George Abraham Vadakathu v Jacob George
[2009] SGHC 79

Case Number : DA 12/2008

Decision Date : 03 April 2009

Tribunal/Court : High Court

Coram : Chan Sek Keong CJ

Counsel Name(s) : Prabhakaran Nair (Ong Tan & Nair) for the appellant; Eugene Thuraisingam and Muralli Rajaram (Allen & Gledhill LLP) for the respondent

Parties : George Abraham Vadakathu — Jacob George

Succession and Wills – Testamentary capacity – Mental disability – Schizophrenic executing a will – Test to determine testamentary capacity – Whether testator had testamentary capacity to execute his will

3 April 2009 Judgment reserved.

Chan Sek Keong CJ:

1 This is an appeal by George Abraham Vadakathu ("the Appellant") against the decision of the district judge below ("the DJ") in declaring the will of George George ("GG") dated 6 December 1998 ("the Will") null and void on the ground that the Appellant failed to prove that GG had testamentary capacity at the time the Will was made (see *George Abraham Vadakathu v Jacob George* [2008] SGDC 114 ("the GD")).

Background

2 The material facts are as follows. GG had two brothers. The elder brother is George V Abraham ("GVA"), who is the father of the Appellant. The younger brother is Jacob George, the respondent in this appeal ("the Respondent"). GG died on 8 December 2006. As both his parents had died before him, GG's estate would have devolved equally to his two brothers under the Intestate Succession Act (Cap 146, 1985 Rev Ed) had he died intestate.

3 GG executed the Will on 6 December 1998 in the presence of a lawyer, Selvadurai Gunaseelan ("Guna"), and Guna's wife as witnesses. The Will was executed in the house of GG's father, Mr Vadakathu Abraham George ("VAG"). Guna had known GG and his parents for many years. The Will was prepared by Guna from a draft given to him by VAG. By the Will, GG appointed his nephew (the Appellant) the sole executor and trustee of the Will and gave his entire estate to the Appellant and his two nieces, the sisters of the Appellant.

4 The Appellant applied for a grant of probate of the Will and found that the Respondent had lodged a caveat against the grant of probate. He thereupon brought these proceedings. The Respondent challenged the validity of the Will on three grounds: (a) lack of testamentary capacity; (b) lack of knowledge of or absence of approval of the contents of the Will; and (c) undue influence in the execution of the Will. The DJ agreed to try the first issue concerning GG's testamentary capacity as a preliminary issue, and deferred the trial of the other two issues. At the conclusion of the trial, the DJ held that the Appellant had failed to prove that GG had testamentary capacity. This appeal is concerned only with the issue of GG's testamentary capacity.

5 GG was diagnosed with schizophrenia in 1957 when he was 18 years old. He was hospitalised in Woodbridge Hospital from August to October 1957. Subsequently, he received psychiatric treatment off and on at the Kallang Government Psychiatric Outpatient Clinic. In 1971, his medical condition became worse and he was further treated from October 1971 to August 2001 by Dr Wong Yip Chong ("Dr Wong") at Adam Road Hospital ("AR Hospital") where he attended regular monthly appointments and was treated with anti-psychotic medication. In July 2001, his condition deteriorated and he was reported to be aggressive, paranoid and agitated. Despite being given more anti-psychotic medication, his condition did not fully stabilise. Dr Wong reviewed GG's condition on 13 August 2001 and recommended hospitalisation, but this was not acted upon. GG received further treatment at the Institute of Mental Health ("IMH") from 2001 onwards until his death on 8 December 2006.

6 The medical records in AR Hospital do not provide sufficient evidence of GG's mental condition at the time he made the Will. The case notes stopped recording any detailed clinical observations from 8 November 1994. Thereafter, and until 13 August 2001, the clinical notes were brief. The medical records in IMH from 2001 show that his medical condition got worse, but there was one short period during which it would appear that he was able to look after himself. I shall return to these medical records later in this judgment.

7 At the trial, the Appellant, GVA, Guna, a psychiatrist (Dr Francis Ngui ("Dr Ngui"), the Medical Director and Senior Consultant Psychiatrist of AR Hospital), and GG's former colleague at work, Mohd Yusof bin Salleh ("Yusof"), gave evidence on behalf the Appellant. The Respondent did not testify. Dr R Nagulendran ("Dr N"), a consultant psychiatrist, was the Respondent's expert witness on GG's mental condition. At the conclusion of the trial, the DJ relied substantially on Dr N's expert opinion to find that the Appellant had not discharged the burden of proving GG's testamentary capacity at the time he made the Will. I will deal with the non-medical evidence first, followed by the medical evidence and then the DJ's analysis of the evidence and her findings.

The non-medical evidence

The Appellant's evidence

8 The Appellant testified that he had no knowledge of the Will until his father gave it to him days after GG's death. GG was fond of him and his two sisters and used to spend much time with him before he went abroad for studies in 1992. GG had reminded him that he was the only grandson in the family and that he should study hard to make his grandparents proud of him. He had no personal knowledge of any problems which existed between GG and the Respondent.

GVA's evidence

9 GVA testified that he was close to his parents and had lived with them after his first marriage in 1966 until 1974, after his wife died and he needed more living space for his three children. But he would visit his parents every evening. The Respondent moved out of the parents' house after his marriage in 1979. Initially, he visited his parents regularly, until their relationship became strained due to the Respondent being rude to his father (VAG) and also due to his demands for money from his parents. After VAG's death, GVA found a note which showed that VAG had given the Respondent and his wife a total sum of $51,435.00 in 1985 to finance the purchase of their flat at Paya Lebar. The note contained a statement signed by VAG which read, "Final payment. Please do not ask for any more money. We are broke."

10 GG was greatly upset by the Respondent's behaviour towards his parents. He disliked the Respondent and his wife, almost to the point of hating them. GG had told GVA that he was suspicious

that they were trying to take away the family house. On a few occasions, GG had said angrily that he would "hammer" the Respondent if he ever came to the house. GVA had to assure GG about the safety of the house. After VAG had made his will on 6 December 1998, GG appeared to be satisfied that VAG had provided for him in his will.

11 GVA was aware of GG's psychiatric condition from young and his treatment at Woodbridge Hospital and AR Hospital. GG was a slow learner and discontinued his studies after Secondary 2, but he managed to secure temporary jobs, usually on his own, until he was employed by the Tanglin Club ("the Club"). GVA's affidavit of evidence-in-chief showed that GG was employed by the Club from 1988 until 1999 when he had to retire at the age of 60, and was then re-employed by the Club until November 2001 when he was paid $1,119.25 a month.

12 GG was very fond of GVA's three children. He played with them when they were infants and also carried them and walked with them around the neighbourhood. He was particularly fond of the Appellant, who was his only nephew. He continued to take an interest in the children's welfare and progress in their studies overseas and kept in touch with them. After GG withdrew part of his Central Provident Fund ("CPF") savings in or about 1989, he gave $39,000 to GVA's younger daughter who was then studying in Victoria, Canada when she needed some money urgently. GVA was not surprised that, in the light of these events, GG had left his entire estate to GVA's children.

13 Under cross-examination, GVA admitted that GG had signed a contract in 2001 for a handphone for a gardener and that he (GVA) had written to IMH for a statement with a view to getting the contract voided on the ground that GG was unwell. He explained that GG had signed the contract as he was trying to help the gardener who was a foreign worker.

Yusof's evidence

14 Yusof testified that he had joined the Club as a security officer in 1983 and had known GG since the time when GG was employed by the Club as a security guard (GG's designation was "Watchman/Car Park Attendant"). GG worked under his supervision. No complaint had been made against GG during his employment by the Club. Yusof had no problem instructing GG on his duties and other matters which he understood and carried out satisfactorily. Under the Club's policy, every employee had to be checked annually by the Club's doctor. Yusof believed that the doctor was aware that GG was receiving medical treatment. As far as Yusof could see, GG was normal and none of his colleagues noticed anything abnormal about him. Yusof's evidence was not challenged by the Respondent.

Guna's evidence

15 Guna is an advocate and solicitor and has been a friend of the George family since 1965. He testified that, on 3 December 1998, VAG sent GG to Guna's home to request him to see VAG. Guna went over and was told by VAG that he, his wife and GG wished to make their wills. VAG handed to him three handwritten drafts of three wills and requested him to see if they were in order and, if so, to prepare typed copies for execution. Guna read the drafts and noticed that VAG and his wife had left nothing to the Respondent in their wills, and that GVA was to be the sole executor, with GG as his alternate and the Appellant as GG's alternate. That evening, Guna asked VAG why GG was to be appointed as alternate executor and not the Respondent, since GG was being treated for a mental illness. VAG replied that the Appellant would assist him, if necessary. Guna asked VAG to reconsider the wills, in relation to the Respondent. He did not query VAG about GG's will as he was not surprised that GG had named his nephew and nieces as the beneficiaries of his estate since GG was fond of them. Guna was aware that GG disliked the Respondent and, on several occasions, had anxiously

asked Guna whether the Respondent could take away the family house and had also said that he would "hammer" the Respondent if he came to the house.

16 The next evening, VAG handed to Guna amended draft wills in which he and his wife gave a part of their estate to the Respondent. He noted that GG's will was not amended. The next evening, he gave the typed wills to VAG and asked him to compare them with his amended copies. Later, at dinner, he saw GG reading his will. VAG informed Guna that the wills were in order and he wished for the three wills to be executed that night. He asked Guna and his wife to witness the execution. Guna went to fetch his wife and the three Georges executed their wills before Guna and his wife as witnesses. With respect to GG's will, Guna stated at paras 18, 19, 22 and 23 of his affidavit of evidence-in-chief as follows:

> 18. Prior to [GG] executing his Will, however, I asked him whether he knew what that document was, and he said that it was his Will. I then asked him whether he knew what a Will was, and he replied that it said what he wanted to be done with his "things" when he died. I then asked him whether he wanted to appoint the [Appellant] to take care of his "things" and he replied in the affirmative. When I asked him why he wanted to appoint the [Appellant] and not his brother, the [Respondent], [GG] replied angrily that he did not want the [Respondent] to "touch my things." I also asked him whether he wanted his money and all the "things" which belonged to him to be given entirely to the Plaintiff and his 2 sisters and he answered this, too, in the affirmative.
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> 19. I specifically asked [GG] the questions mentioned above, because I was aware that [GG] had left school after Sec[ondary] 2 and also that he was at times slow in comprehending matters that he was not familiar with. My other reason was that, since the draft Will was in [VAG's] handwriting, I wanted to satisfy myself that [GG] not only knew and understood its contents, but also intended them himself – i.e., that the Will expressed his wishes.
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> …
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> 22. In the circumstances mentioned above in Paras 18 and 19 hereof, I was, and still am, satisfied that the said late [GG]:
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> (a) was lucid at all material times, particularly on the evening of 6th December 1998;
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> (b) intended to make his abovementioned Will, which is now being questioned by the [Respondent];
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> (c) sufficiently understood the contents of his said Will;
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> (d) intended to appoint the [Appellant] as his sole Executor; and
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> (e) also intended to distribute his Estate only as stated therein.
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> 23. If I had entertained any doubts as to the said [GG's] mental or testamentary capacity to make the said Will, and / or as to the appointment of the [Appellant] as his sole Executor and / or the manner in which he wished his Estate was to be distributed, I would not have allowed him to execute it. If he had nevertheless insisted on and signed on the said Will, I would have refrained from signing on it as a witness and also told my wife to do likewise, and left the Georges' home without it.

17 Guna was cross-examined by counsel for the Respondent. The DJ summarised Guna's testimony at [25]–[27] of the GD as follows:

> 25 In cross-examination, [Guna] explained that he did not arrange for a psychiatrist to be present when [GG] executed the Will as the issue of testamentary capacity did not arise at that time. Although he knew that [GG] had a mental illness, he was not aware that [GG] was suffering from schizophrenia. He had been neighbours to the Georges since 1965 and although he knew that [GG] used to go to Woodbridge Hospital for check-ups, he did not consider [GG] to be mentally ill because, in [Guna's] own words,
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> > "*it did not occur to me that he was mentally ill as such, in the sense that a lay person would use the words "mentally ill" to refer to a person who starts shouting, yelling, running around*.
> >
> > In fact throughout the period from 1965 to 1998, I did not witness such episodes. I always had a normal conversation with [GG].
> >
> > I was also aware that he was holding a full-time job and he went to work and came back on his own."
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> 26 When counsel for the [Respondent] put to [Guna] that [GG] was in no state of mind to understand what he was doing when he signed the Will and this was known to him, the response was as follows:
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> > "[GG] did not know what he was doing – answer is – he did know what he was doing. To the second part, that it was known to me – answer is – *I had no knowledge that [GG] suffered such mental incapacity as not to be able to know the nature of the document and/or the contents*. Insofar as I was concerned, the questions and answers in paragraph 18 of the Affidavit were sufficient to satisfy me that [GG] understood the nature of the document i.e. it being a will whose purpose was to specify the manner in which his estate ought to be distributed upon his death, identities of the beneficiaries and the person whom he wanted to appoint as sole executor. What I found more convincing or more relevant was his rejection of the [Respondent] as executor. Lastly, I refer to paragraph 23 of my Affidavit where I specifically mentioned that if I had any doubts, I would not have witnessed the execution of the will."
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> 27 In re-examination, [Guna] explained that during the period 1998 to 1999, he had talked to [GG] almost every day and as a lawyer of many years' standing, he assessed the mental capacity of [GG] to be "as normal as anyone else".
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> [emphasis added by the DJ]

The medical evidence

Dr Ngui's medical reports

18 Dr Ngui had not examined or treated GG at any time. His medical reports dated 12 June 2007 and 3 September 2007 were based on GG's medical records with AR Hospital, his interview of GVA and GG's medical report dated 19 September 2005 from IMH written by Dr Eu Pui Wai ("Dr Eu"), a senior consultant psychiatrist. Dr Ngui did not examine GG's medical records at IMH. He was of the opinion that the medical reports from IMH from 2001 onwards were irrelevant in determining GG's mental

capacity in December 1998. The relevant portions of the medical reports dated 19 September 2005, 12 June 2007 and 3 September 2007 (after omitting the matters set out in [5]–[6] above) were as follows:

(a) GG showed improvement in his symptoms and maintained a satisfactory remission of his illness from 1971 to 2001 when he was being treated with anti-psychotic medication by Dr Wong.

(b) In July 2001, GG's condition deteriorated and he was reported to be aggressive, paranoid and agitated. He continued to attend his out-patient appointments regularly but his condition was not fully stabilised despite an increase in his anti-psychotic medication. Dr Wong reviewed GG's condition on 13 August 2001 and recommended hospitalisation, but his advice was not acted upon. GG did not turn up for his appointment on 30 August 2001.

(c) The AR Hospital records showed that GG was in a satisfactorily stable phase of his schizophrenic illness when he made the Will on 6 December 1998. The two closest review dates, 10 November 1998 and 8 December 1998, showed that his mental state appeared to be stable and satisfactory. His anti-psychotic medication was actually reduced on 8 December 1998, indicating that he was quite stable in his mental state.

(d) The AR Hospital records did not show any change of significance in GG's mental state in the years 1998 to 1999.

(e) As to GG's testamentary capacity, Dr Wong did not address this issue and there was insufficient data in the medical records to make a definitive conclusion.

Dr Ngui's testimony

19 Dr Ngui was cross-examined by the Respondent's counsel. His testimony under cross-examination was as follows:

(a) When it was put to him that GG had never recovered from schizophrenia and was always on medication, Dr Ngui said that GG was in remission and his condition had stabilised, but he had not fully recovered. When asked whether the mental function of a patient under medication would be affected to a certain extent, he replied that a person in remission under proper control with medication could function and behave like any ordinary person who had no such illness.

(b) When he was asked whether the only way to tell whether someone like GG had testamentary capacity was for a psychiatrist to examine him on the day he made the Will, Dr Ngui replied: "Yes, that would be ideal."

(c) When he was asked whether it would be irresponsible for a psychiatrist to come to court to say that, based on the medical notes of AR Hospital, GG had testamentary capacity, Dr Ngui replied that he was not certain.

(d) When he was asked what a reasonable psychiatrist would have done to ascertain that GG had testamentary capacity, Dr Ngui replied that he would have studied his entire psychiatric history and done a mental examination involving his cognitive functions, especially in regard to his memory. He would also have checked and excluded any delusions that he might have harboured against family members, and also whether the three legal criteria would have been satisfied, *viz*, whether he knew: (i) what a will was; (ii) what his estate comprised; and (iii) who his potential beneficiaries were.

(e) When he was asked whether he agreed with the opinion of Guna that GG knew what he was doing from the answers given by GG to the five questions Guna had asked (see [16] above), Dr Ngui replied that he would have preferred that a doctor had examined him. When further pressed on what he meant, he replied that, due to the state of GG's psychiatric illness, Guna's series of five questions was not enough to establish GG's testamentary capacity (*ie*, without a prior medical examination).

(f) When he was asked whether someone looking at the IMH notes might have come to a different conclusion on the testamentary capacity of GG (*ie*, that GG's condition was so serious that he could not have had testamentary capacity), Dr Ngui replied that that depended on GG's condition after he had left AR Hospital.

(g) When he was asked whether, based on his comments on Guna's affidavit of evidence-in-chief, he would say that it was unsafe for the court to conclude that GG had testamentary capacity, he replied that Guna's questioning prior to the execution of the Will fell short of the standard of a psychiatric assessment for it to be completely ideal. When pressed further on this matter, he replied, "To be watertight would still need psychiatric assessment." When it was further put to him "So – unsafe?", he replied "Yes".

20 Dr Ngui's evidence in re-examination was as follows:

(a) When he was asked what the clinical notes dated between 5 May 1998 and 8 December 1998 had said about GG's condition, he replied that GG was found to be "Well", "Better", "OK", "Same".

(b) When he was asked about GG's medication, he replied that GG was on two kinds of drugs at that time, *viz*, Apo Benztropine and Apo Trifluoperazine, the first being an anti-psychotic medication for mental disorders like schizophrenia, and the second being used to counter the side effects (stiffness and hand tremors) of the first. He explained that the drugs were directed at controlling psychotic symptoms, *ie*, delusional beliefs, hallucinations and thought disorders.

(c) When he was asked for his assessment of GG's condition from the case notes for May 1998 to February 1999, he replied that GG was in a state of remission, *ie*, he had no active psychotic symptoms. He also said that a patient in remission would be able to function to his previous level of intellectual ability before his illness started (*ie*, if he had Secondary 2 level education he would go back to that level). He would be able to take public transport to work and be capable of managing his bank accounts.

(d) When he was asked whether a patient in remission would be able to give instructions on executing a will, he replied, "Probably able to". He agreed that a schizophrenic with a long history of the illness was not necessarily incapable of making a will. When asked specifically of GG's condition in December 1998, Dr Ngui said that GG was in remission, stable and therefore could give instructions for the Will.

(e) When asked about the post-2001 IMH records, Dr Ngui said they were irrelevant to determine GG's state of mind in December 1998.

Dr Eu's medical report dated 19 September 2005

21 Dr Eu (who was not called as a witness) gave a medical report dated 19 September 2005 on GG's condition as follows:

When reviewed on 13 Sep 05, [GG] was able to say that the house that he lived in with his elder brother and sister-in-law belonged to his father. He clearly stated that he would like to entrust his elder brother, [GVA], to help him to manage his money. On psychiatric examination, he answered relevantly to simple questions. Auditory hallucinations were elicited but he did not act on the contents.

… In my opinion, he has Schizophrenia with residual psychotic symptoms. However, this does not render him incapable of managing his personal affairs and he is mentally competent to make a decision to get his elder brother, [GVA], to help him manage his financial affairs.

Dr N's evidence

22 Dr N's medical report was annexed to his affidavit of evidence-in-chief. He was cross-examined on his report and also questioned by the DJ. His evidence is set out at [28]–[34] of the GD:

28 The sole witness called by the [Respondent] on the issue of testamentary capacity was [Dr N], a senior consultant psychiatrist practising at the Singapore Medical Centre. In his report annexed to his affidavit of evidence-in-chief, he first recited the legal criteria for testamentary capacity. He then set out the significant psychiatric findings from the medical notes of [AR Hospital] and the [IMH] and then proffered the following opinion:

"(1) [GG] suffered from a mental disorder Schizophrenia which is an illness that affects the mental functions of thinking, emotion, behaviour and intellect.

(2) At the time he executed the Will, he was suffering from this illness. This is evidenced by the medication he was being treated at that time.

(3) There is paucity of information in the medical notes of [AR Hospital] unlike that in the medical notes of [IMH] which contains the signs and symptoms of his illness.

(4) The psychiatric history in the medical notes showed he had only less than 2 years of primary schooling and his mental illness surfaced in 1956 when he was taken to Woodbridge Hospital and the illness continued until the time of his death in 2006. At the time when he executed the Will in 1998 his illness was already in existence for 42 years. It is inevitable that the toll of his prolonged illness on his mental functions would have an adverse effect on his ability to satisfy the legal criteria mentioned above that is required for a testator to have a sound disposing mind.

(5) I would therefore opine that taking into consideration of all the mental symptoms and signs of his illness contained in the medical notes he did not have the testamentary capacity to execute a Will."

29 [Dr N] explained that his opinion was based entirely on his examination of [GG's] medical notes from the 2 hospitals … Although the medical notes for the relevant period before and after December 1998 when the Will was executed had no information which suggested [GG] being incapable and unable to care for himself, [Dr N] maintained that [GG] did not have testamentary capacity in 1998. He explained his reasons thus:

"I made it clear right from the beginning that my opinion is based on the medical notes right from the beginning until the time of his death which would include the time of writing of his will. We are talking of his capacity to write a will 40 years after diagnosis of schizophrenia

which is a major mental illness that affects a person's behaviour, thinking, emotions and personality. We have clear information of diagnosis and medication that he received during this period of time, the 40 years. Surely to make opinion of state of mind 40 years later one has to consider effect of illness on the person's mind over this long period of time.

This therefore – "Okay, Better" does not give any information on his state of mind. I don't give opinion just based on what is written in these notes here. I have to consider what was the effect of this illness on his mind over these 40 years and therefore what happened after 40 years which is therefore recorded in subsequent notes until the time of his death is a continuous process of this mental illness."

30 He did not agree with [the Appellant's] counsel's assertion that the reports of [GG's] condition in 2005 and 2006 would have no reflection of [GG's] mental condition in 1998. He also went on to explain the effect and extent of schizophrenia in the following terms:

"[...] schizophrenia is a psychotic illness. Psychosis means a break with reality in the mental function so a person's thinking, emotions, behaviour, personality are different from normal people. If that illness continues for a long period as in the case of [GG], inevitably the mental function continues to deteriorate. So at the time of writing the will, the intellectual function of the person meaning his ability to understand what he is doing will be affected and this may include therefore symptoms which can occur in a person suffering from a condition like dementia, which is a condition of memory impairment which usually arises in old age, also known as Alzheimer's disease or dementia. This disease occurs in at about age 70.

[GG] suffered from chronic schizophrenia all this time. Chronic means he suffered this condition continuously for more than 2 years and above. So can't ignore his mental state after 40 years of his life because it is a continuous progression. Notes from IMH from the time he was treated from 2001 until he died, shows progressive illness from symptoms described in his notes. *No indication for me to say that he had a clear state of mind in 1998 when he signed the will*."

31 Further, the fact that the schizophrenic patient held a regular job for 12 years and carried out the responsibilities in his job did not necessarily mean that his condition was stable or in remission. The nature of his work and quality of his work performance had to be taken into account. This point was elucidated by [Dr N] as follows:

"[...] schizophrenia when it begins it has positive symptoms. These are hearing voices, believing people are trying to harm him, aggressive violent behaviour, emotional disturbance. These symptoms can be well controlled by anti-psychotic medication. So a person may be stable i.e not exhibiting these positive symptoms. So may well be that during his 12 years of working not exhibiting positive symptoms because he was continuously on medication at that time.

But what actually happens, negative symptoms like lack of initiative, lack of drive, motivation, etc, this continues. He appears to be stable because not hearing voices. So if he is doing work of a security guard, he can do that but what we are concerned with is his mental capacity to be able to execute a Will, testamentary capacity. He may be stable in that he is going to work, coming home, but it doesn't mean that he has mental capacity to write a Will. Therefore very important when person is going to execute a Will, very important to make sure that his mental ability not impaired, i.e. his ability to think and understand what he is doing. I have listed the criteria for testamentary capacity in my report.

32 When shown the opinion of [Dr Ngui], which stated that "from 1971 to mid-2001, [GG] showed improvement in his symptoms and maintained a satisfactory remission of his Schizophrenic illness" which would enable him to give instructions to make a simple will, [Dr N] disagreed. He explained that one could have a remission or control of the positive symptoms, namely the aggressive violent behaviour, emotional disturbance, hearing voices but this lack of positive symptoms did not mean that [GG] had the intellectual capacity sufficient to satisfy the criteria for a sound disposing mind or testamentary capacity.

33 During re-examination, [Dr N] elaborated that for schizophrenia, anti-psychotic medication only served to control the positive symptoms, but the negative symptoms which affect the mental functions of thinking, emotion, behaviour and intellect would not respond to such medication. Hence, there is a progressive deterioration of the cognitive or mental functions of the patient. These are the functions that affect testamentary capacity.

34 To the Court's question *whether during periods of remission when the schizophrenic patient appears normal, he would have the cognitive ability to be able to execute a will*, [Dr N] answered thus:

> Each individual has to be examined at the time he is about to execute a will whether he has the testamentary capacity. Hypothetical case – if I have [GG] who had disease for 40 years and the last 5 years of his life no relapses, one can conclude that at the time he signed the will he was stable. Nothing to indicate that illness was deteriorating. If I was not given Woodbridge Hospital notes and I only rely on [AR Hospital] notes, I would not be able to say because [AR Hospital] notes don't indicate his symptoms, only diagnosis and medication. Nothing to indicate how his illness started and how it progressed. All those are found in the [IMH] notes.
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> I made my inference of [GG's] mental condition based on [IMH] notes in the last 5 years of his life when he had suffered relapses of his condition which started in 1957 when he was first admitted to Woodbridge Hospital, then followed up at Kallang Clinic and then 1971 onwards to 2001 followed up at [AR Hospital]. *So it is reasonable to conclude that this sickness had continued for 40 years requiring regular anti-psychotic medication and subsequently continued at Woodbridge Hospital until time of his death*.
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> *With my clinical knowledge and experience in this field I am able to say with conviction my opinion that in all probability he did not have the mental capacity to sign or execute a will*.

[emphasis added]

23 Before answering the court's query, which has been set out at [34] of the GD (see [22] above), Dr N had also given the following answer to the DJ's earlier question:[note: 1]

> Q: Do I understand your evidence to be that a person suffering from schizophrenia over a long period could *never* have testamentary capacity as you understand it?
>
> A : *Right*. In our experience of dealing with chronic schizophrenia especially when there are periods of relapse during this long illness it would indicate that he would not have the ability to execute a will because it is a progressive illness; intellectual function continues to deteriorate.

[emphasis added]

It should be noted that Dr N, in his report dated 10 October 2007, was of the opinion that GG did not have testamentary capacity. He reiterated this opinion in the answer quoted above. However, when questioned by the DJ (see [34] of the GD), in the context of GG appearing to be normal while in a state of remission, he said that even then GG "in all probability" did not have testamentary capacity.

24 Another material reply given by Dr N during cross-examination by counsel for the Appellant was as follows:[note: 2]

> Q: Would a person in [GG's] condition from what you see in his medical records be able to manage bank account, buy property?
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> A: Unlikely.

As will be seen later (see also the GD at [40], reproduced at [25] below), Dr N's opinion on this point was contradicted by the non-medical evidence.

The DJ's assessment of the evidence

25 The DJ did not accept the medical and non-medical evidence adduced by the Appellant. She found Dr Ngui's testimony – that GG would probably have the capacity to give instructions to make a will when he exhibited no active psychotic symptoms – to be rather "over-stated". She found the totality of the evidence for the Appellant equivocal. Instead, she accepted Dr N's opinion that GG did not have testamentary capacity on the grounds that his testimony was comprehensive and had a better foundation. Her findings are set out at [35]–[40] of the GD as follows:

> 35 … The evidence [of GVA and Yusof] … served to establish the fact that [GG] had a job as a security guard for many years during the stable phase of his illness and he could manage his affairs to some extent.
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> 36 … As the expert witness, [Dr Ngui] had based his opinion entirely on the medical notes of [AR Hospital]. Despite his view that [GG's] illness was in satisfactory remission, he was however unable to say that [GG] possessed testamentary capacity at the material time. He also conceded that had he examined the medical records of [GG] from the [IMH], he might take a different view, although I noted he did subsequently also say that the records from 2001 were irrelevant to determine testamentary capacity in 1998. Juxtaposing [Dr Ngui's] comments against the observations of [Dr N], in his report that the [AR Hospital] medical notes contained a paucity of information, on examination of those notes I thought [Dr Ngui's] opinion that [GG] "*would probably be able to give instructions to make a will*" when he exhibited no active psychotic symptoms to be rather over-stated. On weighing [Dr Ngui's] evidence in its entirety, it was clear to me that his testimony did not serve to advance the [Appellant's] case.
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> ...
>
> 38 … [Guna] had no knowledge that [GG] suffered from schizophrenia. … [H]e had not considered [GG] to be mentally ill since he had not witnessed any episodes of aggressive or

violent behaviour from [GG]. He had considered [GG] to be as normal as anyone else as he had regularly spoken to him and also because he was aware that [GG] held a full-time job.

39 When tested against the criteria for testamentary capacity, I thought the series of 5 questions [Guna] had posed to [GG] was inadequate as there is significant doubt whether [GG] had the cognitive ability to understand the purport of those questions. At the time the Will was signed, [GG] was 59 years old and had been suffering from schizophrenia for more than 40 years. I accepted [Dr N's] explanation that the illness would have taken a toll on [GG's] mental functions. This was particularly so as his illness showed a progressive deterioration in later years as revealed in the medical notes from the [IMH]. This aspect had not been considered at all by [Guna] who believed [GG] to be functioning like any normal person since he had not experienced [GG] behaving like one who was mentally ill. Due to the long history of his illness [Guna] and/or the family members of [GG] should have arranged for a medical practitioner to examine [GG] on the day the Will was to be signed.

40 … [Dr N] had given a comprehensive picture of the effects of schizophrenia and since he had had the opportunity to review [GG's] entire medical history, his opinion had a better foundation [than that of Dr Ngui who only reviewed the medical records of AR Hospital]. Although he did state that he did not expect someone with [GG's] condition to be able to manage bank accounts and buy property, which was contrary to the evidence given by [GVA] and [Yusof], I did not regard this as sufficient to discredit his evidence *in toto*. I accepted his account that one suffering from schizophrenia with the positive symptoms of this illness being brought under control by anti-psychotic medication could perform simple transactions but the cognitive functioning required to make a will was a different consideration. The cognitive or mental functions were the faculties required for testamentary capacity. If these functions were impaired, then it would necessarily follow that testamentary capacity was also impaired.

[emphasis in original]

26 In the light of her findings as set out in these passages, the DJ held that the Appellant had failed to prove, on a balance of probabilities, that GG had the requisite testamentary capacity to execute the Will. At [43] of the GD, the DJ explained her decision as follows:

The [Appellant] bore the burden of proving that [GG] had testamentary capacity. Owing to [GG's] long history of mental illness, *the presumption arose that he lacked the necessary capacity*. The [Respondent's] expert witness had provided a clear and cogent explanation why he thought [GG] could not have had testamentary capacity at the age of 59 years old when the Will was signed. When the Will was challenged, it was incumbent on the [Appellant] to bring sufficient evidence to show that the Will signed by [GG] was one of a "free and capable testator".

[emphasis added]

Preliminary observations on the DJ's decision

27 It can be seen from the DJ's evaluation of the medical evidence that the DJ placed almost total reliance on Dr N's medical opinion to support her conclusion that the Appellant had not discharged the burden of proving that GG had testamentary capacity at the time he made the Will. The finding was that the medical evidence and non-medical evidence adduced for the Appellant were, collectively, insufficient to outweigh Dr N's opinion that GG definitely or in "all probability" did not have testamentary capacity.

28 The main issue in this appeal is whether the DJ's decision was correct, having regard to the law on testamentary capacity and the evidence adduced in these proceedings. I will first set out the law on testamentary capacity and the burden of proof before moving on to an assessment of the evidence to determine whether GG had testamentary capacity when he made the Will in 1998.

Legal requisites of testamentary capacity

29 The legal requisites of testamentary capacity were enunciated by the English Court of Appeal in *Banks v Goodfellow* (1870) LR 5 QB 549 ("*Banks*") at 565. They may be summarised as follows:

(a) the testator understands the nature of the act and what its consequences are;

(b) he knows the extent of his property of which he is disposing;

(c) he knows who his beneficiaries are and can appreciate their claims to his property; and

(d) he is free from an abnormal state of mind (*eg*, delusions) that might distort feelings or judgments relevant to making the will.

This statement of the law in *Banks* has been accepted and followed by our courts and also the courts in the Commonwealth.

30 In *Banks*, the testator had been confined in a lunatic asylum in 1841. After discharge, he remained subject to delusions. He made his will on 28 December 1863 and gave all his property to his niece. He died on 28 July 1865. The opposer of the will was the testator's heir at law. The propounder of the will was the heir of the niece. The jury upheld the will on the grounds that, despite suffering from delusions (that he was pursued and molested by a certain man, who was already dead, and by devils and evil spirits), the testator had made his will during a lucid interval and that the delusions were not capable of having any influence on the provisions of the will. The English Court of Appeal upheld the direction on the law (as summarised at [29] above) and also the jury's finding.

31 The court made no distinction between a case of lack of testamentary capacity arising from senile dementia and one arising from unsoundness of mind due to a mental disease (which would include schizophrenia). At 570–571 Cockburn CJ said:

> It may be said that the analogy between the two cases is imperfect; that there is an essential difference between unsoundness of mind arising from congenital defect, or supervening infirmity, and the perversion of thought and feeling produced by mental disease, the latter being far more likely to give rise to an inofficious will than the mere deficiency of mental power. This is, no doubt, true, but it becomes immaterial on the hypothesis that the disorder of the mind has left the faculties, on which the proper exercise of the testamentary power depends, unaffected, and that a rational will, uninfluenced by the mental disorder, has been the result.
>
> It is said, indeed, by those who insist that any degree of unsoundness should suffice to take away testamentary capacity, that where insane delusion has shewn itself, it is always possible, and indeed may be assumed to be probable, that a greater degree of mental unsoundness exists than has actually become manifest. But this view, which is by no means universally admitted, is unsupported by proof, and must be looked upon as matter of speculative opinion. *It seems unreasonable to deny testamentary capacity on the speculative possibility of unsoundness which has failed to display itself, and which, if existing in a latent and undiscovered form, would be little likely to have any influence on the disposition of the will*. No doubt, where the fact that the

testator has been subject to any insane delusion is established, a will should be regarded with great distrust, and every presumption should in the first instance be made against it. Where insane delusion has once been shewn to have existed, it may be difficult to say whether the mental disorder may not possibly have extended beyond the particular form or instance in which it has manifested itself. It may be equally difficult to say how far the delusion may not have influenced the testator in the particular disposal of his property. *And the presumption against a will made under such circumstances becomes additionally strong where the will is, to use the term of the civilians, an inofficious one, that is to say, one in which natural affection and the claims of near relationship have been disregarded*. But where in the result a jury are satisfied that the delusion has not affected the general faculties of the mind, and can have had no effect upon the will, we see no sufficient reason why the testator should be held to have lost his right to make a will, or why a will made under such circumstances should not be upheld. Such an inquiry may involve, it is true, considerable difficulty, and require much nicety of discrimination, but we see no reason to think that it is beyond the power of judicial investigation and decision, or may not be disposed of by a jury directed and guided by a judge. In the case before us two delusions disturbed the mind of the testator, the one that he was pursued by spirits, the other that a man long since dead came personally to molest him. Neither of these delusions – the dead man not having been in any way connected with him – had, or could have had any influence upon him in disposing of his property. *The will, though in one sense an idle one, inasmuch as the object of his bounty was his heir at law, and therefore would have taken the property without its being devised to her, was yet rational in this, that it was made in favour of a niece, who lived with him, and who was the object of his affection and regard*. And we must take it on the finding of the jury that irrespectively of the question of these dormant delusions, the testator was in possession of his faculties when the will was executed.

Under these circumstances, we see no ground for holding the will to be invalid. If, indeed, it had been possible to connect the dispositions of the will with the delusions of the testator, the form in which the case was left to the jury might have been open to exception. It may be, as was contended on the part of the plaintiff, that in a case of unsoundness, founded on delusion, but which delusion was not manifested at the time of making the will, it is a question for the jury whether the delusion was not latent in the mind of the testator. But, then, for the reasons we have given in the course of this judgment, we are of opinion that a jury should be told, in such a case, that the existence of a delusion, compatible with the retention of the general powers and faculties of the mind, will not be sufficient to overthrow the will, unless it were such as was calculated to influence the testator in making it.

This, in effect, disposes of the question of misdirection. As, for the reasons we have given, we are of opinion that if the testator was, at the time of making the will, of capacity to make a will as defined by the learned judge, the existence of mental disease, *if latent*, so as to leave him free from the consciousness and influence of delusion, *there having been a total absence of all connection between the delusion and the will, would not overthrow the will*, it follows that there can have been, practically speaking, no misdirection in not leaving the question of latent delusion to the jury. Where delusions are of such a nature as is calculated to influence the testator in making the particular disposition, as was the case in *Waring* v. *Waring* [(1848) 6 Moo PC 341; 13 ER 715] and in *Smith v Tebbitt* [(1867) LR 1 P&D 398], a jury would not in general be justified in coming to the conclusion that the delusion, still existing, was latent at the time, so as to leave the testator free from any influence arising from it; *but in the present case the disposition was quite unconnected with the delusions, and consequently there is no reason to suppose that the omission to call the attention of the jury to this specifically can have affected the verdict*.

[emphasis added]

32 The above passages state the following propositions:

(a) where the testator is subject to an insane delusion, there is a presumption against his having testamentary capacity;

(b) where such a condition exists, it may be difficult to tell whether it exists in some other form;

(c) it may be equally difficult to tell how far the delusion may or may not have influenced the testator in the particular disposal of his property;

(d) the presumption against a will made under such circumstances becomes additionally strong where the will is an inofficious one, that is to say, one in which the testator has disregarded the element of natural affection and the claims of near relationship, *eg*, where he gives all his property to a stranger;

(e) but if the delusion has not affected the general faculties of the mind, and can have had no effect upon the will, a will made under such circumstances is good; and

(f) the rationality of the will tends to support a finding that, irrespective of the question of dormant delusions, the testator was in possession of his faculties when the will was executed.

33 In the Straits Settlements case of *In the Matter of the Estate of Eusoff Mohamed Salleh Angullia* [1939] MLJ 100 ("*Estate of Eusoff*"), the court placed particular emphasis on the rationality of the will as evidence of testamentary capacity in circumstances similar to those in *Banks*. In that case, the testator had suffered from attacks of insanity in the past, and had on four occasions, 1910, 1918, 1924 and 1934, been certified as insane (due to alcohol addiction and being detained in a mental hospital for short periods). The medical evidence showed that in 1918 and 1934 the diagnosis had been "imbecility"; that in 1910 and 1924 the diagnosis had been "mania". It was alleged that the testator had been removed from the mental hospital in 1934 while still insane and had never recovered and had continued to have delusions, and that, as a result, he was incapable of making a will. However, there was also evidence that he had had long lucid intervals between the attacks. On 4 June 1938 he made a will and codicil giving most of his estate to charity. The will was attested by the testator's solicitor and his doctor, both of whom deposed to the fact that the testator, though physically weak and mentally dull at the time, appeared to be of sound mind, memory and understanding. The testator died three days later, on 7 June 1938, from a diabetic attack.

34 Horne J's evaluation of the evidence was as follows (at 101):

I do not propose to deal with fine distinctions as to when the onus of proof shifts from plaintiff to defendant and *vice-versa* in this case. I will state two propositions which are sufficient to guide me to a conclusion "[...] *English law is, and always has been, very strongly in favour of any will or codicil which in terms is not unreasonable and shows no sign of mental deficiency, and the law will not tolerate that it should be replaced or destroyed by any decision of the courts unless it is clear that the testator was incapable of making a will"*. Langton J. *Estate of Bohrmann* (1938), 1 A.E.R. 271 at 274. On the other hand, where a will is impeached, "the Court or jury must be able affirmatively, on a review of the whole evidence, to declare itself satisfied that the testator was of sound mind, memory, and understanding, at the time of its execution" ... *Smith* v. *Tebbitt*, 1 P. & D. at p.436. [emphasis added]

35 At 108, Horne J stated his findings as follows:

> Dr. Laidlaw Thompson [the testator's doctor] was a witness to the will on the following day. Although he is young in professional experience he gives his evidence in a clear and careful manner, and knows that as a medical attendant on the testator he should not witness his will unless satisfied of his competency. It is suggested he made no tests, but his evidence leads me to believe that he had in the period 24th April 1938 to 4th June 1938 been sufficiently observant to come to the conclusion that the testator had a mind of his own. Certainly it is a dull mind, that of a stupid and backward man, who needs to be told everything twice in order to get him to understand. He again did not know anything much of his patient's past history. He is present when the codicil giving a discretionary income to Rahimaboo [the testator's sister] was written by Mr. Miles [the testator's solicitor] and hears the matter discussed. In such circumstances he is capable of observing whether [the testator] understood what he was doing, even though he is making the codicil at Mr Miles' suggestion. …
>
> What then was the condition of [the testator] at the time he made this will? *A will rational on the face of it, and made in an apparently rational manner*. I have from the defendant's witnesses a number of general assertions as to delusions and violence. Generally these witnesses deny all knowledge of addiction to or the intermittent use of alcohol. I have a medical history on the case sheets and several conflicting opinions from lay and medical witness[es]. I find myself unable to accept the conclusion that [the testator] was and always had been an imbecile. His early years, education, his appearances before a number of lawyers up to 1915 and even on the mortgage in 1932 and his long periods without any violent outbreak and finally the will itself do not support that conclusion.
>
> Clearly there has been insanity in the past, and the classification of the disease affecting his mind is difficult. *But he appears to me to have had numerous lucid intervals in the past years and I have no hesitation in saying that this will has been made in a lucid interval, during which, in my opinion, the testator clearly understood the extent of his property and the nature of the claims of others whom, to some extent, he was excluding from participation*.
>
> [emphasis added]

36 It can be seen from Horne J's analysis of the evidence that he placed significant weight on the rationality of the will as indicative of the testator's mental state, and that factor, together with the fact that the testator did have numerous lucid intervals, persuaded him that the testator had testamentary capacity when he made his will even though there were several conflicting opinions from lay and medical witnesses.

Burden of proof

37 The burden of proof of testamentary capacity has been stated by the Court of Appeal in *R Mahendran v R Arumuganathan* [1999] 2 SLR 579 ("*Mahendran*") at [15] to be as follows:

> It is a well settled principle of law stated as far back as 1838 by Baron Parke in *Barry v Butlin* (1838) 2 Moo 480 at 482 and 484; 12 ER 1089 that the legal burden of propounding a will, the onus probandi[,] lies in every case upon the party propounding the will, 'and he must satisfy the conscience of the court that the instrument so propounded is the last will of a free and capable Testator. … it is in general discharged by proof of capacity, and the fact of execution, from which the knowledge of and assent to the contents of the instrument are assumed'.

38 The DJ quoted this statement in her GD and also John G Ross Martyn, Stuart Bridge & Mika Oldham, *Theobald on Wills* (Sweet & Maxwell, 16th Ed, 2001) at para 3-07 as follows:

(b) *Continuance of mental illness*. If during the period prior to the execution of his will the testator suffered from serious mental illness ***a presumption arises that it continued and the testator lacked testamentary capacity***. The person propounding the will may rebut this presumption by establishing that the testator made the will during a lucid interval or after recovery from the illness.

If there is any reason at all to anticipate that a will about to be executed may be challenged in the future on the ground that the testator was not of sound mind, memory and understanding, it is a useful precaution to arrange for the presence of at least one experienced medical practitioner so that he may examine the testator's state of mind at the time when he executes the will and, if he is satisfied, be an attesting witness to the will. This precaution is, for instance, important in cases of senility where there may be marked variations in mental capacity from time to time.

[emphasis added in bold italics]

39 In my view, the presumption referred to in para (b) of the above quote can only arise in a case where the serious mental illness is sufficient to cause testamentary incapacity. It is only in such a case that a continuation of the mental illness results in a continuation of the lack of testamentary capacity. In other words, the lack of testamentary capacity must first exist before it can continue. The presumption in that passage from *Theobald on Wills* refers to the continuance of an incapacitating serious illness. For example, if on Day 10 the testator has no testamentary capacity and he makes a will on Day 15, the presumption arises that the illness has continued with his inherent lack of testamentary capacity. The statement does not mean that, because a testator has a serious illness, it must follow that he lacks, or is presumed to lack, testamentary capacity. After all, he may have lucid intervals. That condition has to be shown as inferable from his mental illness. When analysed in this way, the presumption adds nothing to the burden of proof which is placed on the propounder of the will. When faced with an allegation that the testator was seriously ill when he made the will, the propounder has to show that the illness had not affected the testator's testamentary capacity. That is why *Theobald on Wills* goes on to state that the person propounding the will may rebut the presumption by establishing that the testator made the will during a lucid interval or after recovery from the illness. In my view, the more serious the illness prior to the making of the will is, the higher should be the threshold of proof, and, conversely, the less serious the illness, the lower the threshold of proof. As will be seen in this case, there was disagreement between the two expert witnesses as to the gravity of the illness that GG was suffering from prior to the making of the Will.

Issues on appeal

40 To determine whether the Appellant has discharged the burden of proving that GG had testamentary capacity when he made the Will, it is necessary to examine the evidence in relation to the following questions:

(a) Was there sufficient medical evidence to show that during the period between 1957 and 2001, GG's schizophrenia was so serious that he could not or did not have testamentary capacity to execute the Will?

(b) Was GG in remission when he made the Will (in 1998)?

(c) If GG was in remission, did he have testamentary capacity in law?

This court's assessment of the evidence

Was there sufficient medical evidence to show that GG did not have testamentary capacity?

41 Although GG was suffering from schizophrenia from 1957 onwards until his death, both Dr Ngui and Dr N (neither of whom had met or treated GG) accepted that the AR Hospital medical notes from 1971 to 2001 contained a paucity of information on GG's testamentary capacity. Dr Ngui stated in his medical report dated 12 June 2007 that GG's earlier symptoms included restlessness, insomnia, agitated episodes and irrational speech. The case notes stopped recording any detailed clinical observations from 8 November 1994. Thereafter, and until 13 August 2001, the clinical notes were brief and contained a paucity of information on the kinds of delusions (if any) which GG was suffering from or the incidence or intensity of such delusions. There was also no direct evidence of the nature, incidence or intensity of GG's delusions or hallucinations, if any, except that he was treated with anti-psychotic drugs. Dr Ngui also stated that there was insufficient data in the medical records to make a definitive conclusion on GG's testamentary capacity. In fact, there was insufficient medical evidence to show that GG did not have testamentary capacity around 1998 and also at which point of time, during this period, it could be said that GG did not have testamentary capacity. Neither Dr Ngui nor Dr N testified as to *when* GG might have ceased to have testamentary capacity.

Was GG in remission when he made the Will (in 1998)?

42 Dr Ngui's evidence was that the AR Hospital records showed that GG maintained a satisfactory remission of his illness from 1971 to 2001, as the two closest review dates (10 November 1998 and 8 December 1998) showed that his mental state appeared to be stable and satisfactory. GG's anti-psychotic medication was reduced on 8 December 1998, indicating that he was quite stable in his mental state.

43 Dr N did not express a direct opinion on whether or not GG was in remission in 1998 or at any period of time, but his general and unqualified opinion that GG did not have testamentary capacity implied that GG was in the same condition when he executed the Will. This unqualified general opinion (which was retrospective in nature) is, in my view, unsatisfactory for a number of reasons. With respect to the issue of GG's remission specifically, Dr N's opinion is unsatisfactory because it completely glosses over the question as to when GG's mental faculties would have begun to deteriorate and the degree and the extent of their progression, taking into account the periods when GG's actions and behaviour suggested that he was in remission. Dr N's opinion covered the entire period of 42 years of GG's illness without giving GG the benefit of any periods of remission that he had during this period. How did he deal with the medical and non-medical evidence that was indicative of GG's remission?

44 With respect to the AR Hospital medical notes which recorded phrases such as "Well, okay, better", Dr N dismissed them as unsatisfactory in that they did not indicate GG's symptoms, only GG's diagnosis and medication. With respect to GG's 13-year employment with the Club as a security guard, Dr N explained that GG might be stable, *ie*, not exhibiting positive symptoms (like hearing voices, believing people are trying to harm him, behaving aggressively or violently, or showing emotional disturbance) during this period, but that could be due to his being continuously on medication. His view was that the positive symptoms could be controlled by medication (such as anti-psychotic drugs), but not the negative symptoms (like lack of initiative, drive or motivation). He went on (see [22] above and the GD at [31]):

> He appears to be stable because not hearing voices. So if he is doing work of a security guard, he can do that but what we are concerned with is his mental capacity to be able to execute a Will, testamentary capacity. He may be stable in that he going to work, coming home, but it doesn't mean that he has mental capacity to write a Will. Therefore very important when person

is going to execute a Will, very important to make sure that his mental ability not impaired, i.e. his ability to think and understand what he is doing. I have listed the criteria for testamentary capacity in my report.

45 In my view, there are a number of assumptions in this reply on which there is no empirical proof. The first is Dr N's point that working as a security guard requires a different kind of mental capacity from making a will. Without saying so explicitly, Dr N seemed to be suggesting that GG's satisfactory performance as a security guard for such a long period of time (his service was extended for another two years when he retired at the age of 60 years) did not mean he had the same amount of mental capacity as was needed for possessing testamentary capacity. In this connection, when asked by the DJ how he would determine the state of GG's cognitive function and ability, Dr N replied that he would test memory, attention, concentration, orientation and intellectual ability. However, as Dr N had never examined GG at any time, he was not in a position to tell whether GG would have failed any of these tests in 1998 when he executed the Will. Dr N's evidence was effectively that, since GG did not undergo such an examination, he would, or would in all probability, have failed these tests. In this respect, I should add that Dr Ngui was also of the view that, *ideally*, GG should have been examined by a doctor before he made the Will just to be sure that he had testamentary capacity.

46 Dr Ngui and Dr N both accepted that a schizophrenic in remission would show no positive symptoms (such as delusions and hallucinations). However, Dr Ngui was of the view that, because GG had shown no such positive symptoms for some time prior to the execution of the Will, he was in remission and would revert to the level of his intellectual ability at a Secondary 2 standard and thus he would probably have sufficient mental ability to make a will. Dr N, on the other hand, disagreed. His view was that the positive symptoms could be controlled by medication but the negative symptoms of schizophrenia (lack of initiative, drive or motivation) might have continued in a patient with GG's medical history. Such a patient's cognitive functions could continue to deteriorate. Hence, in his view, because GG was suffering from 42 years of a progressive illness, GG's mental faculties would have deteriorated to such a degree and an extent that he was not capable of making a will. However, this opinion again had no reference whatever to GG's real condition since Dr N had never examined GG. There was also nothing in the AR Hospital medical notes to show that GG had any negative symptoms. Indeed, there was non-medical evidence of some initiative on the part of GG. He looked for work and was able to get odd jobs on his own. He managed to get employed by the Club for 13 years. There was evidence that he was aware of the benefits of an overseas education and was sufficiently concerned to advise the Appellant to study hard as he was the eldest grandson in the family. He was well enough to decide to give a substantial sum of money to his niece when she was abroad. These are not the actions of a man who had no understanding of what was important in life. He went about his life and work for a long period of time without any manifestation that he was mentally unstable. Thus, instead of coming to what would be a reasonable, if not the natural, conclusion of an objective observer, *ie*, that GG was in remission, Dr N came to the opposite conclusion. In contrast, Dr Ngui drew the reasonable conclusion, even though it was not definitive.

47 There was another aspect of Dr N's opinion on GG's psychiatric condition that was also not satisfactory. When Dr N was asked whether a person with a mental condition like GG would be able to manage a bank account, he replied that it was unlikely (see [24] above). This opinion was contrary to the opinion of Dr Ngui and the evidence of the Appellant, Yusof, Guna and Dr Eu's medical report dated 19 September 2005. Dr N's opinion on this point was also contradicted by the evidence. The DJ regarded this discrepancy as inconsequential because it did not discredit *in toto* Dr N's forceful opinion that 42 years of the progressive illness had deprived GG of his testamentary capacity. In my view, the DJ erred in not giving sufficient weight to the implications of this discrepancy in Dr N's testimony (see [59] below).

48 I do not accept Dr N's opinion that GG was not in remission prior to his making the Will. His opinion exhibited a degree of inflexibility that would not accommodate any contrary views, in spite of the objective evidence suggesting the contrary. As will be seen (see [50] below), Dr N's opinion was based on a hypothetical case of a person who had suffered 42 years of a progressive illness, with relapses in the last five years of his life. The hypothetical case gave little or no weight to the existence of periods of remission. It is contrary to evidence which showed that GG was in remission. Having regard to the medical and the non-medical evidence adduced by the Appellant, I find, on a balance of probabilities, that GG was in remission when the Will was executed. This brings me to the question whether GG had testamentary capacity in 1998 when he was in remission.

Did GG have testamentary capacity in 1998?

Dr Ngui's evidence

49 Dr Ngui testified that, based on the clinical notes of AR Hospital, GG had stabilised under treatment and was in remission. He also stated that a schizophrenic in remission would probably be able to give instructions on executing a will.

Dr N's evidence

50 Dr N, on the other hand, was strongly of the opinion that GG did not have testamentary capacity in December 1998. His view was that GG's long illness would inevitably have taken such a toll on his mental faculties as to render him incapable of satisfying the legal criteria for making a will. Dr N was questioned by the DJ on this opinion, and his replies were as follows:[note: 3]

> Q : *Do I understand your evidence to be that a person suffering schizophrenia over a long period could never have testamentary capacity as you understand it?*
>
> A : *Right*. In our experience of dealing with chronic schizophrenia especially when there are periods of relapse during this long illness it would indicate that he would not have the ability to execute a will because it is a progressive illness; intellectual function continues to deteriorate.
>
> Q: During periods of remission when he appears normal, would he have the cognitive ability to be able to execute a will?
>
> A: Each individual has to be examined at the time he is about to execute a will whether he has the testamentary capacity. *Hypothetical case – if I have [GG] who had disease for 40 years and the last 5 years of his life no relapses, one can conclude that at the time he signed the will he was stable. …* All those [*ie*, how his illness started and how it progressed] are found in the [IMH] notes.
>
> I made my inference of [GG's] mental condition based on [IMH] notes in the last 5 years of his life when he had suffered relapses of his condition which started in 1957 when he was first admitted

to Woodbridge Hospital, then followed up at Kallang Clinic and then 1971 onwards to 2001 followed up at [AR Hospital]. So it is reasonable to conclude that this sickness had continued for 40 years requiring regular anti-psychotic medication and subsequently continued at [IMH] until time of his death.

With my clinical knowledge and experience in this field I am able to say with conviction my opinion that *in all probability* he did not have the mental capacity to sign or execute a will.

51 It can seen from the above passages that Dr N's opinion on GG's lack of testamentary capacity ranged from certainty to a high degree of probability. But to determine the cogency of his opinion, it is necessary to analyse how he put it. His hypothetical case (italicised above) was based on the premise that, *because* GG had relapses in the last five years of his life from 2001, his condition was not stable (and he therefore could not have, or in all probability did not have, testamentary capacity in 1998). That would be the corollary of the hypothesis. Dr N's hypothetical argument may be reformulated as follows:

42 years of disease (= lack of testamentary capacity) + relapse = progressive illness = false remission

52 Dr N's hypothetical case is neat and tidy. But its critical weakness is that it is based on GG not having any periods of remission which, as I have pointed out, is contrary to the evidence. Dr N simply dismissed all medical and non-medical evidence which was indicative of GG being in remission. Expert opinions should have a factual basis, and, if there are no facts, then they should at least be backed by medical case histories of a similar nature. The DJ did not ask Dr N to produce case histories or textbook opinions to show that, in a case like GG's, the patient would not be likely to have testamentary capacity. Indeed, if this were the case, it would have been unlikely that another psychiatrist would contest the opinion. But Dr Ngui disagreed with Dr N as he was of the view that the medical records in IMH on GG's condition were irrelevant to the determination of GG's testamentary capacity in 1998.

Guna's evidence

53 Another unsatisfactory feature of Dr N's opinion was his treatment of Guna's evidence. Guna testified that he had always had normal conversations with GG even though they might have been rather short ones. On the night before the signing of the Will, GG appeared to have been normal as his father sent him to see Guna. On the night of the signing of the Will, Guna saw GG reading the Will. GG also looked and answered Guna's questions like a normal person when he signed the Will. Guna's observations would tend to show that GG was in a state of remission.

54 In fact, Guna's evidence went further than this. He testified that he asked GG five questions to test whether GG knew what he was signing was a will and also the contents of the Will. He said that he asked the questions because he was aware that GG was mentally ill. What he did not know was that GG had schizophrenia. He said that, from the answers given, he was satisfied that GG knew that the document he was about to sign was a will and that he would be giving away all his property to his nephew and nieces and that the nephew (the Appellant) would be appointed the sole executor and trustee of the Will.

55 Dr N did not contradict Guna's observations and opinion directly, but obliquely dismissed them as worthless when he was re-examined by the Respondent's counsel, after being cross-examined by the Appellant's counsel. This was what he said:[note: 4]

Q: In the case of [GG] on 6 December 1998, if counsel [Guna] attending to him, seeing him, observing him, is satisfied that [GG] understood what a will was and its consequences, he understood that [GG] knew the extent and nature of his property although not in detail and knows the name of his chosen executor and can assess their claim to his property and that he is free from an abnormal state of mind that might distort feelings and judgment relevant to the making of the will, if at that time counsel is satisfied that all these 4 criteria are met, then a will can be executed?

A: If counsel is satisfied that these 4 criteria are met, then Yes.

When he was re-examined, Dr N said:[note: 5]

Q: Counsel may be satisfied that 4 criteria are satisfied. *Does that mean that the 4 criteria are satisfied?*

A: If counsel knew that he was mentally ill for 40 years he should have asked for a medical opinion to satisfy himself.

[emphasis added]

It may be noted that Dr N did not answer the last question directly in re-examination. His answer was a subtle shift from his previous answer given under cross-examination. He said that Guna should have obtained a medical opinion, thereby suggesting that, because Guna did not do so, Guna's opinion that GG had testamentary capacity was unreliable or worthless. Guna's evidence was that he did not see any need to call a doctor to examine GG as he appeared normal and could understand Guna's questions.

The simplicity and rationality of the Will

56 Another unsatisfactory feature of Dr N's evidence was that he avoided answering questions on whether, given the simple terms of the Will, GG could not have had testamentary capacity to execute it. Dr N's evidence on this point is as follows:[note: 6]

Q: To make a simple will – I appoint my nephew, I give my assets to nephew, nieces. Does that require great testamentary capacity?

A: I did not say that. He could be stable in that he is not exhibiting positive symptoms but I was asked to opine on whether he is capable of executing a Will for which I stated the criteria in my report.

Q: If there is medical opinion to say that his schizophrenia was showing improvement and in satisfactory remission, would he be able to give instructions to make a simple will?

A: He can, provided it is certified by the doctor in his notes.

...

Q: We have on record a doctor who says his symptoms improved and was in remission and he can make a will?

A: He can make a will provided he knows what a will is and the things that he is giving away, ie fulfil the criteria of testamentary capacity. That must be established for him to be able to execute a will.

57 Dr N's replies to counsel's questions suggested that he did not disagree that making a simple will did not require "great" testamentary capacity. However, he also avoided answering whether GG had the capacity to make a simple will (*eg*, in the terms of the Will) that counsel had outlined to him. At the same time, he adroitly rejected Guna's observations on GG's mental capacity as unreliable, and also suggested that GG did not have testamentary capacity even if he were in remission.

58 Thus, Dr N was able to maintain his opinion that GG had no testamentary capacity in 1998 by reference to his hypothetical case. However, as I have mentioned earlier, Dr N did not attempt to give any date on which GG could be said to have lost his testamentary capacity, except that he did not have it in 1998. But even a progressive illness like schizophrenia cannot mean that, from day one of the onset of the illness, the patient ceases to have testamentary capacity. This omission would leave in considerable doubt Dr N's opinion that GG's condition had deteriorated to such an extent that he did not have testamentary capacity in 1998. In my view, Dr N's opinion, based on his hypothetical case, is what it is – a hypothetical case without a firm factual foundation. The evidence showed that GG was in remission in 1998 and Guna's testimony showed that GG understood what it was that he signed that night in his father's house. For these reasons, I am not persuaded by Dr N's hypothetical argument.

Assessment of the DJ's decision

59 The DJ accepted practically everything Dr N said about GG's illness, except his opinion that a person in GG's condition would not be likely to be able to make a will. She accepted that GG's ability to manage his financial affairs meant that Dr N was wrong in stating that a person in GG's condition was unlikely to be able to do so. However, she "did not regard this as sufficient to discredit [Dr N's] evidence *in toto*" (which was that a person "suffering from schizophrenia with the positive symptoms of this illness being brought under control by anti-psychotic medication could perform simple transactions but the cognitive functioning required to make a will was a different consideration") (at [40] of the GD). The DJ did not appear to have given sufficient weight to the fact that if Dr N's opinion on this rather simple matter was contrary to the facts, he could also be wrong in his opinion on the much more complicated issue of GG's testamentary capacity (which opinion is based on his

hypothetical argument). She discounted the possibility that, as GG could manage his financial affairs, he could have been in remission and capable of making a simple will (which might or might not require the same degree of cognitive understanding as that required for managing his finances). She also did not consider that Dr N had never stated at what point of time GG's mental capacity began to deteriorate to the extent that he ceased to have any testamentary capacity. She did not give sufficient consideration to all the non-medical evidence that showed that GG was, to all appearances, in remission around the time he executed the Will, and in particular she rejected the sufficiency of Guna's questions to GG and GG's answers to such questions for the wrong reasons.

60 The DJ gave two reasons for rejecting Guna's evidence on GG's testamentary capacity. They are: firstly, the progressive illness would have taken a toll on GG's mental functions such that GG would not have testamentary capacity (at [39] of the GD), and secondly, Guna was not aware that GG was suffering from schizophrenia at the time he questioned GG (at [38]–[39] of the GD). At [40] of the GD, she explained as follows:

> The cognitive or mental functions were the faculties required for testamentary capacity. If these functions were impaired, then it would necessarily follow that testamentary capacity was also impaired.

With respect, while the reasoning in this holding may seem logical, it did not follow that GG's impairment necessarily meant that he had no testamentary capacity to make a simple will.

61 In *Banks* ([29] *supra*), the court considered whether the testator's mental disorder "prevent[ed] the exercise of his natural faculties" (at 565). It recognised that the mere impairment of cognitive or mental functions did not necessarily lead to testamentary capacity being impaired. Cockburn CJ, at 560 of the judgment, recognised that mental diseases could affect people in different degrees. Dr Ngui, when questioned on this point in the context of GG being in remission, expressed the view that just because a man was a schizophrenic and had a long mental illness did not mean that he could not give instructions to make a will. On the other hand, Dr N's forceful opinion was that GG did not have testamentary capacity in 1998 because of his progressive illness from 1957 and the relapses he had from 2001. Dr N certainly gave his views very surely and forcefully, but ultimately, the court must look at the objective evidence produced before it. In this connection, it is pertinent to recall Cockburn CJ's statement in *Banks* (at 570) that:

> It seems unreasonable to deny testamentary capacity on the speculative possibility of unsoundness which has failed to display itself, and which, if existing in a latent and undiscovered form, would be little likely to have any influence on the disposition of the will.

This statement is particularly apposite in the light of Dr N's evidence (which had no actual bearing on GG's case) that whilst medication could control his positive symptoms of schizophrenia, the negative symptoms might continue.

62 Dr N's evidence was that the toll on GG's mental faculty was such that he could not have any testamentary capacity. But, as I have mentioned earlier, Dr N's opinion was based on GG not having been in remission at all. The DJ found that Guna's five questions and GG's answers to them were inadequate "as there is significant doubt whether [GG] had the cognitive ability to understand the purport of those questions" (at [39] of the GD). With respect, this reasoning is putting the cart before the horse. Instead of considering whether Guna's five questions and GG's answers were sufficient to indicate testamentary capacity, she decided that they could not because GG's mental capacity had already been impaired. But, of course, on this basis, whatever questions that Guna might have asked GG would not have repaired his mental capacity. The fact was that GG gave

rational answers to Guna's five questions, all of which were relevant to proving whether he understood his action in signing the Will. He replied, *inter alia*, that he did not want the Respondent "to touch his things", with reference to Guna's question of why he wanted to appoint the Appellant rather than the Respondent as his executor. For all these reasons, I am unable to accept the DJ's implicit conclusion that Guna, an experienced solicitor of about 30 years' standing, was incapable to telling whether a person had the mental capacity to make a will.

63 The DJ's second reason fails to give sufficient consideration to the fact that Guna *was aware* that GG had a medical condition from young, although he admitted that he did not know it was schizophrenia medically. It should be noted that the DJ did not disbelieve Guna's evidence. She rejected it because it was inconsistent with Dr N's opinion that GG did not have testamentary capacity. In my view, the DJ failed to direct her mind to the sufficiency of GG's answers to Guna's questions as a test of testamentary capacity, in the same way that she failed to direct her mind to Dr N's failure to answer the question in relation to Guna being satisfied that GG had testamentary capacity (see [55] above).

Function of the court in assessing expert evidence

64 In a case of this nature, the function of the court is to decide whether the testator has testamentary capacity at the relevant time. This involves making a finding of fact by applying the law to the evidence. In matters involving specialised knowledge, such as schizophrenia, the court has to rely on the opinion of medical experts, but it does not have to accept any medical opinion if it is not supported by the objective evidence. An expert opinion should have at the least a substratum of facts. Although Dr N had considered the clinical notes from AR Hospital (which were not helpful to him) and from IMH (which were decisive for him), his opinion, no doubt backed by his clinical experience and knowledge, was really based on the hypothetical case which he had constructed from the clinical notes to explain why he considered that GG did not have any testamentary capacity. The hypothesis itself was based on his version of the reconstructed facts which disregarded the actual evidence that contradicted the factual premises of his hypothetical case. For this and other reasons, I am unable to accept Dr N's opinion on GG's lack of testamentary capacity at the relevant time.

65 In the present case, the expert opinions were not unanimous. Dr Ngui did not agree with Dr N, although he gave his evidence in a less assertive fashion. The law is clear in cases where the expert witnesses disagree: the court may place greater weight on factual witnesses (see *Mahendran* ([37] *supra*) at [38]). In *Ng So Kuen Connie v PP* [2003] 3 SLR 178, the court upheld the trial judge's decision to reject the evidence of both psychiatrists even though they were in agreement with each other, and said at [32]:

> As a trier of fact, the trial judge was just as capable of assessing the evidence as the psychiatrists. At best, the role of the psychiatrists was to support the trial judge's finding of fact. At no point should the trial judge's fact-finding role be abrogated to the experts.

66 In my view, the DJ was unfortunately intimidated by Dr N's forceful exposition of GG's lack of testamentary capacity, and virtually allowed him to decide this issue. This was contrary to the nature of the judicial function. The court must decide the issues of fact and law, and not allow an expert to decide them (see *Gunapathy Muniandy v Khoo James* [2001] SGHC 165 at [12.3]). In the present case, the DJ was too deferential to Dr N's expertise and did not apply her mind sufficiently to the medical and non-medical evidence which showed that GG was in remission and was able to understand what a will was. She should have given more weight to the non-medical evidence. One such piece of evidence is the rationality of the Will itself, a matter I will now examine.

The rationality of the Will

67 Besides being simple, the Will was also entirely rational. Neither Dr Ngui nor Dr N was questioned on the rationality of the Will in relation to GG's testamentary capacity. The DJ did not raise it either. In my view, the rationality of a will has a significant bearing on the testator's rationality, and is a sound indication of testamentary capacity. In *Banks* ([29] *supra*) and *Estate of Eusoff* **([33] *supra*), the courts took into account the "inofficiousness" of the will as indicating a lack of testamentary capacity**. In my view, just as an inofficious will is some evidence of an irrational testator, a rational will is some evidence of a rational testator. In the present case, not only was the Will not inofficious, it was completely rational and something that was naturally expected. As a brother of the Respondent, GG was under no familial or moral duty to give anything to the Respondent. GG was not close to the Respondent; in fact, he detested him. On the other hand, he was fond of his nephew and nieces. It was therefore not surprising, even natural, for GG to have given them his estate out of love and affection for them. Indeed, given the relationship between GG and the Respondent, it would have been unnatural for GG to have given anything to the Respondent. In these circumstances, it would be reasonable to argue that if GG had given a substantial part of his estate to the Respondent, it would have raised a reasonable doubt as to his testamentary capacity!

68 In *Cartwright v Cartwright* (1793) 1 Phill Ecc 90; 161 ER 923 (referred to in *Banks*), Sir William Wynne was of the opinion that the rationality of the act done afforded an effectual test of the mental capacity of the party doing it, even in the case of a will executed in a lunatic asylum. At 100; 927 he said:

> … I think the strongest and best proof that can arise as to a lucid interval is that which arises from the act itself; that I look upon as the thing to be first examined, and if it can be proved and established that it is a rational act rationally done the whole case is proved. What can you do more to establish the act? because, suppose you are able to shew the party did that which appears to be a rational act, and it is his own act entirely, nothing is left to presumption in order to prove a lucid interval.

69 Horne J adopted the same approach in *Estate of Eusoff* (see [35] above). I agree with this rather commonsensical view, in the absence of strong evidence that a testator has no testamentary capacity. In the present case, the DJ ignored this aspect of the case entirely. She failed to take into account the rationality of the Will and simply accepted Dr N's opinion (which also did not take into account this important point).

Conclusion

70 For all these reasons, I am of the view that the Appellant has adduced more than sufficient evidence to rebut the presumption (even assuming that it is applicable) that GG lacked testamentary capacity arising from his schizophrenia. I am satisfied, on an analysis of the whole of the evidence, that the Appellant has discharged the burden of proving that GG had testamentary capacity when he made the Will.

71 The appeal is allowed with costs here and below to the Appellant, with the usual consequential orders.

[note: 1] Notes of evidence of 31 January 2008, p 82.

[note: 2] *Id*, at p 84.

[note: 3] Notes of evidence of 31 January 2008, at pp 82–83.

[note: 4] Notes of evidence of 31 January 2008, p 79.

[note: 5] *Id*, at p 80.

[note: 6] *Id*, at p 77–78.

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