**FAMILY COURT OF AUSTRALIA**

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| **Oliver (deceased) & oliver** | **[****2014] FamCA 57** |

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| FAMILY LAW – MARRIAGE – NULLITY – Application for declaration under section 113 of the *Family Law Act 1975* (Cth) – Whether the husband was mentally incapacitated at the time of the marriage ceremony in respect of section 23B(1)(d)(iii) of the *Marriage Act 1961* (Cth) – Whether the onus of proof shifts to a respondent to disprove mental incapacity at the time of the marriage ceremony if the evidence establishes a general mental incapacity |

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| Family Law Act 1975 (Cth) s 113Marriage Act 1961 (Cth) s 23B(1)(d)(iii) |

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| *Babich & Sokur and Anor* [2007] FamCA 236*Turner v Meyers, falsely called Turner* (1808) 1 Hag Con 414 |

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| **APPLICANT:** | Mr Oliver (Deceased) |

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| **RESPONDENT:** | Ms Oliver |

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| **FILE NUMBER:** | PAC | 5589 |  | of | 2012 |

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| **DATE DELIVERED:** | 12 February 2014 |

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| **PLACE DELIVERED:** | Parramatta |

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| **PLACE HEARD:** | Parramatta |

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| **JUDGMENT OF:** | Foster J |

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| **HEARING DATE:** | 2, 3, 4 and 5 December 2013 |

REPRESENTATION

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| **COUNSEL FOR THE APPLICANT:** | Mr Katsinas |

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| **SOLICITOR FOR THE APPLICANT:** | Alan Rigas Solicitors |

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| **COUNSEL FOR THE RESPONDENT:** | Mr Weaver |

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| **SOLICiTOR FOR THE RESPONDENT:** | Bell Lawyers |

# Orders

1. That the marriage of Mr Oliver and Ms Oliver solemnised on … April 2011 be declared as void in accordance with section 23B(1)(d)(iii) of the *Marriage Act 1961* (Cth).

**IT IS NOTED** that publication of this judgment by this Court under the pseudonym *Oliver (Deceased) & Oliver* has been approved by the Chief Justice pursuant to s 121(9)(g) of the *Family Law Act 1975* (Cth).

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| Family Court of Australia at Parramatta |

FILE NUMBER: PAC 5589 of 2012

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| Mr Oliver (Deceased)  |

Applicant

And

|  |
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| **Ms Oliver**  |

Respondent

REASONS FOR JUDGMENT

# The proceedings

1. These are proceedings seeking a declaration under section 113 of the *Family Law Act 1975* (Cth) (“the Family Law Act”) as to the validity of the marriage between the late Mr Oliver (“the deceased”) and the Respondent in these proceedings, his wife Ms Oliver (“the Respondent”).
2. The marriage was celebrated in late April 2011 at which time the deceased was aged 78 and the Respondent was aged 49.
3. The deceased died in September 2013.
4. The Applicant in the present proceedings is Ms J, the granddaughter of the deceased.
5. It is contended by her that the subject marriage is invalid as the consent of the deceased to the marriage was not a real consent because at the time of the marriage he was mentally incapable of understanding the nature and effect of the marriage ceremony as provided for in section 23B(1)(d)(iii) of the *Marriage Act 1961* (Cth).
6. It is common ground between the parties that the relief sought by the Applicant is for a declaration pursuant to section 113 of the Family Law Act and that the Applicant has standing to make the present application.

### Background

1. At the commencement of these proceedings the deceased was resident in a retirement village and required full-time care as a result of his immobility, general health and diminished cognitive capacity.
2. At that time the financial affairs of the deceased were under the care of the New South Wales Trustee and Guardian following a hearing in the Guardianship Tribunal (NSW) on 23 August 2011. Prior to the determination of the Guardianship Tribunal the Applicant’s father, Mr H, had been the deceased’s Power of Attorney since 28 April 2005.
3. The deceased, from at least 2001, had issues in relation to his mental capacity, in addition to other medical conditions arising from his long-standing abuse of alcohol.
4. The deceased had been under the care of a specialist geriatrician, Dr C, from early 2001.
5. On 24 April 2001 the deceased was admitted to Town D Hospital. He was diagnosed with a wide spectrum of issues including pneumonia, gait and balance disorder, cognitive impairment, postural hypotension, urinary incontinence and alcohol excess.
6. The hospital records note in relation to cognitive impairment:

… has a lot of problems with short-term memory. Probably mixed mild Alzheimer’s and alcohol related. Complicated by delirium with paranoid delusions especially at night – much improved on olanzapine, but still confused at times.

1. The deceased remained in hospital until 17 May 2001 and was discharged with a further consultation with Dr C planned for about two or three months after discharge.
2. On 19 April 2004 the Guardianship Tribunal (NSW) delivered reasons for its decision in relation to the deceased’s wife, Ms E. On 8 April 2003 the Tribunal appointed Ms H as her mother’s Guardian for a period of 12 months with the functions of determining her accommodation, health care, medical and dental consents, and services. The hearing was for the purposes of reviewing that appointment.
3. The Tribunal had been provided with a medical report from Ms E’s general practitioner, Dr G, dated 31 March 2004. That report noted:

[Ms E’s] capacity to make rational decisions regards her own care remain as impaired as ever with the recent indefinite hospitalisation of her husband due to alcohol induced dementia and psychosis making no difference to her drinking patterns.

1. The Tribunal was satisfied as to the continuing appointment of Ms H as the Guardian of Ms E. It is to be noted that the deceased was not considered as suitable to manage his wife’s affairs.

# The Applicant’s Case

### The Applicant

1. The Applicant visited her grandfather quite often after the birth of her daughter in April 2010. She recalls seeing her grandfather at her grandmother’s funeral in August 2010.
2. Her husband, Mr J, was present at the funeral and he observed that the deceased was confused, not aware of his surroundings or what was going on.
3. She visited her grandfather subsequently in hospital, at which time her grandfather did not initially recognise her but did so after she introduced herself. To her observation her grandfather, notwithstanding being at his wife’s funeral, was not aware that she had passed away and otherwise he did not appear to be aware of his surroundings.
4. Thereafter and prior to Christmas 2010 the Applicant visited her grandfather sometimes weekly. On visits to his home in September 2010 he confessed to her that he was drinking rum and Bonox for breakfast. He often on these visits talked of his late wife as though she was still alive or of having undertaken certain activities that were simply impossible to have occurred.
5. Just before Christmas 2010 she was informed by her grandfather that he had told the Respondent who had commenced to live in the deceased’s home, to leave his home and not to return. The Applicant asked her grandfather whether the Respondent had been back and he said that he did not want her back in the home.
6. On a Christmas visit in 2010 to the deceased’s home, the Applicant’s husband observed that the deceased was “in and out”, as he had been for some time. The deceased talked of going drinking with his brother, who was deceased at that time.
7. The Applicant was aware that the Respondent was the daughter of a family friend of her grandparents and was paid for her cleaning services.
8. By January 2011 the Applicant observed that her grandfather was regularly forgetting things shortly after discussing them with him and, on occasions, would not recognise the Applicant as his granddaughter.
9. In the period from February to April 2011 the Applicant attempted to contact her grandfather on the telephone. The phone was answered by the Respondent, and the Applicant was rarely able to talk to her grandfather. However, in late February or early March 2011 the Applicant was able to speak to her grandfather, who informed her of his proposal to get married to the Respondent. The conversation was as follows:

[Applicant]: Pop how are you, I’ve been trying to get in touch with you, I have left you a lot of messages with [the Respondent].

[The deceased]: Oh hi [the Applicant’s name], I’m good, I’m getting married.

[Applicant]: How are you getting married, I didn’t even realise you had a girlfriend.

[The deceased]: Neither did I.

The Applicant then spoke to the Respondent who said: “Hi [the Applicant’s name], were (sic) getting married, the wedding will be in June 2011 and you are all invited.”

1. The Applicant was completely shocked by the news of her grandfather’s impending marriage.
2. On 23 March 2011 the Applicant’s mother was hospitalised and, for the two month period that her mother was in hospital, the Applicant was unable to visit her grandfather. On the occasions she attempted to telephone her grandfather she was informed by the Respondent that her grandfather was unable to talk as he was in the shower or sleeping.
3. In May 2011, the Applicant became aware that the husband had indeed married the Respondent not in June 2011, but in April 2011. The Applicant and her family were not informed as to the wedding ceremony or invited.
4. In early August 2011 the deceased, who had been in hospital following a fall, was admitted to the I Nursing Home as a full-time resident. It is clear that at the time of his admission he was suffering from significant cognitive impairment, dementia and a raft of other health issues.
5. Subsequent to her grandfather being admitted to the nursing home the Applicant visited him each month or so and in the intervening periods made regular telephone contact with him. To her observation her grandfather appeared very confused and on occasions it was some minutes before he was able to recall who the Applicant was.
6. During the Applicant’s visits to the nursing home from August 2011 until shortly before the death of her grandfather, she did not see the Respondent on any occasion.

### Mr H

1. On 5 May 2005 the deceased appointed his former son-in-law, Mr H, as his Power of Attorney. Mr H did not exercise that power until July 2011.
2. In August 2010 the deceased’s wife, Ms E, died whilst in a nursing home. At the funeral Mr H met for the first time the Respondent, who is the daughter of long-time family friends of the deceased and his late wife.
3. He was aware that the Respondent would visit the deceased and his late wife on some weekends to help with household chores or do some gardening in return for payment.
4. Mr H visited the deceased on a weekly basis following the death of his late wife, assisting the deceased with his financial affairs, paying bills, attending to cheque payments and arranging for the deceased’s taxation affairs in circumstances where the deceased clearly was incapable of doing so. Otherwise, he was aware that, subsequent to the death of his late wife, the deceased received in the home care support from Care Organisation K.
5. In mid-November 2010 Mr H spoke to the deceased, who said to him “I’ve had an argument with [the Respondent], and I have asked her not to return to the house anymore as she was asking too many invasive questions about my money, and where I kept my money.”
6. On visiting the deceased on Christmas Eve 2010, in company with his daughter and son, Mr H observed that the deceased was vague in his demeanour and struggled to recall that his late wife had passed away. The deceased spoke often of his late wife in the present tense.
7. During his visits in January 2011 Mr H observed that the Respondent had returned to the property and was attending to some gardening at the back of the house and on occasions on weekends doing odd jobs, and had cancelled the deceased’s in-home care package. He observed the deceased’s health to be much the same.
8. In mid-January 2011, on a visit to the deceased at his home, Mr H had a conversation with the deceased, as follows:

[Mr H]: How are things [the deceased’s name]?

[The deceased]: Things are ok. [The Respondent] and I are going to go on a holiday; we are looking at selling some property to be able to go on the holiday.

[Mr H]: Selling the property is probably not the best idea, its (sic) best to hang onto your assets, why don’t you look at financing your holiday?

[The deceased]: Don’t tell me what to do.

During this conversation Mr H became concerned for the deceased. He was struggling to walk with a walking frame and did not appear to have rationally thought out plans for the proposed holiday.

1. In late January 2011 on a visit to the deceased’s home, the deceased said to Mr H: “You should not have so much power over me [Mr H’s name].” At this time Mr H had not exercised any of his powers under the Power of Attorney granted to him by the deceased.
2. In early February 2011 Mr H visited the deceased at his home. Initially the deceased was confrontational and accused Mr H in the following words “Do you want it all? You want all my money; you want to control my life”. Subsequently, Mr H spent time with the deceased, who became more relaxed and more accepting of Mr H.
3. In mid-February 2011 Mr H again visited the deceased at his home. On this occasion the deceased said to him: “[Mr H’s name] I am getting married to [the Respondent]. [The Respondent] is going to look after me and the bills.”
4. Mr H was unsure as to what was going on but did not think he had the ability to intervene. He was spun out and confused and contacted some agencies the same day as to previous health assessments of the deceased but was not sure as to whether his enquiries were of the right people. Mr H tried but was unable to speak to the deceased’s GP.
5. To Mr H’s observation the deceased had lost his late wife and did not feel complete. Mr H did not confront the deceased as to the proposed marriage, as he was told the Respondent was moving in to take care of him.
6. Mr H communicated this information to his son, Mr P H.
7. He continued to visit the deceased each two weeks.
8. On a visit in March 2011 the deceased did not recognise him. The deceased had good days and bad days.
9. He received no notification of the marriage until after it had taken place. He was waiting for some official invitation as to the intended marriage.
10. Mr H’s next contact with the deceased was on 6 June 2011 when he visited the deceased at Town D Hospital after the deceased’s admission following a fall. He was shocked to see the deceased’s health at that time. To his observation the deceased’s mental health had deteriorated, he was having difficulty remembering that his late wife had passed away and was cloudy in his memory. The deceased appeared confused as to events.
11. It was at this time that Mr H became aware that the deceased had married the Respondent in April 2011.
12. Subsequently there was contact between Mr H and the Respondent in relation to the provision of money from the deceased’s accounts to pay bills. Mr H at this time became aware that the Respondent was making regular drawings at Town D Club on the deceased’s account.
13. Since July 2011 until shortly before the deceased death, Mr H continued to visit the deceased at the I Nursing Home. On those occasions Mr H did not see the Respondent, nor indeed did the deceased make any reference to her.

### Mr P H

1. Mr P H is the deceased’s step-grandson. He has known the deceased all his life as his grandfather.
2. Mr P H observed that shortly prior to the death of Ms E, the deceased at times was struggling with his short-term memory and was often cloudy as to the time of day.
3. Mr P H visited the deceased on occasions between August and December 2010, subsequent to the death of Ms E. He visited him at various intervals. He became concerned as to his mental state with the deceased referring to his late wife as if she was still alive. He further observed that the deceased was having difficulty recalling simple details. He observed that during this period the deceased had assistance from carers.
4. Mr P H visited the deceased in early January 2011 and says that in his visit to the deceased on that day, and prior thereto, the deceased made no reference to the Respondent.
5. In mid-February 2011 he spoke to the deceased by telephone and the following conversation took place:

[Mr P H]: “Hi Pop, How are you? What’s going on?”

[The deceased]: “Oh Hi [Mr P H’s name], Not much I’m alright.”

[Mr P H]: “Hey Pop I was just talking to Dad and he said that you were getting married, what’s going on?”

[The deceased]: “I’ll do what I like.”

[Mr P H]: “Why are you doing this Pop you know Nan only just passed away.”

[The deceased]: “No one ever visits me why should I care.”

 …

1. The deceased was aggressive in his tone.
2. He was aware that the wedding was proposed for May 2011. He thought it was a joke. He wanted to visit his grandfather believing he was being taken advantage of because of his state of mind.
3. In mid-May 2011 Mr P H visited the deceased at Town D Hospital. He observed that his grandfather looked terrible. The following conversation took place:

[Mr P H]: “Pop why did you marry [the Respondent]?” She used to call you uncle [the deceased’s given name]?

[The deceased]: “I don’t know, why didn’t anyone tell me? Why didn’t anyone stop me?”

1. Subsequent to the deceased being admitted to I Nursing Home, Mr P H regularly visited the deceased and on none of those occasions did he see the Respondent.

### Ms H

1. Ms H is the daughter of the deceased.
2. She observed that the deceased was a chronic alcoholic and over many years observed the deceased to drink excessively, sometimes to the point where he became incontinent.
3. She acknowledges a strained relationship with her parents over the years due to their alcoholism, but has had regular contact with her father since the death of her mother in August 2010.
4. In 2004 she engaged the services of Care Organisation K for her parents. At this time, to her observation, her parents needed high-level care as they were unable to care for themselves. She had observed that on her visits to the home the house was a very untidy, both of her parents were incontinent and did not wear sanitary care for the condition. She observed that the refrigerator at her parents’ home would be empty for weeks on end or would have mouldy or decaying food in it. She observed that her parents would often forget to shop and would drink alcohol for days without any sustenance.
5. In 2004 her mother was admitted to Town D Hospital suffering from malnutrition and alcoholism. It was subsequent to this hospital admission that Ms H organised Care Organisation K to assist her parents in their home. There was conflict between Ms H and her mother in relation to her mother’s alcoholism and little contact between Ms H and her parents between 2005 and 2010.
6. On Father’s Day in early September 2010 Ms H visited her father at his home for about four hours. She was shocked at the deterioration in her father’s mental state and observed his continuing consumption of alcohol.
7. In February 2011, following a conversation with her daughter, the Applicant, Ms H became aware of her father’s proposed marriage to the Respondent in June 2011. Subsequently that month she attempted to contact her father by telephone. Calls were answered by the Respondent, who informed her that the deceased was unable to come to the phone.
8. She later became aware that her father had married the Respondent in April 2011, and that the Respondent had cancelled the home care arrangement that she had put in place for her father.
9. In May 2011 Ms H visited her father in hospital. She observed that her father’s mental state was in serious decline. He referred to the woman in the adjoining bed as his wife and, on Ms H ending her visit, the deceased asked: “Can you bring in your mother to see me?”
10. At no time during the visit did the deceased make any reference to the Respondent. On subsequent visits to see her father in hospital, Ms H continued to observe his mental decline. He would often stare off into the distance, have conversations of no relevance or conversations out of context.
11. Subsequent to the deceased being admitted to I Nursing Home she visited her father on a monthly basis and on other special occasions with family, such as Easter, Father’s Day, birthdays and Christmas. On no occasion was the Respondent present.

# The Marriage and its circumstances

1. On 17 February 2011 the deceased, in company with the Respondent, attended upon the deceased’s general practitioner, Dr G, at the Town D General Practice. On that date Dr G provided a certificate in the following terms:

This is to certify that [the deceased] is, in my opinion, of sound mind and capable of making rational decisions about his affairs.

1. Subsequently, on 28 February 2011 the deceased, in company with the Respondent, attended upon his solicitor and signed a new will that, in summary, provided:
	1. the will was made in contemplation of his marriage to the Respondent, but was not conditional on the marriage taking place;
	2. that the deceased’s solicitor was appointed sole executor and trustee of the will; and
	3. that the whole of the deceased’s estate was to pass to the Respondent should she survive him.
2. In April 2011 the Respondent, then aged 49, married the deceased, then aged 78, at his home at Suburb L, New South Wales.
3. The Respondent and the deceased had earlier attended upon Ms M, a marriage celebrant, of Town D on 22 February 2011 and completed the necessary preliminary legal paperwork in relation to the proposed marriage. That paperwork consisted of a Notice of Intended Marriage, Statutory Declaration and the wording selected for the ceremony.
4. A further appointment was made with that celebrant to complete documentation but the intervening ill health of the celebrant prevented that appointment going ahead.
5. The Respondent acknowledged that Ms M could be located. Ms M was not called to give evidence in the Respondent’s case.
6. The Respondent’s affidavit evidence as to the marriage and the circumstances leading up to the marriage is scant in the extreme. Save for the assertion as to marriage in April 2011, she says “(d)uring the wedding ceremony the marriage celebrant’s husband was taking photographs. I was provided with the photographs taken.”
7. The civil ceremony was undertaken without notice to the Applicant or any of the deceased’s family. None of the neighbours and friends of the deceased were notified of or invited to the ceremony. The ceremony was only attended by the Respondent’s sister, the Respondent’s parents, the celebrant and a photographer.
8. The Respondent’s sister, Ms O, was in attendance at the wedding ceremony. She says that in or about 2010 the Respondent informed her that the deceased had asked her to marry him. She says that the Respondent remarked “[Ms E] hasn’t been dead for very long and its (sic) probably the company he wants rather than to be married.” Subsequently, the Respondent informed Ms O that the deceased had asked her to marry him again and that “we are going to speak to a celebrant”.
9. Ms O’s observations on the day of the wedding are that the Respondent and the deceased were observed by her “to be happy and comfortable during the ceremony”. She gives no evidence as to her conversations on the day of the ceremony with the deceased either prior to the ceremony or thereafter. Surprisingly, she had not visited the deceased after he was placed into the I Nursing Home, asserting that her work commitments and her need to care for her children and grandchildren were in priority to her.
10. The Respondent’s father, Mr N, also was in attendance at the ceremony. He acknowledges a long-term friendship with the deceased and his late wife, yet professes no knowledge of any of the deceased’s health issues until after the deceased’s hospitalisation in May 2011.
11. His daughter, the Respondent, he says cared for the deceased and his late wife on weekends as the usual carers could not care for them on the weekends. He observes that following the death of his late wife the deceased became very lonely. Sometime after the deceased’s wife died he had a conversation with the deceased where the deceased asked: “Is it alright if I ask [the Respondent] to marry me?” and he replied: “(t) hat is entirely up to [the Respondent].”
12. It appears he held no concerns as to the deceased’s health circumstances, the age disparity between the deceased and his daughter and the deceased’s emotional circumstances after the death of his late wife.
13. Mr N says that not long after this conversation his daughter moved in to the deceased’s home. It is to be inferred that this was in late 2010.
14. On the day of the ceremony, Mr N says that the deceased said to him “I’m glad you all came”. Mr N observed that the deceased appeared to be happy and was laughing on the day. His evidence in relation to the ceremony, itself, is very limited, observing that he saw the Respondent and the deceased holding hands, kiss each other, say “I do” and exchange wedding rings.

### The Wedding Celebrant

1. By reason of the unavailability of the first celebrant, Ms M, the Respondent arranged for a second celebrant, Ms Q, to undertake the ceremony, but in April 2011 and not in June 2011 as the deceased’s family were informed.
2. Ms Q met with the Respondent and the deceased about a week prior to the wedding date and asserts that she asked questions of both parties. No evidence is given as to the precise conversations between her and each of the proposed participants in the wedding. She says that the deceased responded to her questions clearly. The celebrant did not ask the deceased anything about the duties and responsibilities of marriage. She simply observed that he appeared pleased to be getting married and appeared devoted to the Respondent.
3. Ms Q expressed concerns regarding the age difference of the parties, the fact that the Respondent had been his housekeeper and had a history of several marriages. She, in the absence of the Respondent, spoke to the deceased, who she says was excited and looking forward to marrying the Respondent. No precise evidence of this conversation is given.
4. It was to the surprise of Ms Q that none of the deceased’s relatives were in attendance at the wedding, which was only attended by the Respondent, her parents and her sister.
5. Ms Q, on the day of the ceremony, said to the deceased, “Are you pleased to be marrying [the Respondent]?”, and he replied, “Absolutely. I can’t wait.”
6. She observed that the deceased at the ceremony was struggling to walk and needed to be assisted from the conservatory in his home to the lounge room for the wedding. During the ceremony she says the deceased and the Respondent exchanged vows clearly and without help, although she gives no evidence as to how the ceremony progressed, that is, with the participants without assistance proffering their vows or simply repeating words spoken by the celebrant.
7. Ms Q remarks that it was odd that the Respondent did not want to make a fuss of the day, having forgotten even to arrange a bouquet of flowers for herself.

# The Respondent’s oral evidence

1. The Respondent had been a paid carer for the deceased and his late wife from 2006. Her parents had been their longstanding friends. After the death of the deceased’s late wife, the Respondent would attend at his home for one day each weekend.
2. She was otherwise employed as a cleaner, ceasing that work when she moved in to the deceased’s home.
3. The Respondent, despite being aware that the deceased had been diagnosed with dementia, at first denied any knowledge of the deceased having mental health issues or any diminished cognitive capacity.
4. Later, in her oral evidence, she acknowledges that he “came out with funny stuff” and that she had seen “signs” from time to time.
5. She did not wish to volunteer as to what “signs” she was referring to. It was suggested to her that the deceased exhibited signs of cognitive impairment in the years 2006 through to 2010. She acknowledged that this was possible, but that she was not aware of it.
6. The deceased, to her observation, had rum for breakfast when she had been there assisting on weekends, but she had no knowledge as to his alcohol intake during the week before she moved into his home.
7. The deceased, she said, asked her to marry him only three weeks after the death of his late wife. She said that that concerned her at first. She asked him why and he replied that he was lonely. She said to the deceased that that was not a good enough reason.
8. The Respondent conceded in oral evidence that she observed the deceased to be getting forgetful, that he still spoke of his late wife every day as if she was still alive and in the next room, asking the Respondent to make his late wife a cup of coffee.
9. The Respondent moved in to the deceased’s home on 18 February 2011, the day after she had escorted the deceased to see Dr G.
10. No evidence is given as to the nature of the cohabitation.
11. The Respondent had the previous day taken the deceased to see his solicitor, Mr R, and sat in during their discussions. She asserts that the deceased was clear to Mr R in his speech and his judgement. Notwithstanding that assertion, she acknowledged that the solicitor requested the deceased to obtain a doctor’s certificate and that she did not know why such a request was made.
12. She conceded that if there were some concerns as to the deceased’s state of mind that may have been why the certificate was requested in order to satisfy Mr R that the deceased knew what he was doing. She says that towards the end of the conference between the deceased and Mr R she was asked to leave the room and does not know what transpired between Mr R and the deceased in her absence.
13. The Respondent was aware that Mr R’s firm had been the deceased’s family solicitors for years, that Mr R was in about his 50s and still in practice at Town D.
14. It is significant that the Respondent failed to call Mr R to give evidence.
15. After leaving the solicitor’s office the Respondent then walked the deceased to Dr G’s surgery. She acknowledges that she was in the room throughout the deceased’s consultation with Dr G. Prior to the attendance at Dr G’s surgery on 17 February 2011, the Respondent had never attended upon Dr G with the deceased, although she did thereafter.
16. Subsequently, the certificate from Dr G was provided to the solicitor’s office. The Respondent gave the certificate to an employee of that firm, who she assumed provided it to Mr R.
17. She subsequently drove the deceased to the solicitor’s office to facilitate the new will being signed. The deceased’s new will was not signed before the solicitor, but before two secretaries in his office, although the Respondent did not see the deceased sign the will.
18. Neither of the witnesses to the will were called by the Respondent in these proceedings.
19. The Respondent says that the deceased knew he had a 2005 will, but probably did not know what was in it. She was aware of the previous will made in 2005 that made no provision for her but that made provision for his family. She acknowledges that she was present with the deceased when he spoke to his solicitor about the terms of his new will.
20. The Respondent asserts that the deceased said to her:

If you go before me I’m going to change my Will and leave it to the Salvation Army.

1. Yet the Respondent told the social worker when the deceased was in hospital in October 2010 that he wanted to marry her so that his house would not “go to the Salvation Army”.
2. In cross examination, the Respondent acknowledged that she knew there was no possibility of the deceased’s home going to the Salvation Army, as feared by him, but she did not tell him so.
3. When asked in cross examination why the deceased changed his will to favour her at that time, the Respondent proffered “he wanted to cut people out of it”.
4. The Respondent acknowledged that the deceased would, at times, falsely refer to going fishing with his deceased brother Mr S, and late at night being confused, thinking he was still in hospital or standing at the front door of the home seeking to “go home”, with this occurring six or seven times between February 2011 and the wedding in April 2011.
5. The Respondent was “a little bit” concerned for the deceased.
6. A month before the wedding the deceased shorted the power out by inserting a knife into a power socket. When asked by the Respondent why he did it, the deceased replied “I don’t know”. On another occasion, prior to the marriage, the deceased set a small fire in his ashtray. The Respondent removed the deceased’s lighter. She hid sharp knives in a large drawer below the stove.
7. Further, in oral evidence, the Respondent conceded the deceased’s mental condition was slowly deteriorating from August 2010 and that she had informed the social worker at the hospital in May 2011 that the deceased had been showing signs of dementia for the preceding 12 months, that the deceased was at risk of wandering, that she had to lock the door of the home to prevent this and that the deceased was forgetful.
8. The Respondent asserts that it was her love for the deceased that prompted her to marry him. When asked whether it was like the love of a wife for a husband she said “in a way”.
9. She denied that she married the deceased to make a claim on his estate. She denied that she misled the deceased’s family about the date of the wedding and that she kept the family away from the wedding, asserting that they were simply not invited by the deceased.
10. The Respondent acknowledged having spoken to the Applicant in late February or early March 2011 about the proposed June 2011 wedding date. She acknowledged that subsequently she did not contact the Applicant to tell her the wedding was not to be at that time, nor to tell her that she was not invited to the earlier wedding, and could not explain why she did not.
11. She further acknowledged that, prior to the wedding, she had taken telephone calls from members of the deceased’s family and had told them that he was in the shower and unable to speak to them. When asked why the deceased did not return the calls, she asserted that he did not wish to speak to them.
12. During the period the Respondent resided in the deceased’s home prior to the wedding, she says that various neighbours would call it from time to time to see how he was. She was able to name nine or 10 people who perhaps would have observed the deceased in the early months of 2011, prior to the impugned marriage. None of these people were called to give evidence by the Respondent.
13. The Respondent acknowledged that subsequent to the death of the deceased she did not notify his family that he had passed away. She held a small memorial service at the deceased’s home and invited some of the neighbours.

# The deceased’s medical history

### August 2010

1. On 16 August 2010 the deceased was admitted to Town T Hospital following a fall. While the deceased was in hospital during this admission, in August 2010 his late wife Ms E died.

### October 2010

1. The deceased was again admitted to hospital on 2 October 2010 following an unwitnessed fall at his home and the activation of his Vital Call alert system.
2. The hospital notes reveal that the deceased was fearful at his admission to hospital and appeared distressed when informed of his admission. At the time of admission the deceased was living in his own home at Suburb L with the assistance of paid carers.
3. The deceased appeared confused about how long he had been married and provided conflicting information when in the Emergency Department. In the Emergency Department the deceased denied any medical history. He also denied any incontinence but the Emergency Department notes state he was wearing incontinence pads. The deceased later conceded that he had had an episode of faecal incontinence about a week before admission.
4. The deceased reported on admission that he had short-term memory loss. A mini mental state examination test, in which the deceased required constant instruction, provided a result of 20/30.
5. A delirium risk screen was conducted that provided a “high risk “result.

### The Hospital Admission in May 2011 & the U Report

1. In midMay 2011, barely three weeks after the marriage ceremony, the deceased was admitted to Town T Hospital as a result of a fall at his home.
2. On 17 June 2011 Ms U, a social worker at Town T Hospital, provided a report for the consideration of the Guardianship Tribunal (NSW).
3. The report notes that the deceased was admitted to Town T Hospital in mid-May 2011 under Dr V, Orthopaedic Surgeon, with a fractured left hip.
4. The deceased’s medical issues on admission included a fracture to his left hip (or the left neck of the femur), aspirational pneumonia, post-operative delirium on the background of dementia and severe Vitamin D deficiency.
5. The deceased’s past medical history was noted as alcohol abuse, alcoholic peripheral neuropathy, asbestosis, closed fracture of the clavicle, chronic obstructive airways disease, dementia, osteoporosis and postural hypotension.
6. The report noted that the deceased had been admitted to the hospital under the geriatric team twice in 2010.
7. As to the deceased’s history the report noted:

[The deceased] lived with his previous wife [Ms E], in his home [in Suburb L], New South Wales, until she died in August 2010. [Care Organisation A] were engaged to provide a Community Aged Care Package (CACP) for [Ms E] prior to her death. Both [Ms E] and [the deceased] have a history of alcohol abuse. [The deceased] was admitted twice under the Geriatric Team in 2010. He is noted to have poor insight and judgement as documented in the medical records during these admissions …

[Care Organisation A] continued to provide a Community Aged Care Package to [the deceased] following his wife’s death. [Care Organisation A] referred [the deceased] to the Aged Care Assessment Team (ACAT), recommending services be increased to an Extended Aged Care Package (EACH) due to his increasing frailty and symptoms of depression relating to grief following the death of his wife. …

[Care Organisation K] services were cancelled in early 2011 when [the deceased] became engaged to [the Respondent]. It appears that the aim was for [the Respondent] to assume all care needs.

1. The report further notes that following surgery the deceased was assessed by an Orthogeriatrician, who noted the deceased’s history of dementia and his current very confused state.
2. On 23 May 2011 Ms U spoke by telephone to the Respondent, who informed Ms U:
	1. that the deceased has no children;
	2. that he has a niece who is sick with cancer and lives in Town W;
	3. that she has known the Olivers for many years as the previous wife, Ms E, was a friend of her mother, Ms Y;
	4. following his late wife’s death in August 2010 the deceased was constantly asking her to marry him so that his house would not “go to the Salvation Army”;
	5. there is no appointed power of attorney or guardian or guardian and the will was changed in March – assets left to her;
	6. the deceased does not receive an aged pension, he lives off his investments;
	7. the deceased has been showing signs of dementia for the past 12 months; and
	8. she is unaware of services that can help as she comes from the Western Sydney area and has only recently moved to the Central Coast.
3. Following the conversation with the Respondent, Ms U reviewed the patient’s medical files. She noted a referral to the aged care assessment team and contacted that agency. She confirmed that care packages had been approved for the patient and that Mr H was noted in their files as the deceased’s Power of Attorney. Mr H had contacted the aged care assessment team on 17 February 2011 with concerns about the patient being financially abused.
4. Ms U then contacted the community care providers, who confirmed that they were providing services to the patient but such services were cancelled in February 2011 on his engagement to the Respondent, with the view that the Respondent would assume all care of the deceased.
5. Ms U thereupon arranged an appointment with the Respondent.
6. On 30 May 2011 the nursing unit manager informed Ms U that the Respondent and an older couple had visited the deceased on the afternoon of 27 May 2011 and had attempted to get him to sign some forms. The nurse unit manager informed the Respondent that the deceased did not have the cognitive capacity to sign documents.
7. On 1 June 2011 Ms U met the Respondent at Town T Hospital. The consultant orthogeriatrician attended for part of the meeting.
8. The Respondent informed Ms U:
	1. that the documents that she wanted the deceased to sign were to sell an asset so she could have access to funds to pay bills, the only other source of income being rent received from the deceased’s investment properties;
	2. that prior to her marriage to the deceased she had worked as a cleaner;
	3. that she had attended upon the deceased’s solicitor, Mr R, on 27 May 2011 enquiring as to a power of attorney in relation to the deceased’s affairs. She said that the meeting with the solicitor was very brief and she felt dismissed by him. The Respondent requested a social worker and medical report to support an application for power of attorney;
	4. that the deceased’s assets included a waterfront home in Suburb L, a houseboat and two investment rental properties;
	5. that the deceased had been demonstrating symptoms of dementia for the past 12 months, for example, calling for his brother Mr S (deceased) and also for his wife Ms E (deceased);
	6. that she had to keep the doors locked at home as the deceased was at risk of wandering;
	7. that the deceased changed his will in March 2011 and that the solicitor requested a capacity assessment by Dr G. The deceased, apparently, was deemed to have capacity at this time to change his will; and
	8. that she married the deceased in late April 2011.
9. Whilst in hospital the deceased was referred for RAID neuropsychological assessment by Mr X, neuropsychologist.
10. Ms U expresses the view that:

… it is difficult to determine if the [Respondent] is acting in her husband’s best interests due to the concerns outlined above. [The deceased’s] cognitive decline and his fragile mental health following the death of his wife indicates that he may be vulnerable to being influenced by others to make inappropriate decisions which are not in his best interest. It is recommended that a guardianship hearing is held to determine whether [the deceased] is able to make his own decisions with regard to personal and financial matters.

### Dr G

1. The Respondent adduced evidence from Dr G, who was the deceased’s treating general practitioner from 1996 until the time of the deceased’s death.
2. Dr G provided copies of his patient records in relation to the deceased from 2001 onwards.
3. On 17 February 2011 the deceased and the Respondent attended at his surgery. Dr G has a reasonably clear recollection of the consultation because of its unusual nature. He says that his discussions during the consultation were with the deceased and that the Respondent was present as a passive observer. The deceased presented at his surgery on a mobility aid (walker).
4. Dr G observed that the deceased spoke clearly and lucidly with good eye contact, a firm voice and complete, coherent and grammatically sound sentences. He notes that there was no wandering in speech, his responses were quick and appropriate and there was no hesitation. The deceased was clear in his intent for the consultation, which was to obtain a letter from Dr G as instructed by his lawyer.
5. He recalls the deceased saying, “I have gone to see my lawyer about changing my will and my lawyer has asked me to obtain a letter from you stating I am of sound mind.”
6. The deceased provided no written instructions from his lawyer at the time, nor did it occur to Dr G to telephone the deceased’s lawyer for instructions.
7. Dr G enquired of the deceased “why are you changing your will?”, to which the deceased replied “I want to make sure some people are taken care of and there are some I no longer want in my Will”. Dr G did not question the deceased further about the proposed will changes.
8. Dr G spoke to the deceased in relation to his ongoing grief as to the death of his wife and the deceased’s level of alcohol consumption.
9. The doctor administered a mini mental state examination test in which the deceased scored 23/30, which he explained generally implies moderate cognitive impairment.
10. At the conclusion of the consultation, Dr G provided the deceased with a brief note stating “that [the deceased] is, in my opinion, of sound mind and capable of making rational decisions about his affairs”. Dr G says that the note reflected his personal opinion about the deceased’s capacity on the day of the consultation.

### Dr G - oral evidence

1. In his oral evidence Dr G acknowledged that, prior to providing the deceased with the note, he did not go through his file for the purpose of refreshing his memory in respect to the deceased’s history, and just assessed the deceased as he saw him on the day.
2. Dr G was aware that in 2001 the deceased was admitted into hospital suffering from pneumonia and diagnosed at that time with alcohol dementia and early Alzheimer’s. He further acknowledged that in previous years he had received reports from Dr C, staff specialist geriatrician at Town T Hospital.
3. Dr G accepted that on the deceased’s admission to Town T Hospital in 2001 he was diagnosed with extensive right upper lobe pneumonia, complicated by severe delirium, gait and balance disorder, with probable early Alzheimer’s dementia, severe postural hypotension from autonomic neuropathy, alcohol induced peripheral neuropathy and malnutrition. Dr G acknowledged that Dr C’s report to him dated 10 August 2001 observed that the deceased had residual significant cognitive impairments, particularly impaired short-term memory, insight and problem-solving.
4. Dr G acknowledged that the medical history documents provided by him provide a history for the deceased and various diagnoses by other practitioners and discharge summaries following the deceased’s various admissions to hospital. He acknowledged no surprise that some of the historical reports note the deceased confabulating in conversation.
5. Dr G acknowledged that he accepted the history and a diagnosis of the deceased as disclosed in the various historical documents attached to his affidavit.
6. The discharge referral in relation to the deceased following his hospitalisation in July 2009 discloses various principal diagnoses, including alcohol dependence, dementia and cognitive impairment. At the time of his admission the deceased was 77 years of age and the referral notes “(h) as cognitive impairment, no insight”. On discharge as to cognition and behaviour the referral notes “(c)onfused and agitated at times”, with the deceased’s prognosis being “guarded given progressive cognitive impairment and complications because of smoking and alcohol”.
7. Dr G acknowledges that he made no reference to this discharge referral in providing the note in relation to the deceased in February 2011.
8. The discharge referral was provided to Dr G following the deceased’s admission to hospital in August 2010. It was during this admission that the deceased’s late wife passed away and the deceased requested discharge against medical order to attend her funeral. On discharge, as to cognition and behaviour the referral noted “can be confused and agitated at times.”
9. Dr G was referred to a further discharge referral following the deceased’s hospitalisation in October 2010. The deceased was admitted following an unwitnessed fall and was unable to recall the event. The deceased refused any assistance and requested discharge against medical order. His functioning on discharge as to cognition and behaviour was noted as:

Can be confused and agitated at times. Very moody at a time and refused any idea of placement. MMSE attended in ED, [patient] required constant instruction 20/30. Orientation 8/10. Recall 0/3. Abnormal clock incorrect hand placement. Abnormal pentagons. Poor sentence construction.

Dr G acknowledges that he had no regard to this referral in providing the note in relation to the deceased in February 2011.

1. Dr G saw the deceased following his discharge from hospital in October 2010 on 13 October 2010. His notes reveal:

See discharge summary – record of continuing to refuse care/help.

He does not know why he is here. – discharge summary does not indicate clear plan, mostly because [the deceased] rejecting help.

Given death of [his late wife] probably (sic) little motivation – grief is strong.

1. On 30 November 2010 Dr G undertook an assessment of the deceased for the purposes of measuring the deceased’s level of depression. As a consequence of the assessment, Dr G conceded that the deceased presented to him in a very depressed state and that such depression could have an effect on the deceased’s dementia and Korsakoff’s syndrome. On 6 December 2010 Dr G prepared a general practitioner management plan review in relation to the deceased. Dr G acknowledged that the history given in that plan omitted to include the deceased’s past history of dementia, Korsakoff’s syndrome and cognitive impairment. He explains these omissions on the computer-generated form, however, he notes that the plan was more concerned with the deceased’s physical care at that time.
2. Dr G was unaware of aspects of the deceased’s behaviour in the period prior to the consultation in February 2011, including putting a knife into a power socket, lighting a fire in an ashtray, being found on five or six occasions at the front door of his home saying he was going home, conversations with his late wife as if she were still alive and references to going fishing with his brother Mr S, who had been deceased for some time. Dr G conceded that in the absence of affectation by alcohol, some of the aspects referred to would be indicative of some cognitive impairment and, if he had been aware of these behaviours, he would have approached his certification of the deceased’s capacity in a different way. He would have facilitated a referral of the deceased to a clinical neuropsychologist, subject to the deceased proffering some rational explanation for his behaviours. Dr G conceded that had he been presented with objective evidence of the deceased’s behaviours, he would not have provided the note that he did.
3. Dr G conceded that in order to determine what types of questions might be asked of someone to consider their capacity for making rational decisions it would be wise to consider that person’s history. He was, he says, unaware as to what the legal test was for someone to have the capacity to change their will and, in that regard, received no guidance from the deceased’s solicitor.
4. Dr G conceded that, in retrospect, his conversations with the deceased in February 2011 were not as detailed as he would have done if he had known he would have to give evidence about it. Dr G was unaware that the Respondent, who was with the deceased throughout his consultation with Dr G in February 2011, was the proposed primary beneficiary in the proposed changes to the deceased’s will, or that the Respondent and the deceased planned to marry. Dr G assumed that the Respondent was simply his carer.
5. Dr G acknowledged that he was now aware of guidelines from the Australian Medical Association that assist practitioners in assessing testamentary capacity, but that he had no regard to those guidelines at the time. He conceded that questions that might have been asked of the deceased were the extent and value of his property, who would be his natural or moral beneficiaries, the actual proposals in relation to the new will.
6. Dr G, acknowledged that on his observations the deceased was capable of dramatic swings in his mental state, having periods of reasonable lucidity and swings away therefrom. He conceded, however, that knowing what had been put to him in his oral evidence, he would not have provided the letter in February 2011 and would have referred the deceased back to his solicitor without the note requested.

### The Single Expert: Dr Z, Clinical Neuropsychologist.

1. Admitted into evidence by consent as Exhibit C in the proceedings were to reports by Dr Z, Clinical Neuropsychologist, dated 24 March 2013 and 3 November 2013.
2. Dr Z had regard to a number of background documents in relation to the deceased including:
	1. hospital discharge summary of April 2001;
	2. Guardianship Tribunal decision dated 19 April 2004;
	3. ASET assessment, AB Health Service dated 3 October 2010;
	4. letter of Dr G dated 17 February 2011;
	5. report of Mr X, Senior Clinical Psychologist, Town T Hospital, dated 10 August 2011;
	6. report of Ms U, Social Worker, Town T Hospital, dated 17 June 2011;
	7. report of Ms BB, Occupational Therapist, Town D Hospital, dated 13 July 2011;
	8. report of Dr CC, Geriatrician, Town T Hospital, dated 12 July 2011;
	9. report of Dr G, General Practitioner, dated 15 August 2011; and
	10. medical notes of Dr G, General Practitioner.
3. Dr Z notes that in February 2011 the deceased had a mini mental state examination score of 23/30, indicating mild dementia, but there can be a lot of variation in a person’s cognitive ability within this category.
4. Dr Z was asked whether the testing conducted by Dr G was a thorough and sufficient test to determine if the deceased was of sound mind and capable of making rational decisions. Her answer was no. She notes that an assessment of testamentary capacity performed by any clinician should always involve specific assessment of the legal standards and there was no reference to these issues being discussed or assessed. Moreover, she says a mini mental state examination score tells you very little about a person’s cognitive capacity for any high-level legal matters. When there are psychiatric issues, such as hallucinations, delusions or behavioural issues, this makes assessment of capacity for high-level decision making even more complex. Dr Z notes that the deceased had been reported as having such symptoms for the past 12 months prior to his hospitalisation in May 2011, described by the Respondent to the hospital social worker, Ms U.
5. As to Dr G’s qualifications to formulate an opinion as to whether the deceased was of sound mind and capable of managing his affairs, Dr Z opines that any medical practitioner can be capable of performing an assessment to formulate an opinion in this regard. However, in her experience, it is unusual for a general practitioner to perform such an assessment, as it usually takes quite a long time and should involve cognitive testing beyond a mini mental state examination. A neuropsychologist, she says, usually spends at least a couple of hours assessing the client’s knowledge of the current situation, background the decision they wish to make, all legal documents they wish to sign and extensive questioning regarding the specific matter. The remainder of the time is spent performing a battery of well validated and standardised cognitive tests, with focus on memory, higher-level reasoning and problem solving capacity. Different capacity requirements are needed, she says, depending upon the decision being made.
6. As to whether the deceased was capable of understanding the nature and effect of the marriage ceremony in April 2011, Dr Z observes that the deceased does not seem to have been specifically assessed with respect to his understanding of what a marriage would entail, either legally or personally. She is sure, she says, that he would have understood the basic premise of marriage, but there are higher issues in the situation of the deceased given his high-level medical needs, including that the Respondent would become his next of kin and would probably become his person responsible in light of the need for medical decisions to be made. Based on available information, she says there are numerous risk factors for cognitive impairment in the deceased that may have affected his ability to understand the nature and effect of the marriage ceremony in April 2011.
7. Dr Z says that it is not possible to say with certainty whether he was capable of understanding these issues, and Dr Z was not aware as to whether any such issues were brought up by the marriage celebrant.
8. As to the deceased’s diagnosis in April 2011, Dr Z opines that the deceased had a number of pre-existing diagnoses that were affecting his cognition and capacity to live independently. Diagnoses potentially affecting his cognitive capacity at the time include:
	1. previously diagnosed dementia (possible Alzheimer’s disease);
	2. alcohol-related cognitive impairment;
	3. proneness to delirious and fluctuations in cognition; and
	4. pre-existing cerebral vascular disease.

In relation to cognition, there is clear evidence of slowly declining cognition with marked worsening during periods of delirium related to medical conditions.

1. As to whether the deceased was capable of understanding the nature of the contract (marriage) that he was entering into, free from the influence of morbid delusions, upon the subject Dr Z says that is a difficult question to answer. There was clear evidence of long-standing cognitive impairment prior to April 2011, which may have influenced the deceased’s capacity in this regard. Dr Z notes:

… in relation to the specific issue of “morbid delusions”, information provided by his family suggests he was experienced delusions and paranoia through December 2010 into the New Year, including his belief sometimes that his first wife, [Ms E], was still alive and also his belief that Mr [H] was being too controlling of his money. Moreover, there is a long history documented in hospital notes of paranoid delusions and treatment for these, dating back to 2001, especially during times of delirium. As such, it is possible (but I cannot be certain) that [the deceased] was experiencing some degree of delusions around this time and that this might have influenced his thinking, especially if he had certain inaccurate beliefs about some family members and if he was being unduly influenced by them.

### Dr Z – oral evidence

1. In oral evidence Dr Z explained that Korsakoff’s syndrome is a condition that results from severe alcohol use and thiamine deficiency. It results in significant changes in the brain, permanent changes in the brain that significantly affect someone’s memory for both new information and past history. It can sometimes result in some other behavioural changes and apathy and also a tendency for confabulation, which is where people invent memories to fill gaps for things that they do not remember. It is very common, she says, for people with this syndrome to have problems with higher-level reasoning and judgement. The ongoing use of alcohol can cause the resultant deficits to worsen over time.
2. As to the deceased’s grief following the death of his late wife, Dr Z observed that grief, which potentially turns into a depressive illness, can certainly impair, especially in elderly persons, cognition further.
3. As to the deceased’s risk factors for cognitive impairment, Dr Z identified them as Korsakoff’s syndrome, alcohol-induced dementia, alcohol-related cognitive impairment, evidence of cerebral vascular accident and other vascular changes within the brain that can contribute to cognitive defects.
4. Dr Z conceded that her ability to assess the deceased in relation to capacity was limited by only having documents upon which to form an opinion, but she was significantly assisted by the report of Mr X, Clinical Neuropsychologist, as to the deceased’s medical background and previous medical notes, even though Mr X’s assessment of the deceased was after the impugned marriage.
5. Dr Z acknowledged that the deceased’s condition fluctuated and that she presumed that he had good days and bad days. It was suggested to Dr Z that he had the assistance of the carer in 2010 and 2011 because of his physical condition, not his mental condition. Dr Z was not sure as to that proposition referring to plenty of references to the lack of the deceased’s insight into what help he needed and his degree of cognitive impairment.
6. As to the mini mental state examination conducted by Dr G on 17 February 2011, Dr Z observes that the test reveals the deceased was disoriented as to time - did not know the year, the season and the date - and suggests that his concentration or ability to focus was not optimal.

# The evidence

1. The Court has had the opportunity of observing the various witnesses giving evidence and being cross-examined. The Court is satisfied that the Applicant and those called in support of the Applicant’s case are witnesses of truth and gave evidence as lay people to the best of their recollection and ability.
2. On the other hand, the Court has reservations as to the evidence of the Respondent. Her affidavit evidence would suggest she had no knowledge of history or background relevant to the question of the deceased’s capacity to marry whatsoever. Yet, during the course of cross examination, significant concessions were made as to the deceased’s behaviour in the presence of the Respondent during the period that the Respondent resided in his home prior to the marriage. The Respondent acknowledged in cross examination her conversation with the social worker at the Town D Hospital wherein she acknowledged the deceased’s history of dementia for the previous 12 months and made observations as to some aspects of the deceased’s concerning behaviour.
3. The witnesses relied upon by the Respondent give a scant and superficial version of circumstances leading up to and at the wedding ceremony itself. On the one hand, it could be asserted that the evidence was designed so as to assist the Respondent’s case. On the other hand, it can be asserted that their evidence assists the evidence of the Applicant if, indeed, the observations on the day of the wedding ceremony given by them are to be accepted.
4. The evidence of the wedding celebrant is supportive of the general proposition that the deceased may have known that he was participating in a marriage ceremony. Otherwise, the evidence of the celebrant is also scant and throws little light on the ultimate question for determination.
5. Ultimately, the evidence of Dr G is of little or no consequence. He concedes that, having apprised himself of the deceased’s medical history and being aware that the person accompanying the deceased at the consultation was the deceased’s carer, proposed wife and proposed sole beneficiary, he would not have provided the note that he did.
6. Of significant import is the failure of the Respondent to call various witnesses that are known and available. They include:
	1. Mr R, the solicitor;
	2. Ms M, the first marriage celebrant;
	3. The photographer in attendance at the ceremony; and
	4. Neighbours of the deceased who, it is asserted by the Respondent, visited the deceased in his home in the months prior to the wedding.

No explanation was proffered by the Respondent as to the absence of these witnesses. A strong inference arises that, if called, these witnesses would not have assisted the Respondent’s case. This issue is of some import as discussed below in relation to the burden of proof in these proceedings.

1. The Court is satisfied that the evidence of the Applicant and her witnesses is to be preferred to that of the Respondent.

# Discussion

1. These proceedings are brought under section 113 of the Family Law Act for a declaration in respect of the validity of the deceased and the Respondent’s marriage in April 2011.
2. Section 23B(1)(d) of the Marriage Act sets out grounds under which a marriage can be declared void. It is the Applicant’s contention that, adopting the words of sub-subparagraph (iii) of that section that the deceased’s consent was “not real consent” because he was “mentally incapable of understanding the nature and effect of the marriage ceremony”.
3. The relevant point of time in proving mental incapacity is the time of the marriage ceremony, not some other time before or after the ceremony.
4. A history of the development of the law in Australia was set out by Mullane J in *Babich & Sokur and Anor* [2007] FamCA 236:

238. The case law background to the English law has been considered more recently in a series of decisions by Justice Mumby of the Family Division of the High Court, particularly in *Sheffield City Council v E & Anor.* [2004] EWHC 2942 (Fam) 15 December 2005.

239. Prior to 1959 in New South Wales there was no statutory test. In *Mathieson (falsely called Perry) v Perry* (1939) 56 WN (NSW) 89, Boyce J applied English case law as to the test of mental capacity and said:

In *Forster v. Forster* (39 T.L.R. 658), the Learned President, in a somewhat similar case to the present, said:- “This case is one, it seems to me, of the very greatest difficulty. The position of the petitioner is most deplorable; there can be no question that she has gone through a ceremony of marriage with a mental degenerate. But that is not the question. The question is whether the respondent was mentally capable of understanding the nature of the marriage contact, and the duties and responsibilities which it creates. As Sir J. Hannen said in *Durham v. Durham* (1 T.L.R. 338: 10 P.D. at 82) a mere comprehension of the words of the promises exchanged is not sufficient. The mind of one of the parties may be capable of understanding the language used, but may yet be effected by such delusions, or other symptoms of insanity, as may satisfy the tribunal that there was no a real appreciation of the engagement apparently entered into.”
Here I believe that the respondent knew he was getting married, but I do not think that at the time he was in such a condition that he appreciated and understood the real effect of the ceremony. The evidence before me has satisfied me that he had not a real appreciation of the engagement apparently entered into and was to all intents and purposes, insane at that time. [Footnote omitted]

240. In reported Australian decisions since *Park v Park*, even after the introduction of the legislative test in Australia, it seems to be assumed that the English case law is directly applicable to the Australian legislative test, whereas that is not necessarily so.

241. The legislative test was first introduced in Australia as part of S.18 of the Matrimonial Causes Act, 1959. It provided that a marriage was void if the consent of either of the parties “is not a real consent” because “that party is mentally incapable of understanding the nature of the marriage contract”.

242. That remained the test until the Matrimonial Causes Act 1959 was repealed by the Family Law Act 1975, and Sec.51 of that Act provided that a marriage that took place after commencement of that Act, is void if the consent of either party is not a real consent because “that party is mentally incapable of understanding the nature and effect of the marriage ceremony”. [emphasis removed]

243. The legislative test was subsequently moved by amendments in 1976 to subpara 23(1)(d)(iii) of the Marriage Act,1961. The same test is in subpara 23B (1)(d)(iii) of the Marriage Act, which was inserted in 1985.

244. On the face of it the English common law test and the Australian statutory test are different, particularly because of the Australian test requiring that for a valid consent a person must be mentally capable of understanding the effect of the marriage ceremony as well as the nature of the ceremony. Whether in fact there is a difference in interpretation is another issue. [emphasis removed]

245. In the 32 years since the legislative test has applied, there has not been a plethora of decisions of the Australian courts as to its interpretation. There are only 2 reported decisions that I was referred to and I located no others.

246. The first of these is the decision of McCall J in *Brown and Brown* (1982) FLC 91-232, and the second is the decision of Chisholm J in *AK and NC* [2003] FamCA 1006; (2004) FLC 93-178. The current test of “mentally incapable of understanding the nature and effect of the marriage ceremony” was applied in both cases.

247. In *Brown and Brown* both parties relied upon the dicta of Singleton LJ in *In the Estate of Park* quoted earlier. His Honour said, though:

The nature of the contract, and the responsibilities attaching to the particular marriage must vary from couple to couple. In the circumstances of this marriage the responsibilities were different to many others. The parties were, perforce, to live apart because of the husband’s illness and the inability of the wife to properly care for him. It was a marriage in which the husband would, from then onwards, be confined to living in a hospital or nursing home situation where appropriate nursing home care was available to him. The wife, in the meantime, would continue to live in what had been their matrimonial home for fifteen years. The had during their time in Mandurah been regarded as husband and wife and the wife had apparently been known in that community as Mrs. Brown. Marriage, to them, did not involve living together. Nor did it involve undertaking any new responsibilities by either, or any change in an existing and long-standing relationship or situation. As the Reverend Barrett said in this context he assumed the husband knew what marriage was. The marriage was regularising a fact.

Although this man was not capable of writing or presumably looking after his own affairs which must have been left to the wife, in my view he nevertheless understood the step he was taking and the significance of it. I may not have come to this conclusion had this been a marriage between the husband and some person other than the wife. I accept the evidence that he knew his wife and he knew what he was doing, that is, that he was getting married. [Footnote omitted]

248. McCall J referred to no other decided case or other authority.

249. In *AK and NC,* Chisholm J held:

18. The relevant statutory provision, as applied to this case, is that the marriage will be void where the consent of the wife was not a real consent because she was *mentally incapable of understanding the nature and effect of the marriage ceremony.*

19. What does this provision require? In *Park v Park* the court held that the person in question was capable of understanding the nature and effect of the marriage, although he was not capable of making a valid Will. The court quoted a well-known remark by Sir James Hannan P:

“It appears to me that the contract of marriage is a very simple one, which does not require a high degree of intelligence to comprehend. It is an engagement between and man and a woman to live together and love one another as husband and wife, to the exclusion of all others.”

20. Both in law and in society, a marriage has a large variety of consequences. Few lawyers let alone non-lawyers would be able to make a comprehensive list of even the legal consequences. I note in this connection a reported exchange between an English judge and a medical witness as follows:

“Did you even know anybody who was in a condition to understand all the consequences of matrimony?

 - No, my lord.”

21. It is clear from the authorities that the law does not require the person to have such a detailed and specific understanding of the legal consequences. Of course if there were such a requirement, few if any marriages would be valid.[[4]](http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/FamCA/2007/236.html?stem=0&synonyms=0&query=title(Babich%20)" \l "fn4)

250. Chisholm J reviewed the authorities quoted before him which were:

*Mathieson (falsely called Perry) v Perry* (1939) 56 WN (NSW) 89, *Faull v Reilly* [[1970] VicRp 110](http://www.austlii.edu.au/au/cases/vic/VicRp/1970/110.html); [1971] ALR 157, *Evans v Brenton (Falsely called Tredennick)* (1887) 3 WN (NSW) 129c; *Brown and Brown* (1982) FLC 91-232; (1982) 8 FamLR 1.

251. He then said:

24 Reviewing these authorities, I agree with Dr Dickey that “mere awareness of going through a marriage ceremony is not enough; a person must also understand the nature and effect of the ceremony involved”. (Anthony Dickey QC, *Family Law* (4th ed, 2002) at 175). This is illustrated by *Mathieson v Perry,* where Boyce, J said, granting a decree of nullity:

*Here I believe the respondent knew he was getting married, but I do not think that at the time he was in such a condition that he appreciated and understood the real effect of the ceremony. The evidence before me has satisfied me that he had not a real appreciation of the engagement apparently entered into and was, to all intents and purposes insane at that time. I believe, in the words of [Dr N], he was unable to face ordinary marriage affairs. Part of the ceremony in the Church of England, where they were married, is a promise by the husband to forsake all others and to keep only unto her so long as both shall live; to such promise I believe he gave no rational assent.*

25 The problem of identifying precisely what it is that the person must understand was dealt with in some detail by McCall J in *Marriage of Brown*.[Footnote omitted] That was also a case of an elderly party: the husband was aged 82 and had been suffering from senile dementia. McCall J referred to the fact that the husband was marrying the woman with whom he had been living in a defacto relationship for 15 years although for nine months before the marriage they had been living apart. The husband had been in the hospital and the wife continued to live in the home, visiting him nearly every day. She “had been his companion since 1965 and had behaved in all respects as a wife”. At the time of the marriage the husband had difficulty recognising his own daughters, with whom he had had minimal contact in the years previously, but had no difficulty in recognising the wife.

26 In considering whether the husband had the requisite mental capacity, McCall J focused on the particular significance of the marriage in the particular case. .....

And further:

28 I am not aware of any other decision that so specifically identifies the required mental capacity with the particular circumstances of the parties. This approach is not really contemplated in the other authorities, so far as I am aware. The earlier authorities seem to have in mind a general understanding of the nature of marriage and the obligations it entails rather than the more specific consequences it might have for the individuals in question.

29 It emerges from these authorities, I think, that a valid consent involves either a general understanding of marriage and its consequences, or an understanding of the specific consequences of the marriage for the person whose consent is in issue. It is not necessary, at least at this stage in the judgment, to rule on whether there is an inconsistency between these two approaches.[[6]](http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/FamCA/2007/236.html?stem=0&synonyms=0&query=title(Babich%20)" \l "fn6)

252. The questions arises whether under the Australian test there needs to be a general understanding of marriage and its consequences or an understanding of specific consequences of the marriage that the person is about to enter into.

253. Dr Anthony Dickey QC has also expressed a view:

Although S.23B(1)(d)(iii) refers to a person being mentally incapable of understanding the nature and effect of the marriage ceremony, it would seem that there is in fact only one substantial requirement here, for an application of the nature of a marriage ceremony necessarily involves an appreciation of its general effect. (Such an approach was adopted by the majority of the Court of Appeal in *In the Estate of Park* (1954) p89 at 127 and 133, applied in Australia in *Brown and Brown* (1982) 60 FLR 212 at 222-223.)

254. He has expressed a similar view elsewhere.

255. It is not necessary in these proceedings to decide how wide the test in subpara. 23B(1)(d)(iii) is, but only whether it applies to the wife. But it is in my view **significant that the legislation not only requires a capacity to understand “the effect” but also refers to “the marriage” rather than “a marriage”. In my view taken together those matters require more than a general understanding of what marriage involves** [emphasis added]. That is consistent with consent in contract being consent to the specific contract with specific parties, consent in criminal law to sexual intercourse being consent to intercourse with the specific person, and consent to marriage being consent to marriage to the specific person.

### The evidentiary onus

1. The nature of the marriage ceremony, itself, raises the presumption of regularity.
2. It falls to those asserting otherwise to rebut the presumption on the balance of probabilities, based on the evidence before the Court and inferences arising therefrom.
3. The question to be determined is whether the deceased was mentally incapable of understanding the nature and effect of the marriage ceremony to the Respondent.
4. Relevant factors to this consideration include:
	1. the physical observations of the Applicant and her witnesses as to the cognitive and mental capacity of the deceased in the months leading up to the marriage ceremony;
	2. the concessions made by the Respondent in oral evidence as to matters touching upon the cognitive and mental capacity of the deceased in the period from February 2011 until the date of marriage;
	3. the extensive pre-marriage medical history of the deceased, going back to 2001, which supports a very strong inference of ongoing diminished cognitive capacity and dementia;
	4. the diagnoses of the deceased upon his admission to hospital in May 2011, only some three weeks after the date of the wedding, which supports a very strong inference of ongoing diminished cognitive capacity and dementia;
	5. the resiling by the deceased’s General Practitioner, Dr G, from the certificate provided by him in February 2011 as to the deceased’s capacity to make rational decisions;
	6. the conclusions of the single expert as to the deceased’s medical and mental health circumstances at the time of the marriage; and
	7. the scant evidence from the Respondent and her witnesses in relation to the deceased’s capacity at the time of the ceremony to understand the nature and effect of the marriage, not just his mere presence at and participation in the ceremony.
5. On the balance of probabilities, the Court is satisfied that the deceased had ongoing significant mental and cognitive incapacity, particularly in the 12 month period preceding the wedding ceremony, that continued as at the date of the ceremony.
6. In such a circumstance an obligation is cast upon the Respondent to adduce evidence as to the deceased’s capacity to understand the nature and effect of the marriage ceremony at the time of the ceremony (see: *Turner v Meyers, falsely called Turner* (1808) 1 Hag Con 414).
7. As has been observed above, the Respondent’s evidence is scant in the extreme as to this issue, and it is further inhibited by the inference arising from her failure to call various pertinent witnesses as also referred to above.
8. The evidence is supportive of the conclusion that the deceased may have been aware that he was participating in a marriage ceremony to the Respondent, or at least some sort of ceremony with the Respondent, but no further.
9. There was no evidence before the Court, Dr G having resiled from his assessment of the deceased’s mental capacity shortly before the marriage, that the husband was capable of understanding the nature and effect of his marriage to the Respondent.
10. The obligation cast upon the Respondent to adduce such evidence is reinforced by factual circumstances in this matter and the inferences arising therefrom, including, but not limited to:
	1. the age disparity between the parties to the marriage;
	2. the nature of the previous relationship between the Respondent and the deceased in that the Respondent was a part-time carer of the deceased;
	3. the significant financial disparity between the deceased and the Respondent;
	4. the motivation of the Respondent in facilitating a change to the will of the deceased with the effect of totally excluding family beneficiaries in her own favour should she survive the deceased;
	5. the concessions made by the Respondent as to her knowledge and observations of the deceased’s behaviour evidencing cognitive incapacity and dementia over the 12 months preceding the wedding;
	6. the evidence of concerns of others as to the Respondent’s motives and whether she was in fact acting in the best interests of the deceased; and
	7. the financial motivations of the Respondent in facilitating a marriage to the deceased.
11. In all of the circumstances, the Court is satisfied that, as at the date of the impugned ceremony, the deceased did not have the capacity to understand the nature and effect of the marriage to the Respondent. Accordingly, a declaration will be made that the subject marriage is invalid.

I certify that the preceding two hundred and thirteen (213) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Foster delivered on 12 February 2014.

Legal Associate:

Date: 12 February 2014