion that Dr Lee's clinical notes ought to have been disclosed earlier

during Saridewi's trial. There was every opportunity for the Defence to have asked to peruse these notes, if deemed relevant, during the trial and I had expressly confirmed with Saridewi's (then) counsel that he had no issues with Dr Lee making reference to his notes.[193]

Conclusion

102 Having carefully considered the further evidence in totality, I conclude that Saridewi had at most been suffering from mild to moderate methamphetamine withdrawal during the statement-taking period. I agree with Dr Zakir's assessment that her withdrawal symptoms were minimal and not noticeable, and she did not surface them, thus suggesting that they were not particularly debilitating.

103 In my assessment, Saridewi embellished her account of alleged withdrawal symptoms at the remitted hearing for self-serving purposes. Her alleged symptoms went far beyond what (if any) had been observed contemporaneously by the doctors, nurses and the SPS officers. She did not mention additional details of these symptoms at her trial. She also did not raise any complaints to the doctors or the nurses, or to the recording officer during the statement-taking period. Some of her alleged symptoms were not even mentioned to Dr Rajesh despite the fact that he had interviewed her on six separate occasions between March 2019 to October 2020.

104 I further find that Saridewi did not exhibit or suffer significant withdrawal symptoms at all material times. If Saridewi's symptoms were indeed as serious as she claimed, it is implausible that *all* the doctors who examined

193 NE 2 May 2018, p 10 lines 5–12.

her contemporaneously would not have noticed them, even if they did not adopt any specific methodology for detecting methamphetamine withdrawal. The nurses who observed her also generally did not notice clear symptoms which could be attributed solely to methamphetamine withdrawal.

105 The totality of the further evidence does not affect my earlier rulings in relation to Saridewi's statements. Notwithstanding my finding that she had been suffering from mild to moderate methamphetamine withdrawal, Saridewi was still capable of providing intentional, detailed and lucid accounts in her statements. She provided specific and contextualised particulars which were only within her personal knowledge (see [94] above). She was also deliberate and consistent in fabricating a defence to the IO in all her statements that she was not involved in drug trafficking. Her ability to give her statements was thus not impaired.

106 Having regard to the further evidence at the remitted hearing, I am of the view that Saridewi has not raised any reasonable doubt as to her mental state and condition during the statement-taking period. I see no reason therefore to depart from my conclusion at the trial in relation to Saridewi's guilt.

107 I would add that even if the statements recorded from 21 to 23 June 2016 are excluded from consideration, there is still sufficient evidence to support the Prosecution's case. As explained in my GD at [61] to [69] in particular, Saridewi had failed to rebut the presumption under s 17 of the MDA that she was in possession of the drugs for the purpose of trafficking, and this remains so even without consideration of her statements.

108 I remit my findings on the further evidence accordingly to the Court of Appeal for its consideration.

See Kee Oon
Judge of the High Court

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Koh Choon Guan Daniel (Eldan Law LLP), Chenthil Kumar Kumarasingam (Withers KhattarWong LLP) and Wong Hong Weng Stephen (Matthew Chiong Partnership) for the accused.