THE SUPREME COURT OF APPEAL OF SOUTH AFRICA
JUDGMENT

Not reportable
Case No: 20632/2014

In the matter between:

VAN NIEKERK ELIZABETH ALETTA	**APPELLANT**
and	
KRUGER GERT ABRAHAM	**FIRST RESPONDENT**
CLIFTON CHARLOTTA CATHARINA	**SECOND RESPONDENT**
KRUGER ROELOFF JURGENS JOHANNES	**THIRD RESPONDENT**
KRUGER MARIA JOHANNA MAGDALENA	**FOURTH RESPONDENT**
KRUGER PIETER	**FIFTH RESPONDENT**
CLIFTON SEBASTIAN LEGALLY REPRESENTED BY CHARLOTTA CATHARINA CLIFTON	**SIXTH RESPONDENT**
CLIFTON STEFAN LEGALLY REPRESENTED BY CHARLOTTA CATHARINA CLIFTON	**SEVENTH RESPONDENT**
KRUGER RUHAN LEGALLY REPRESENTED BY ROELOF JURGENS JOHANNES KRUGER	**EIGHTH RESPONDENT**
KRUGER WERNER LEGALLY REPRESENTED BY ROELOF JURGENS JOHANNES KRUGER	**NINTH RESPONDENT**
KRUGER: WIEHAN LEGALLY REPRESENTED BY ROELOF JURGENS JOHANNES KRUGER	**TENTH RESPONDENT**
ABSA TRUST LIMITED	**ELEVENTH RESPONDENT**
MASTER OF THE HIGH COURT (ESTATES DIVISION)	**TWELFTH RESPONDENT**

Neutral Citation: *Van Niekerk v Kruger and others* (20632/14) [2016] ZASCA 55 (1 April 2016)

Coram: Navsa ADP, Leach and Saldulker JJA and Tsoka and Baartman AJJA

Heard: 3 March 2016

Delivered: 1 April 2016

Summary: Wills Act 7 of 1953, section 4 – whether deceased had testamentary capacity to execute a will – Expert evidence – court must be satisfied with the reasoning which led to conclusion by expert witness- held testatrix not of sound mind at time of execution of will.

ORDER

On appeal from: Gauteng Local Division of the High Court, Johannesburg (Mokgoatlheng J sitting as court of first instance).

The following order is made:

1 The appeal is dismissed with costs, such costs to include the costs of two counsel.

2 The order of the Court below is altered to read:

'The claim is dismissed with costs such costs to include the costs of two counsel and the qualifying fees of the following expert witnesses:

Dr Edeling, Mr Ormond-Brown and Professor Vorster.

JUDGMENT

Saldulker JA and Baartman AJA (Navsa ADP, Leach JA and Tsoka AJA concurring):

Introduction

[1] On 28 November 2006, Mrs Maria Johanna Kruger (the deceased) executed a will, the original of which allegedly cannot be found (the disputed will). After her death, the appellant sought an order that a copy of the disputed will, Annexure X1 to the papers, be declared a true copy of the deceased's last will and testament, and a further order directing the Master to accept it. In regard to this relief the issues in the court below were (i) whether the deceased had the required mental capacity to have executed the will; (ii) whether the appellant, Mrs Elizabeth Aletta van Niekerk, the deceased's niece had unduly influenced the deceased into executing the disputed will and (iii) whether the deceased's purported signature appended to the disputed will was authentic. The court below held that the document presented was not a true copy of the original will and that the deceased did not have the testamentary capacity. This appeal with the leave of the court below is directed against inter alia the following order:

‘1. Annexure "X1" *[the disputed will]* is declared not to be a true copy of the Deceased's original last will and testament;

2. *Annexure "X1"* is declared not to be valid on the face of it;

3. The Deceased is declared not to have had testamentary capacity on 28 November 2006, nor to have possessed sufficient intelligence, sound mind or memory to understand and appreciate the import of her signature when she signed *Annexure "X1"* on 28 November 2006, consequently, *Annexure "X1"* is declared not to be the last will and testament of the Deceased;’

[2] Before us, the parties were in agreement that the primary question to be addressed was whether the deceased had the required testamentary capacity at the time the will was allegedly executed. In the event of a finding that the deceased lacked the necessary capacity, that would be dispositive of the appeal. Before turning to address that issue it is necessary to have regard to the background.

Background

[3] The deceased and her husband, the late Mr Pieter Andries Kruger, had three natural children (Gert, Charlotta and Roeloff), the first three respondents. The deceased and the first respondent had been estranged for eight years prior to the material events. The deceased made a career of taking care of young babies who were up for adoption until the adoption process was complete. In the course of her career, the deceased and her husband adopted Ms Magdalena Kruger, the fourth respondent, and ‘took in’ Mr Pieter Kruger, the fifth respondent when he was three weeks old, never adopting him formally. However, Pieter was treated as their natural son and when he was 16 years old, they officially changed his surname to match theirs. The deceased referred to him affectionately as her ‘welfare child’. The deceased was a strong-willed 78-year-old woman. At the time of her death on 24 December 2006 she was obese and suffered from hypertension and diabetes. These conditions, no doubt, contributed to her death.

[4] The deceased suffered two strokes, one on 15 June 2006 followed by another on 19 October 2006. Between those two events, on 19 August 2006, she suffered

dehydration and gastroenteritis. The deceased was hospitalised for each of these medical conditions.

[5] On 15 June 2006, after the deceased had suffered her first stroke, she was treated at Milpark Hospital in Johannesburg by Dr Rowji, a neurologist who attended to her from 15 June until a time shortly before her death. On the day of her admission, Dr Rowji requested that a brain scan be conducted. The scan showed '…an ill-defined area of hypo-intensity in the region of the right basal ganglia involving the head of caudate nucleus the right internal capsule and the lentiform nucleus with some extension into the adjacent deep white matter.' Also apparent from the scan was age-related involutional change to the cerebral cortex (age-related brain shrinkage). The hospital records show that by 22 June 2006, the deceased was 'fully conscious and communicating well with staff and visitors', although prone to wetting her bed.

[6] On 30 June 2006, the deceased was transferred to Netcare Rehabilitation facility where Dr Mochan and a team of specialists, including a patient counsellor and a physiotherapist, attended to her. She eventually regained full continence. According to the Netcare records, by 5 July 2006 the deceased was only partially orientated to time and place and only knew the day of the week. Furthermore the Netcare records indicated that the deceased's short term memory and concentration had been affected by the stroke. The following week, 12 July 2006, her cognitive function was still impaired, indicating 'no rapid improvement' of cognitive function.

[7] On 12 July 2006, the deceased's husband, daughter, son and grandsons attended a family meeting with Netcare personnel, presumably to discuss the deceased's condition and what she would need after her discharge to improve her concentration. According to the Netcare records, by 17 July 2006 her cognitive function had improved and she was orientated to time but still required verbal cueing, and made mistakes when working independently. It is recorded that the medical team continued to work on daily basic concentration tasks.

[8] By 19 July 2006, the same records show that the deceased was fully orientated to time and place. The Netcare staff continued to treat and assist her with the aid of creative activities to improve her concentration. The medical advice was that the deceased could go home for a weekend. It was suggested that the services of a caregiver should be procured for the visit. On 26 July 2006, the deceased went home, for the weekend, but with no arrangements for a caregiver, which left her husband to shoulder the burden. Upon her return to Netcare, the deceased remained fully orientated and the medical team continued to engage her in activities to improve her concentration although she was reported to be occasionally incontinent. Thereafter, Netcare personnel recommended home alterations such as 'grip rails and a bath board' to prepare for the deceased's homecoming and to facilitate her mobility which had become impaired. It was uncontested that the first stroke left her partially paralysed on the left side of her body. On 1 August 2006, the occupational therapist made several other recommendations regarding further alterations to be effected in anticipation of her discharge. On 4 August 2006, she was discharged, a week prior to the planned date, mainly due to her uncooperative and obstructive behaviour. On the day of her discharge, the deceased's husband committed suicide. She was informed of this fact whilst awaiting transport home.

[9] As indicated earlier, on 19 August 2006, the deceased was admitted to Milpark Hospital and treated for dehydration and gastroenteritis. On 22 August 2006, the deceased was discharged from Milpark but taken into Panorama frail care facility (Panorama) at the instance of her children. It was envisaged that her stay at Panorama would be temporary, pending the contemplated alterations to her home to address the disabilities brought on by her medical condition.

[10] It was noted that at Panorama, the deceased was difficult, uncooperative, refused treatment, accused personnel and patients of stealing her property, refused to eat and periodically wet her bed. It is common cause that she was unhappy, dissatisfied with her admission to the facility and took the view that she was well able to take care of herself. The Panorama records include a note in which the

deceased's behaviour and physical condition were considered to be 'an indication of starting dementia.'

[11] On 15 September 2006, Dr Rowji consulted with the deceased and found her severely emotionally distressed. Dr Rowji increased the dosage of the anti-depressants which he had previously prescribed. It is uncontested that Dr Rowji favoured the deceased's continued stay at Panorama. On the day she consulted with Dr Rowji, the appellant signed her out for a weekend visit at the latter's home. It is necessary to record that but for a few days between the first stroke and her death, the deceased spent all her time outside the hospital and rehabilitation facilities at the appellant's home. On 19 September 2006, after an appointment had been arranged by the appellant, the deceased met with Mr Johan Van der Merwe, an ABSA broker, for the purposes of instructing him to draft the disputed will which is the subject matter of the present litigation. Van der Merwe requested the relevant ABSA department to draft the will in accordance with the deceased's instructions to him. He received the following typed document which according to him was in line with her instructions:

'Ek bemaak my boedel soos volg:

1.1 Die vaste eiendom bekend as St. Helenslaan 82, Mayfair-Wes, aan my dogter MARIA JOHANNA MAGDALENA KRUGER.

1.2 Die vaste eiendom bekend as St. Helenslaan 81, Mayfair-Wes, aan my kinders CATHARINA CLIFTON en GERT ABRAHAM KRUGER.

1.3 *Die vaste eiendom bekend as 3de Laan 12A, Westdene, aan my seun ROELOF JURGENS JOHANNES KRUGER.*

1.4 Die motorvoertuig aan my pleegkind PIETER KRUGER (GEBORE 03/06/1967).

1.5 Die kontant in my boedel gevind, soos volg:

1.5.1 50% (VYFTIG PERSENT) aan my susterskind ELIZABETH ALETTA MAGDALENA VAN NIEKERK (GEBORE 27/05/1963).

1.5.2 50% (VYFTIG PERSENT) aan sodanige van my kleinkinders SEBASTIAN CLIFTON, STEFAN CLIFTON, ROHAN KRUGER, WERNER KRUGER en WIEHAN KRUGER wat my oorleef….' (own emphasis.)

[12] On 19 October 2006, the appellant found the deceased in her room in the following condition: ‘ sy het nie lekker gelyk nie. Ek het met haar gepraat en dit was al of sy, jy kon nie met haar komminukeer nie.’ On that day, the deceased suffered a second stroke and was, readmitted to Milpark Hospital. The second respondent, the deceased’s daughter Charlotta, visited her on 20 October 2006 and found her confused and unresponsive. She said, ‘My ma was heeltemal, ek dink nie eers sy het geweet ek is daar nie. …Sy het net so gelê daar en ek het haar probeer skud en vat en dit, en sy het net so gelê’. The deceased was apparently in the same condition when the second, third and fourth respondents visited her the following week.

[13] On 9 November 2006, the deceased was readmitted to Netcare Rehabilitation Hospital. On the same day, Ms Russell, a psychometrist employed by Mr Ormond-Brown, a resident clinical neuropsychologist, met the deceased. Ms Russell saw the deceased because the Netcare practice was for Mr Ormond-Brown to assess all neurological patients. Ms Russell’s records show that the deceased was ‘confused…and not testable’. In this regard she was referring to psychometric testing. Ms Russel monitored her until the deceased was able to sit and concentrate for at least 20 minutes, by which time she would be testable. It was only on 22 November that Ms Russell took the view that the deceased could be tested and so performed ‘the mini mental status examination’ (the MMSE) on her. The test results showed that the deceased believed it was 1906, that her husband had died the previous year – rather than in August 2006, and that she was unaware of anything on her left side due to paralysis. The deceased scored 20/30, which Ms Russell described as a poor result. In addition, Ms Russell conducted ‘a clock test’ in terms of which the patient is required to draw a clock face and indicate the time as 09h50. She had great difficulty in doing so. The purpose of the clock test is to evaluate the patient’s planning skills and concentration. The experts accepted the value of the test to be following:’…because you are able to plan, you can draw the circle, you know you must put the numbers so that they are equally spaced and you know therefore to put the hands of the time…’ We shall, in due course, deal with the proper meaning and value to be attributed to the MMSE score and also the result of the meaning of the clock test.

[14] On 23 November 2006, the day after Ms Russell performed the MMSE, the deceased was discharged from Netcare because she had refused to cooperate with medical personnel and for that reason her medical scheme had refused to pay for any further treatment. On 28 November 2006, five days after her discharge, the deceased allegedly signed the disputed will at the appellant's home witnessed by Van der Merwe and Mrs Flemming, the appellant's neighbour. On that day, she allegedly altered the disputed will in regard to 'the Westdene property' (clause 1.3 para 11 above) which had previously indicated 'my seun', the third respondent, as legatee, and instead bequeathed it to the appellant. It was common cause that the deceased had inherited that property from the appellant's brother, a police officer. It was not disputed that before the latter's death the deceased and he had enjoyed a good relationship. The deceased had assisted him when he was in financial difficulties and after he was shot, took him in and nursed him back to health.

[15] On 7 December 2006, accompanied by the appellant, the deceased while consulting Dr Rowji as an out-patient, told him that she had disinherited her children, saying, 'I will not give them anything'. On 24 December 2006, the deceased died of a pulmonary embolism (a third stroke). On 28 December 2006, Dr Klepp conducted a post-mortem recording the following:'. .. . Intracranial contents: There are two areas of haemorrhage into the right cerebral hemisphere. Resolution is more marked in one of the areas. There is marked complicated atheroma of the cerebral vessel.' We deal with the significance of these findings below.

[16] We pause to record an incident which might have some relevance to the ultimate question to be decided. In September 2006, the first respondent sought police assistance claiming that 11 firearms in the deceased's home had not been properly secured while the deceased was convalescing at the appellant's home following her departure from Panorama. This is an indication of the extent of the family feud that followed the deceased's ill-advised move from Panorama to the appellant's home. Pursuant to the complaint, Inspector Claasen (Claasen), a member of the South African Police Services, visited the deceased on 18 October 2006. He

found her in bed, emotional and still resentful of her placement in Panorama despite the obvious benefits it held for her recovery. She further complained that the first respondent had taken her red Jetta motor vehicle without her permission. The deceased consented, however, to the appellant collecting the firearms in question from her house, which was done, with the firearms remaining thereafter in the appellant's custody.

[17] After the deceased's death, the appellant requested the Master of the High Court, the twelfth respondent, to accept a copy of the disputed will for the purposes of the administration of the deceased's estate. In terms of the disputed will the eleventh respondent, ABSA bank was appointed as the executor of the deceased's estate. The Master of the High Court, Johannesburg refused to accept the disputed will as it was a copy of the will and not an original. It is this refusal that prompted the appellant to institute action on 28 August 2007, seeking, inter alia, the following relief:

'1. Declaring that the copy of the Deceased's last Will and Testament annexed hereto marked "X1" constitutes a true copy of the original of the Deceased's last Will and Testament.

2. That the Twelfth Defendant be authorised and directed to accept annexure "X1" annexed hereto as the last Will and Testament of the late Maria Johanna Kruger.

3. That the Twelfth Defendant be and is hereby authorised to register the copy of the Deceased's last Will and Testament annexed hereto marked "X".

4. That the Eleventh and Twelfth Defendants be and are hereby authorised and directed to administer the estate of the late Maria Johanna Kruger in accordance with the contents of annexure "X1" annexed hereto.'

[18] The respondents, one to four (the deceased's children) and six to ten (the deceased's grandchildren) opposed the action. Since they challenged the validity of the disputed will on the basis of the deceased's lack of testamentary capacity, they bore the onus of proving that fact.[1] They also did not accept the authenticity of the deceased's signature. They pleaded in the alternative, that in the event of an

[1] Wills Act 7 of 1953 , s 4.

affirmative finding of the authenticity of the deceased's signature, that the appellant had influenced the deceased. Below we deal to the extent necessary with the further evidence led in the court below.

Further evidence

[19] According to the appellant, who was employed at ABSA bank as a Risk Manager, the deceased executed the disputed will on 28 November 2006 at her home and was of sound mind when she did so. The appellant testified that she had a good relationship with the deceased, whom she occasionally referred to as 'Tannie Ma'. She had weekly contact with the deceased; either personal visits or telephonically. She further indicated that she took the deceased in at the latter's request when her children had admitted her to Panorama. While in her care, with the assistance of Mrs Nchube, a caregiver, the deceased returned to her normal self although she remained physically challenged. Regarding the deceased's state of mind on 28 November 2006, the appellant's evidence was that 'Tannie was by haar volle positiewe en sy het altyd logies gedink en haar besluit was gewees as sy 'n ding besluit het, het sy dit besluit en niemand kon dit verander nie.'

[20] Van der Merwe, who testified in support of the appellant's case, stated that he had approximately thirty years' experience in drafting wills. On 19 September 2006, he met the deceased as a result of the appellant arranging such appointment. At that meeting the deceased requested him to draft a will and supplied the necessary information. Van der Merwe sent the information to the relevant ABSA department, which drafted the disputed will referred to above. On 28 November 2006, he met with the deceased and the appellant's husband and presented the disputed will for signing. The deceased, prior to signing, instructed him to alter the draft document so that paragraph 1.3 would reflect the appellant as heir of 'the Westdene property', instead of 'my seun', the third respondent. This amendment was witnessed by Mrs Flemming, the deceased and him. He presented the altered document to the ABSA department to be retyped. The deceased died before she could sign the retyped document. According to Van der Merwe, he deduced that the original altered will was

in his briefcase which had been stolen from his shopping trolley at a supermarket. Thus only a copy is available.

[21] Mrs Flemming, the appellant's 71-year old neighbour, testified that she had witnessed the disputed will in the presence of the deceased, Van Der Merwe and the appellant's husband who had fetched her for that purpose. Mrs Flemming had not known the deceased prior to that day. She described the deceased as 'pleasant . . . fine and alert' and stated that she communicated well.

[22] The fifth respondent, 'the welfare child', testified in support of the appellant's case. He testified that he was the only one who had taken care of the deceased after her husband passed away. He testified about the stormy relationship that the deceased had with her other children who, according to him, had abandoned her when she suffered the strokes. He described the deceased as someone who could not be easily influenced. On 25 November 2006 the deceased visited him at his home and was fully orientated. During that visit the deceased told him that she was going to change her will and leave him her entire estate because her children had abandoned her. He advised against this and instead requested that she leave him her car and the policy that he had been paying for. He conceded that he was bitterly upset with his siblings and felt that he was not valued by them.

[23] We do not deem it necessary to deal in more detail with the evidence of the other lay witnesses who testified at the trial. We proceed instead to deal in some detail with the expert evidence led.

The expert evidence

[24] The experts, Dr Rowji called by the appellant, and Dr Edeling, a neurosurgeon, Mr Ormond-Brown, and Professor Vorster, a psychiatrist, called by the respondents, had conflicting views on whether the medical conditions, referred to above, had resulted in frontal lobe executive mental impairment which would have rendered the deceased of unsound mind and incapable of executing a valid will.

[25] Although, neither Dr Edeling nor Professor Vorster treated the deceased, they had accessed the medical records relevant to the deceased's time in hospital and in the rehabilitation facilities, and based their opinions on those records. Dr Edeling said that they were accordingly in as good a position as the treating doctors to formulate their opinions. The experts called by the respondents suggested that the deceased had suffered from dementia following the first stroke and that she got progressively worse. We deal with their evidence in turn below.

[26] Dr Edeling, whose expertise as a neurosurgeon was not in dispute, testified that the first stroke occurred in the right middle cerebral artery, which means that it was an ischaemic stroke, which blocked an artery and thus that area of the brain supplied by that artery 'died' through lack of blood supply. The affected area was in the right side of her brain deep in the basal ganglia regions, not around the surface but deep in the right hemisphere of her brain. The stroke was triggered by her history of hypertension and diabetes, both of which are risk factors for the development of cerebrovascular disease. When she was admitted, her blood pressure was high with a systolic reading over 200mmHg; she was also paralysed on the left side, leaving her left arm and leg weak. He translated the results of the scan, referred to above, as follows:

'…a stroke involving those structures would predictably cause left hemiparesis and also left hemianopia. So the pathway coming from the vision to the eyes going to the back of the head the nerves bringing information from the left visual field so the left side of the left eye and the left side of the right eye would go through that area.'

[27] Also apparent from the scan was age-related involutional change to the cerebral cortex (age-related brain shrinkage), which according to Dr Edeling, was significant as it would have made the deceased more vulnerable to the effects of a stroke. Dr Edeling said the following about her incontinence, reflected in the Milpark hospital records of 22 June 2006:

'…from that anatomical situation of the stroke if that was the only part of her brain that was damaged one would not expect incontinence the fact that she was incontinent following the first stroke means that there was other damage to other parts of her brain that the scan could not see. The part of the brain that is involved in this kind of incontinence is the cortex in the

frontal lobes. So the cortex was affected but the fact that she was incontinent means that the shrinkage of the frontal lobes was to such an extent that there was impaired functioning.'

[28] Although by 19 July 2006, the deceased was fully orientated as to time and place, Dr Edeling testified that such 'orientation is a very low-level basic mental function. One needs to have a lot more advanced and complex mental function before one can conduct one's affairs.' Following her admission to Milpark Hospital for dehydration and gastroenteritis, Dr Williams, her attending doctor certified her as unable to manage her affairs. Dr Edeling confirmed that Dr Williams' certification was in line with his opinion that the dehydration had hampered her mental function, despite the fact that mental impairment was not clearly documented in Milpark's records. Dr Edeling said that this condition would have had following effect on the deceased:

'…[A] person who has had a stroke and a person who has cerebral vascular disease as she is known to have had and a person who has mental impairment on the basis of that and cerebral atrophy which we know she all had by that time will be aggravated by dehydration because it will impair the blood flow to the brain. *So I would expect that this dehydration from gastroenteritis would have further compromised her mental function.*' (own emphasis.)

[29] Dr Edeling testified that the Panorama records showed that the deceased was awake and alert, though sleeping most of the time, which he said was in keeping with brain damage as had her brain had been normal, she would not have slept most of the time because gastroenteritis and dehydration would not on its own have made her sleep; brain damage and dehydration, however, hampers cerebral blood flow thus causing drowsiness.

[30] Dr Edeling explained the deceased's uncooperative and obstructive behaviour as recorded in the Panorama records as follows: '. . . frontal lobe executive mental impairment, where a person's mental function has deteriorated to the level where she is unable to care for herself.' He went on to say that once mental impairment has reached the level of impaired social functioning or occupational functioning, it is called dementia. This view was shared by, Ms Viljoen, the owner and manager of Panorama, who obtained her honours degree in nursing at the University of the

Orange Free State in 1981 and had been in the profession since that time. She described the deceased's condition as 'an indication of starting dementia.'

[31] According to Mr Ormond-Brown, the deceased had suffered a cerebrovascular incident or CVA stroke, involving the right middle cerebral artery which supplies about 60 per cent blood to the brain. He further agreed with the views expressed by Dr Edeling above.

[32] Mr Ormond-Brown described the deceased's mental and physical condition after the second stroke as follows:

'…She was confined to a wheelchair and had a dense hemiparesis, in other words, she was paralysed on the left side of her body. Muscle tone was 3/5 in the left arm and leg, in other words, it is reduced. She had generalised left-sided hyperaesthesia, meaning that she could not feel on the left side of her body. She had left hemianopia, meaning the she was blind in the left visual field of both eyes.'

[33] Dr Edeling described the second stroke as follows:

'…[I]t was in the same area of the brain as the first stroke but as opposed to a blockage of a vessel there was bursting of a vessel so there was haemorrhage or bleeding into that region of the brain and the haemorrhage actually went further than the confines of the first stroke but it was in the same area of the brain.'

[34] Dr Edeling also testified that the expected consequence of the second stroke was that the hemiparesis and the lack of vision would become worse but her level of consciousness would be impaired. He claimed, therefore, that the scan did not depict the full extent of the brain damage and that the post-mortem findings confirmed this view.

[35] The visual impairment meant the deceased was only able to see '50 percent of her visual field'. Mr Ormond-Brown considered the impairment significant as the left side did not exist for the deceased.

[36] Professor Vorster testified that the MMSE is of value in the cognitive assessment of patients. She confirmed that psychiatrists generally use the MMSE to test for cognitive impairment, and is a standardised part ('gold standard') of their evaluation. She said that a score of 20 out of 30 indicated a very poor result and was suggestive that the deceased had suffered a multi-infarction syndrome in the nature of dementia, given her history of hypertension, diabetes and cholerostomia. She said the following about the scores achieved by the deceased, views shared by Doctors Edeling and Ormond-Brown:

'Ja 20 out of 30 is an abnormal score it is low and would be indicative of some kind of pathology and what one would need to look at is where she did poorly. . . . . Her major losses are on orientation where she scored 1 out of 5 and on calculation where she scored 1 out of 5, those are indicative of pathology. In terms of the date the importance of asking people the date is in fact to see how well their memories are functioning because it is your memory that tracks the date and in terms of attention and calculation where one sees you have to subtract you know 7 from 100 that little test. So she was able to correctly subtract the first one but from there on made an error and then did not proceed by the looks of the scoring here shows that she had very poor concentration. So from here it looks as though her memory and concentration is poor and if one then looks at her draw a clock . . .there one can see evidence of abnormality quite easily see the evidence of the abnormality in that she is unable to plan where the numbers should be in appropriate places on the clock, a clock being something one sees very commonly….

Your frontal lobe is the most important part of your brain for thinking people, your frontal lobe is what allows you to plan and if one looks alone without doing anything else at her drawing a clock you can see the evidence of the lack of planning…*because you are able to plan, you draw the circle you know you must put the numbers so that they are equally spaced and you know thereafter you put the hands of the time that on its own shows a lack of planning so it is quite likely she had frontal lobe damage….'* (own emphasis.).

[37] Dr Edeling said the following about the impairment, concluding that the result of the 'mini mental status examination 20 over 30 . . . is diagnostic of dementia':

'…Now this "left sided unilateral spatial neglect" is a very serious problem and you would not expect that even just from where the stroke was. Because neglect means your brain is not aware of the fact that there are things on the left side of you and in her case even her paralysed left arm she did not realise that she had a left arm, she did not realise that her arm

was paralysed. … That is a severe impairment of cerebral cortical processing at a basic level, it is far more basic than the mental function of understanding and insight and complex decision making, I do not even know that there is a left side to the world.'

[38] Mr Ormond-Brown's conclusion based on the MMSE results is that the deceased who had suffered two strokes 'was dementing because she had had a series of tiny little strokes that had compromised her brain function, that is the multi infarction dementia component of the diagnosis'. The MMSE score of 20/30 bolstered his 'suspicion that the deceased may have been suffering from multi-infarction dementia and not simply the sequelae of two cerebrovascular accidents, that the deceased had major cognitive dysfunction . . .' 'that is clearly defined, which is indisputably a major impairment of mental functioning'.

[39] Mr Ormond-Brown concluded that the deceased suffered from multi-infarction dementia. It was later conceded by Dr Rowji that a score of 20 out of 30 on the MMSE indicated vascular dementia. According to Mr Ormond-Brown, the neuropsychological evidence in the Milpark and Netcare hospital records conclusively established that the deceased's executive functioning and reasoning, which are based in the left hemisphere frontal lobes, were cognitively impaired as a result of the two strokes the deceased suffered. Mr Ormond-Brown said that the fragmented nature of the clock diagram was suggestive of impaired mental functioning and cerebral vascular pathology.

[40] In regard to the post-mortem findings referred to above, Mr Ormond-Brown said that blood supply to a major section of the brain had been compromised. Dr Edeling said that the findings confirmed his diagnosis of 'a progressive decline' which indicated that the blood supply to the whole brain had been compromised.

[41] Dr Edeling concluded that it was improbable that the deceased would have had testamentary capacity on 28 November 2006. Mr Ormond – Brown shared this view and said it was not possible that the deceased would have been capable of processing the information in the disputed will as it would not have been possible for

her to make sense of what she was reading given the combination of hemianopia, her unilateral left spatial neglect and dementia. Professor Vorster and Mrs Viljoen shared this view.

Dr Rowji's opposing view

[42] Prior to the stroke, Dr Rowji had never met the deceased. His impression of her, however, was that she was a difficult person who exercised her will at all times. He was not convinced that the deceased had been confused. He rather believed that she was just difficult, wanting things done her way. Dr Rowji said the following about dementia:

'Dementia implies that the person has cognitive impairment and the cognitive impairment we are looking for is a variety of neurological deficits of higher executive function. The way we would associate is to use as a basic screen the mini-mental state examination and based on the score that we would get and the impression we get from the examination we would then go into specific areas of the brain function to guide us with attention, registration, short-term memory, geographical orientation, language insufficiencies which would guide us towards a specific clinical diagnosis and the mini-mental state would obviously help us do that. Dementia implies that the person has significant cognitive impairment. We categorise impairment into mild, moderate and severe. *We consider anybody with mild cognitive impairment as somebody who might go on to develop a dementing disorder*. A person with moderate to severe dementia or moderate impairment would then be regarded as a demented person.' (own emphasis)

[43] Dr Rowji who attended to the deceased from 15 June until the end of the period relevant to this judgment, did not think that the first stroke had introduced dementia in the deceased. Instead he described the first stroke as a subcortical stroke or an infarct, occurring in the sub cortex – the area of the brain housing the fibres or 'Telkom wires' as he described it that take information to the part of the spinal cord that ultimately supplies that segment of the body. According to Dr Rowji, this is not something that affects the cortical area where the real reasoning and functions exist. He said that the brain was divided into different sections and that damage to one section does not necessarily impair other brain functioning.

[44] Dr Rowji disagreed with Dr Edeling's conclusions and questioned whether Dr Edeling was qualified to make the assessment, claiming that at most the deceased suffered from delirium, a temporary phase common in hospitalised elderly persons. He said the condition would improve within 48 hours of return to normal routine. Dr Rowji also criticised Dr Edeling's suggestion that the deceased had suffered from vascular dementia, a slow progressive diminished cognitive faculty which worsens with each subsequent event. Dr Rowji relied on the fact that the deceased had improved, which he said indicated the absence of dementia.

[45] Dr Rowji also considered that the deceased was 'a larger than life person, in more than one way…[who] exercised her will over everybody, including myself…was just upset with everybody…at that stage the first hospitalisation I could not wait to get her out of the hospital….' During her stay in hospital he only had contact with the deceased's husband and therefore formed this strong opinion on the deceased's pre-stroke personality based on information received from her husband. On that basis, Dr Rowji did not clinically interrogate the reason the deceased was still prone to wetting her bed a week after her first stroke on 22 June 2006. Dr Rowji said the following about the second stroke:

'Again this is a haemorrhage which occurred in the thalamus which is a group of nuclei that are very important in relaying information. So this is a relay station for information in the brain and it was a small haemorrhage . . .[a]n important consequence of this kind of a haemorrhage is that they recover very quickly, which we saw in this patient and most importantly when you get a haemorrhage into these areas you do not get cells dying in her. . .we saw that in Mrs Kruger's case is that physically and cognitively in terms of what happened initially was after each stroke we expect that there would be a little bit of confusion, because there is new changes in the brain. The recovery is very quickly and the reason for that haemorrhages are not as incapacitating as infarcts, especially if the haemorrhage is small.'

The findings of the court below

[46] The court below per Mokgoatlheng J dismissed the appellant's action with costs, and found amongst others, that the deceased was not mentally competent

when she executed the disputed will, and that this was as a result of the two strokes that she had suffered. The court below concluded:

'(283) . . . In my view, the Milpark and Netcare Hospital records from 15 June to 23 November 2006 respectively, the two vascular accidents suffered by the deceased on 15 June 2006 and 19 October 2006 respectively, progressively show as conceded by Dr Rowji that the deceased's neuro cognitive impairment progressively worsened, that his acute confusional state and clouding of consciousness degenerated into a delirium and ultimately vascular dementia, a state which authoritative medical literature irrefutably concur is sufficient cogent proof that on 28 November 2006 the deceased could not by any stretch of the imagination be said to have possessed testamentary capacity to execute a valid will.

(284) . . . It is indisputable that the deceased's second stroke on 19 October 2006 exacerbated the deceased's cognitive impairment, consequently, up to her discharge on 23 November 2006 the deceased's cognitive impairment status remained unchanged.

(285) On the probabilities it is neuropsychologically improbable if not impossible that the deceased's cognitive condition could suddenly within a period of six days after MMSE test score of 20 out of 30 on 22 November 2006 which established that the deceased had dementia, could change to the extent that on 28 November 2006 her cognitive impairment and mental deficits were reversed, despite being severely afflicted with dementia an irreversible permanent progressive disease.

(286) On the probabilities it is neuropsychologically not possible having regard to the deceased's age of 78, obesity, diabetes, hypertension and cholestoromia, and two vascular strokes, dementia, that the deceased could cognitively fully recover to such an extent that on 28 November 2006, it can be said that the deceased had full testamentary capacity to execute a will.'

[47] In addition to the above, the court said 'the plaintiff's false and improbable denial that she did not discuss the content of the alleged disputed will of the deceased is a contrivance to distance herself from the obvious probability that she must have influenced the deceased in her enfeebled cognitively impaired state to devolve her estate in the alleged original of Annexure X1 [the disputed will] by making her a beneficiary of the Westdene property, and to disinherit the fifth defendant as a beneficiary of the Westdene property against her better judgment because the deceased on 23 September 2006 and on 28 November 2016 was of unsound mind and memory and lacked testamentary capacity.'

Conclusion

[48] An expert is there to assist the court, not to be partisan towards the party who calls them. A court of appeal can test the expert's reasoning and is therefore in the same position as the trial court to determine an expert's credibility.[2] When faced with conflicting expert opinions, it is for the court to determine which, if any, of the opinions to accept based on the reasoning and reliability of the various expert witnesses. 'Objectivity is the central prerequisite for his or her opinions.'[3]

[49] In our view, the signs were there, as Ms Russell and Dr Edeling and Mr Ormond-Brown concluded, that the deceased was mentally dysfunctional after the two strokes. The contemporaneous medical notes and the post-mortem findings, from which it is apparent that the blood supply to the whole brain had been compromised, bears that out. It follows that Dr Rowji's evidence that the brain was only partially affected was wrong. The deceased's fluctuating confused state further appears from the evidence of Ms Ncube, the caregiver, who took care of the deceased from 27 November 2006 until her death on 24 December 2006. She testified that the deceased had told her 'sy dink nie dat haar kinders sal enige iets erf uit haar bates nie', at a time when the disputed will had already been signed. Moreover, on 7 December 2007, the deceased told Dr Rowji that she had disinherited her children, when she had not.

[50] Dr Rowji formed an opinion about the deceased's personality prior to her first stroke without having met her before. He therefore failed to do the most basic psychological inquiry into the deceased's confused state and did not interrogate her continued incontinence; he showed lack of insight into her condition. When confronted with the MMSE scores and the numerous indications in the medical

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[2] *Stock v Stock* 1981(3) 1280 (A) at 1296E–G.

[3] *Jacobs & another v Transnet Ltd t/a Metrorail & another* [2014] ZASCA 113*;* 2015 (1) (SCA) 139 paras 14–15; R*oman's Transport CC v Zihlwele* (13/2014) [2015] ZASCA 13 (16 March 2015) '[9]…An expert's opinion represents his reasoned conclusion based on certain facts or data, which are common cause, or established by his own evidence…Before weight can be given to expert's opinion, the facts upon which the opinion is based must be proved.'

records indicating brain damage, he reluctantly conceded that the severe depression could have been linked to brain damage. It follows that his reasoning is of limited assistance. Conversely, Dr Edeling, Mr Ormond-Brown and Professor Vorster took the court logically through their reasoning based on the objective facts and confirmed by the post-mortem findings. In the light of Dr Edeling's well-reasoned opinion, supported by the medical records and post-mortem findings, and further confirmed by the other professionals, including Mr Ormond-Brown, Professor Vorster, Ms Viljoen and Ms Russell, there is no reason to find that the trial court erred in holding that the deceased was not of sound mind at the time of signing the disputed will.

[51] In argument before this court, counsel who appeared on behalf of the appellant submitted that the affidavit, which the deceased made to Claasen, contained personal detail such as the deceased's identity number, residence and an account of her dissatisfaction with her children, all of which indicated that she was alert and thus contradicted any opinion that her mental capacity was steadily declining. We disagree. The information referred to largely appears from the first respondent's complaint, which Claasen had in his possession. Claasen had found some of the 11 firearms in an unsecured safe. The deceased clearly lacked insight to appreciate the real risk to life and property the unsecured firearms posed. The court below, correctly, did not place any weight on Claasen's assessment of the deceased.

[52] It was submitted further that the progressive decline theory was at odds with the objective evidence that the deceased was able to attest to an affidavit on 18 October 2006. On the contrary, Claasen's observation that the deceased was emotional supports the diagnosis that she was in 'progressive decline'. Dr Rowji found her severely emotional on 15 September 2006 and conceded it could have been symptomatic of brain damage. He further conceded that the deceased had remained 'blunted for the duration of her stay in hospital' and severely depressed.

[53] Counsel on her behalf, was constrained to agree that the appellant's sudden rise to prominence in the life of the deceased in this time of crisis in her life appeared calculated and aimed at serving her own interest. Prior to the deceased's illness, the

appellant was not an integral part of the family. The appellant facilitated the meeting between the deceased and Van der Merwe, in which the deceased instructed Van der Merwe to draft the disputed will, a mere four days after the deceased had left Panorama against medical advice. As indicated above, the deceased had three natural children and one adopted child. The fifth respondent appeared to be bitter and was not an unbiased witness. When he married and bought a house, the deceased had helped him. He said the deceased had furnished the house telling him it was his inheritance because she feared that the other children would exclude him upon her death. It follows that at that stage she envisaged leaving her estate to her children. The premises upon which the appellant operated, the changes in the will occurred because the deceased was disenchanted with her children and that she repeatedly spoke out about disinheriting them, is not borne out by the evidence.

[54] On 23 September 2006, the day she left Panorama, the deceased gave the appellant a power of attorney over her estate. Prior to her illness, not even her husband had had signing powers in respect of her bank accounts. After her first stroke, the second respondent took the deceased to the bank to draw money to pay utility bills. The second respondent suggested that the deceased give authorisation in respect of her accounts to allow the second respondent to make the payments on her behalf. The deceased refused saying, 'Ek het nie eers vir jou pa teken reg gegee nie, wie dink jy is jy.'

[55] The deceased paid her own way while she was convalescing at the appellant's home notwithstanding the appellant's attempt to create the impression that she bore those costs. All of the above show the appellant's calculating nature. Despite the fifth respondent's asserted admirable conduct towards the deceased in her hour of need, she left him only a motor vehicle. The evidence of the appellant and the fifth respondent do not detract from the expert evidence. Similarly, no reliance could be placed on the evidence of Mr Van Rooyen, the deceased's brother.

[56] Clearly, the above irrational behaviour of the deceased, confirms the expert opinion that she was in a confused state after her first stroke that became

progressively worse after her further medical problems. The probabilities point to the deceased being confused when she attested to the disputed will, evidenced by her telling Dr Rowji that she had disinherited her children and Ms Ncube that she was not sure whether her children would inherit after she had apparently signed the disputed will.

[57] From the aforegoing, there is no reason to find that the court a quo incorrectly found that on 28 November 2006, the deceased had not been of sound mind and memory, suffered from a lack of insight and was unable to execute a valid will. The order of the court below appears to be based on the erroneous assumption that the respondents had counter claimed for the order in the terms that it had granted, an error that must be corrected. On the facts it found to be proved, it should merely have dismissed the appellants' action.

[58] The following order is made:

1 The appeal is dismissed with costs, such costs to include the costs of two counsel.

2 The order of the Court below is altered to read:

‘The claim is dismissed with costs, such costs to include the cost of two counsel and the qualifying fees of the following expert witnesses:

Dr Edeling, Mr Ormond-Brown and Professor Vorster.

_____
H Saldulker
Judge of Appeal

_____
E D Baartman
Acting Judge of Appeal

Appearances

For Appellant:	G C Pretorius SC Instructed by: Nerina Wessels Attorneys, Randburg Phatshoane Henney, Bloemfontein
For Respondent:	G J Strydom SC (4th – 10th) H Kriel Instructed by: Van der Merwe, Cronje & Kaplan, Krugersdrop Schoeman Maree Inc, Bloemfontein