

FILE NO. A11-610

STATE OF MINNESOTA

IN SUPREME COURT

In Re Petition for Disciplinary Action
against LOUIS ANDREW STOCKMAN,
a Minnesota Attorney,
Registration No. 241210.

**AMENDED AND
SUPPLEMENTARY PETITION
FOR DISCIPLINARY ACTION**

TO THE SUPREME COURT OF THE STATE OF MINNESOTA:

The Director of the Office of Lawyers Professional Responsibility, hereinafter Director, files this amended and supplementary petition for disciplinary action pursuant to Rules 10(e) and 12(a), Rules on Lawyers Professional Responsibility (RLPR).

Respondent is currently the subject of a March 31, 2011, petition for disciplinary action. The Director has investigated further allegations of unprofessional conduct against respondent.

The Director alleges that respondent has committed the following amended and additional unprofessional conduct warranting public discipline:

DISCIPLINARY HISTORY

On January 15, 2009, respondent was issued an admonition for failing to obtain his client's consent before making a settlement demand to an insurer, failing to notify the client of the insurer's counter-offer, failing to diligently handle the client's case and failing to keep the client reasonably informed about the status of his case, in violation of Rules 1.2(a), 1.3 and 1.4(a)(1) and (3), Minnesota Rules of Professional Conduct (MRPC).

FIRST COUNT

Negligent Misappropriation of Client Funds, Mishandling of Client Funds, Commingling, Failure to Maintain Required Trust Account Books and Sharing Legal Fees with a Non-Lawyer Assistant

Introduction

1. At all times relevant, respondent has maintained trust account no. -2471 at Beacon Bank (hereinafter, "respondent's trust account"). Respondent opened his trust account in August 2006.

2. At all times relevant, respondent has maintained operating account no. -7141 at Beacon Bank (hereinafter, "respondent's operating account").

Trust Account Shortages

3. During the periods September 1 to November 30, 2006; December 12, 2006, to June 3, 2009; July 27 to 29, 2009; November 24 to December 1, 2009; April 14 to 27, 2010; April 28 to June 29, 2010; July 7 to August 25, 2010; and October 4 to 8, 2010, the balance in respondent's trust account was short of that necessary to cover client balances, resulting in the negligent misappropriation of client funds. This shortage, which is further detailed below, ranged in amount from \$22 (on October 4, 2010) to more than \$31,000 (on September 25, 2008).

4. Attached as Exhibit A is a chart reflecting the shortages in respondent's trust account during the period September 1, 2006, to October 8, 2010. Some of the transactions that constituted the negligent misappropriation of client funds and contributed to the shortage were for respondent's own personal and/or professional benefit. Those transactions are identified on the chart by an asterisk (*) in the "AMOUNT OF TRANSACTION" field.

Commingling in Trust Account

5. During the periods November 30 to December 7, 2006; June 3 to July 27, 2009; July 29 to November 24, 2009; December 1, 2009, to April 14, 2010; April 27 to 28, 2010; and June 29 to July 7, 2010, respondent's trust account balance included both substantial amounts of earned fees to which he was entitled and client funds. During those periods, respondent thus commingled client funds and his own funds in his trust account.

6. Attached as Exhibit B is a chart reflecting the occasions on which respondent commingled his own funds with client funds in his trust account during the period November 30, 2006, to July 7, 2010.

Mishandling of Client Funds and Commingling in Operating Account

7. On multiple occasions during the period January 2007 to June 2010, respondent deposited client funds directly into his operating account, or transferred client funds from his trust account into his operating account, and disbursed the funds to the clients from his operating account.¹ Respondent's actions in this regard constituted the improper handling of client funds and resulted in the commingling of client funds with respondent's own funds in his operating account.

8. Attached as Exhibit C is a chart reflecting the occasions on which respondent *deposited* client funds directly into his operating account and disbursed those funds to clients and others from his operating account.

9. On the following occasions, respondent *transferred* client funds from his trust account into his operating account and disbursed the funds to the clients from his operating account:

¹ It also appears respondent disbursed the client funds he deposited or transferred into his operating account to client medical and other creditors.

<u>DATE</u>	<u>CLIENT</u>	<u>TRANSFERS</u>	<u>DISBURSEMENTS</u>
12/11/06	P.H.	\$9,588.92	Ck (TA) 2040 to P.H. for \$7,191.69 cleared 12/12/06
01/02/07	G.B.	\$1,305.82	Ck 1503 to G.B. for \$870.54 cleared 01/03/07
01/09/07	J.B.	\$3,444.00	Ck 1521 to J.B. for \$2,250.53 cleared 01/19/07
01/09/07	T.H.	\$4,200.00	Ck 1522 to T.H. for \$2,773.89 cleared 01/24/07
01/09/07	M.M.	\$1,800.00	Ck 1515 to M.M. for \$1,200.00 cleared 01/11/07
01/09/07	M.G.	\$6,500.00	Ck (TA) 2046 to M.G. for \$3,904.89 cleared 1/10/07
02/23/07	J.S.	\$1,000.00	Ck 1560 to J.S. for \$494.69 cleared 03/01/07
03/09/07	A.T.	\$5,000.00	Ck 1567 to A.T. for \$2,684.36 cleared 03/16/07
03/21/07	L.H.	\$18,000.00	Ck 1578 to L.H. for \$5,713.76 cleared 03/23/07
03/23/07	G.B.	\$862.40	Ck 1583 to G.B. for \$579.94 cleared 03/26/07
03/23/07	M.G.	\$3,500.00	Ck 1582 to M.G. for \$2,333.34 cleared 3/23/07
04/19/07	R.T.	\$7,500.00	Ck 1618 to R.T. for \$4,700.12 cleared 04/19/07
09/20/07	J.D.	\$16,250.00	Ck 1797 to J.D. for \$10,072.79 cleared 09/24/07
10/05/07	J.G.	\$25,000.00	Ck 1814 to J.G. for \$16,321.18 cleared 10/10/07
10/30/07	A.M.E.	\$72,000.00	Ck 1851 to A.M.E. for \$40,000 cleared 10/31/07
11/12/07	L.K.	\$6,398.67	Ck 1869 to L.K. for \$2,498.67 cleared 11/28/07
08/22/08	E.S.	\$32,100.00	Ck 2264 to E.S. for \$20,838.78 cleared 08/25/08
01/30/09	D.H.	\$68,698.72	Ck 2562 to R. Karwt for \$17,000 cleared 02/05/09 Ck 2560 to Phia Gr. for \$11,500 cleared 02/09/09 Ck 2561 to W. Vasil for \$550 cleared 02/09/09 Ck 2563 to R. Ulleberg for \$13,022.22 cleared 02/19/09
05/18/09	C.N.	\$3,733.34	Ck 2761 to C.N. for \$3,733.34 cleared 05/18/09

10. As a result of the deposits and transfers of client funds identified in paragraphs 7 through 9 above, respondent commingled client funds with his own funds in his operating account during the following periods of time: December 11 to 12, 2006; January 2 to 3, 2007; January 9 to 24, 2007; February 23 to March 1, 2007; March 9 to 16, 2007; March 23 to 28, 2007; April 4 to 20, 2007; April 24 to May 1, 2007; May 4 to 11, 2007; May 21 to June 13, 2007; July 31 to August 1, 2007; August 10 to 14, 2007;

September 4 to 6, 2007; September 20 to 24, 2007; September 28 to October 3, 2007; October 5 to 10, 2007; October 22 to 24, 2007; October 30 to 31, 2007; November 2 to 6, 2007; November 12 to 28, 2007; December 3 to 7, 2007; January 3 to 4, 2008; March 6, 2008, to February 26, 2009; March 6 to 12, 2009; July 20 to 22, 2009; August 3 to 4, 2009; August 28 to September 1, 2009; September 2 to 4, 2009; September 21 to October 1, 2009; October 8 to 19, 2009; October 23 to 27, 2009; December 2 to 17, 2009; December 24 to 28, 2009; January 8 to 13, 2010; January 26 to February 10, 2010; February 15 to 19, 2010; March 2 to 30, 2010; April 5 to 7, 2010; and May 27 to 28, 2010.

11. The client funds respondent commingled in his operating account ranged in amount from \$157 (on September 4, 2007) to \$43,821 (on February 2, 2009).

Failure to Maintain Required Trust Account Books

12. During the period August 2006 to approximately August 2010, respondent failed to maintain the trust account books and records required by Rule 1.15, MRPC, as interpreted by Appendix 1 thereto. In particular, respondent failed to maintain a trust account checkbook register, client subsidiary ledgers, trial balances or reconciliations.

13. Respondent's conduct in negligently misappropriating client funds in his trust account, failing to safeguard client funds by depositing or transferring client funds into his operating account, commingling client funds with his own funds in both his trust and business accounts and failing to maintain the required trust account books, violated Rules 1.15(a), (b), (c)(5) and (h), and 7.2(b), MRPC.

SECOND COUNT

Loans to Clients

14. On numerous occasions, respondent issued operating account checks to clients before he had deposited any funds on the client's behalf to either his operating or trust account. Respondent's issuance of these operating account checks constituted short-term loans to clients. Attached as Exhibit D is a list of the operating account

checks respondent issued to clients under these circumstances and the dates on which respondent deposited covering funds into his operating account.

15. Respondent made the following additional loans to clients:

a. On November 28, 2007, check no. 1884 for \$1,400, which respondent issued to his client R.W. as an advance on R.W.'s anticipated recovery, cleared respondent's operating account. Respondent received funds on R.W.'s behalf (from which respondent's loan to R.W. was presumably repaid) and deposited them into his trust account on December 20, 2007.

b. On December 12, 2007, check no. 1905 for \$700, which respondent issued to his client R.W. as an advance on R.W.'s anticipated recovery, cleared respondent's operating account. Respondent received funds on R.W.'s behalf (from which his loan to R.W. was presumably repaid) and deposited them into his trust account on December 20, 2007.

c. On December 19, 2007, check no. 1920 for \$2,000, which respondent issued to his client R.W. as an advance on his anticipated recovery, cleared respondent's operating account. Respondent received funds on R.W.'s behalf (from which his loan to R.W. was presumably repaid) and deposited them into his trust account on December 20, 2007.

d. On February 20, 2009, check no. 2600 for \$2,000, which respondent issued to his client E.A. as an advance on her anticipated recovery, cleared respondent's operating account. Respondent received funds on E.A.'s behalf (from which his loan to E.A. was presumably repaid) and deposited them into his trust account on July 23, 2009.

e. On May 14, 2009, check no. 2781 for \$100, which respondent issued to his client M.S. as an advance on his anticipated recovery, cleared respondent's operating account. It is unknown whether or when respondent received funds on M.S.'s behalf from which this loan was repaid.

f. On July 3, 2009, check no. 2917 for \$1,000, which respondent issued to his client M.S. as an advance on his anticipated recovery, cleared respondent's operating account. It is unknown whether or when respondent received funds on M.S.'s behalf from which this loan was repaid.

g. On August 24, 2009, check no. 3025 for \$155, which respondent issued to his client M.S. as an advance on his anticipated recovery, cleared respondent's operating account. It is unknown whether or when respondent received funds on M.S.'s behalf from which this loan was repaid.

16. Respondent's conduct in loaning funds to clients violated Rules 1.8(a) and (e), MRPC.

THIRD COUNT

Francis Barney Matter

17. On May 29, 2006, Frances Barney's minor sons, J.J. and C.B., were injured when a vehicle ran over a tent in which they were sleeping. Immediately following the accident, J.J. and C.B. were transported to MeritCare Hospital ("MeritCare") in Fargo, North Dakota.

18. On June 16, 2006, Barney retained respondent on behalf of her sons. Barney signed a written fee agreement that (a) identified respondent's client(s) as "C.J.," *i.e.*, an erroneous name that combined the first name of one of Barney's sons and the last name of the other, (b) indicated that respondent represented the "legal interests of" C.J., "in relation to injuries sustained by said minor," and (c) provided that respondent was entitled to "one-third of the gross recovery." Respondent failed to obtain separate written signed fee agreements on behalf of J.J. and C.B. as was required under Rule 1.5(c), MRPC. In addition, the June 16, 2006, fee agreement failed to identify the recovery against which respondent's attorney's fees would be applied. For example, the fee agreement did not indicate that respondent intended to take a contingent fee on no-fault recoveries.

19. American Family Insurance Group (“American Family”) insured the vehicle involved in the accident. Since there was no first priority coverage available from a vehicle owned by Barney, American Family provided both no-fault and liability coverage. The statutory minimum of \$40,000 in no-fault benefits was available; therefore, J.J. and C.B. were entitled to \$20,000 in no-fault benefits each. In addition to no-fault coverage, J.J. and C.B. were eligible for Medical Assistance (MA) and had been enrolled in a MA plan administered by Blue Cross Blue Shield (Blue Cross).

20. Respondent provided American Family with authorizations to obtain medical bills directly from the medical providers. During the period June 30 to July 17, 2006, MeritCare and other medical providers forwarded to American Family a series of bills for the children, who had sustained extensive injuries. J.J. incurred approximately \$18,000 in medical bills and C.B. incurred approximately \$68,000 in medical bills. Payment of these bills was not contested by American Family or Blue Cross. In the case of J.J., there was sufficient no-fault coverage to cover all of his medical bills. In the case of C.B., \$20,000 in no-fault coverage was insufficient to cover his medical bills, but Blue Cross had informed respondent that it would provide coverage once C.B.’s no fault benefits were exhausted.

21. On July 31, 2006, American Family provided respondent with a release for signature by Barney and stated that upon receipt of the signed release, “we will forward a draft made payable to you and Ms. Barney in the amount of \$20,000.00,” which will “exhaust the medical portion of [C.B.]’s no-fault claim.”

22. At or about the same time, American Family requested respondent to provide it with verification that Barney was the sole legal custodian of J.J. In an August 23, 2006, letter to respondent, American Family stated, “we had previously asked for verification that Francis Barney has sole legal custody [of J.J.]. . . . If we do not have the information, we will send payment of the medical bills directly to the providers.”

23. On September 13, 2006, respondent forwarded to American Family the signed release regarding C.B.'s no-fault claim and a "proposed" letter to be signed by Barney regarding J.J.'s custody.

24. During one or more of his communications with American Family, respondent directed American Family to forward payment of C.B. and J.J.'s no-fault benefits to him, rather than directly to the medical providers.

25. On September 22, 2006, American Family sent to respondent its check for \$20,000, made payable to respondent and Barney, in payment of C.B.'s no-fault claim.

26. On September 26, 2006, respondent forwarded to American Family a letter signed by Barney regarding J.J.'s custody. That letter was insufficient to address American Family's concerns and, on October 20, 2006, respondent forwarded to American Family a letter signed by Barney regarding J.J.'s custody on a form that American Family had apparently provided to respondent.

27. On November 3, 2006, American Family sent to respondent its check for \$16,999.95, made payable to respondent and Barney, in payment of J.J.'s no-fault claim.

28. Respondent obtained Barney's endorsement on both no-fault checks and, on November 28, 2006, deposited them into his trust account. On December 7, 2006, respondent transferred \$12,399.56 of the no-fault proceeds from his trust account into his operating account in payment of his contingent fee.² For unknown reasons, (a) on December 18, 2006, respondent transferred \$7,612.55 from his operating account into his trust account on behalf of C.B. and J.J., and (b) on January 10, 2007, respondent transferred \$7,376.38 from his trust account back into his operating account on behalf of C.B. and J.J. Thus, as of January 10, 2007, \$24,770.31 remained in respondent's trust

² Respondent had previously issued a trust account check to MeritCare for \$66.25, apparently in payment of medical records it produced. This check cleared respondent's trust account on December 1, 2006.

account on behalf of C.B. and J.J.³ At no other point did respondent return to his trust account any portion of the contingent fee he had paid to himself from the C.B. and J.J. no-fault proceeds.

29. Respondent's taking of \$12,399.56 as a contingent fee on the no-fault claims of C.B. and J.J. constituted an unreasonable fee since the children's medical bills were uncontested and respondent performed little to no legal work in resolving the no-fault claims.

30. Respondent's taking of a contingent fee on the children's no-fault claims also harmed the clients by reducing the money available to pay MeritCare and other medical providers and interfered with coverage by Blue Cross. In the case of J.J. who had approximately \$18,000 in medical bills, the \$20,000 in no-fault benefits was sufficient to pay his entire medical bill. Respondent's one-third contingent fee made the amount in no-fault benefits insufficient to cover J.J.'s medical bills. In the case of C.B., respondent was on notice that Blue Cross would not begin payment of C.B.'s medical bills until the \$20,000 in no-fault coverage was exhausted and respondent notified Blue Cross thereof. Respondent's taking of contingent fee prevented the full \$20,000 in no-fault benefits from being paid to medical providers as required by Blue Cross.

31. The Vogel Law Firm ("Vogel") represented MeritCare regarding amounts owed it for medical care provided to C.B. and J.J. On February 13, 2007, Vogel wrote to respondent to confirm matters they discussed during a February 9 telephone conversation. Vogel stated, "[y]ou informed me that you have taken receipt of [C.B.]'s no-fault medical payment in the amount of \$20,000.00 from American Family and that those funds remain in your possession in their entirety."

³ On April 9, 2007, for reasons that are unknown, respondent transferred \$25 of these funds from his trust account into his operating account, reducing the balance of C.B. and J.J. funds in his trust account to \$24,745.31.

32. The Vogel Law Firm ("Vogel") represented MeritCare regarding amounts owed it for medical care provided to C.B. and J.J. On February 7, 2007, Vogel wrote to respondent. Vogel stated that it had learned that American Family had paid no-fault benefits to respondent on C.B.'s behalf and demanded that respondent pay those benefits to MeritCare. Respondent responded to Vogel's letter by way of a February 9, 2007, telephone conversation.

33. On February 13, 2007, Vogel wrote to respondent to confirm matters they discussed during their February 9 telephone conversation. Vogel stated, "[y]ou informed me that you have taken receipt of [C.B.]'s no-fault medical payment in the amount of \$20,000.00 from American Family and that those funds remain in your possession in their entirety." Vogel continued, "I understand that you will not pay those proceeds to the medical provider, MeritCare Health System, until you have resolved your liability dispute and proceed with a minor settlement proceeding." Vogel expressed its position that no-fault benefits are not properly to be included in a minor settlement proceeding and again demanded that respondent remit those funds in partial payment of MeritCare's bills. Vogel noted that respondent's continued failure to do so prevented Blue Cross from paying the balance owed to MeritCare. Finally, Vogel asked respondent whether he had received no-fault benefits on behalf of J.J.

34. In a March 5, 2007, telephone conversation with Vogel, respondent offered to give MeritCare priority over C.B. and J.J.'s other health care providers if it agreed to respondent's retention of his one-third contingency fee despite the fact that Blue Cross had informed him that Blue Cross would not pay any of the children's outstanding medical bills until verification that the \$20,000 in no-fault benefits had been exhausted. If MeritCare had accepted respondent's offer, it would have prevented Blue Cross coverage from taking effect.

35. By letter dated March 20, 2007, Vogel rejected respondent's offer stating respondent's payment of a contingent fee from the no-fault benefits was "contrary to our understanding of Minnesota's no-fault laws and is unacceptable to MeritCare."

36. MeritCare thereafter commenced a lawsuit against Barney seeking recovery of the no-fault benefits. On April 2, 2007, Vogel mailed a summons and complaint to respondent and requested that he sign and return an admission of service on behalf Barney. At or about that time, Vogel also arranged for personal service of the summons and complaint on Barney. Barney was personally served with the summons and complaint on June 13, 2007. Respondent failed to answer the complaint on Barney's behalf.

37. On April 13, 2007, MeritCare filed and served a motion for an injunction enjoining Barney from using or otherwise dissipating any of C.B. and J.J.'s no-fault benefits and to require her to deposit those benefits into court pending a determination of what medical providers were entitled to the benefits and in what amounts.

38. In a June 6, 2007, letter, Vogel informed respondent that the hearing on MeritCare's motion had been rescheduled.

39. Neither respondent nor Barney appeared at the hearing on MeritCare's motion for an injunction. On July 9, 2007, the court issued an order enjoining Barney from "using, removing, transferring, assigning or otherwise disposing of the subject no-fault benefits pending further order of the Court." Vogel mailed a copy of the court's order to respondent on July 9, 2007.

40. On July 11, 2007, not having received an answer to the complaint, Vogel filed and served on respondent a motion for default judgment. Respondent made no response on Barney's behalf. As a result, on August 8, 2007, the court entered a \$67,996.17 default judgment against Barney.

41. On October 3, 2007, Vogel served respondent with a garnishment summons and other documents in an effort to learn what portion of C.B. and J.J.'s no-fault benefits remained in respondent's possession. Respondent failed to respond.

42. On November 19, 2007, Vogel filed and served an application for a default judgment against respondent based on his failure to respond to the garnishment papers. Respondent failed to respond.

43. As a result, on December 3, 2007, a \$69,492.68 default judgment was entered against respondent.

44. On March 5, 2008, respondent transferred the \$24,745.31 balance of C.B. and J.J. funds that remained in his trust account into his operating account. That same day, respondent issued to MeritCare an operating account check in the amount of \$32,394.74. That check cleared respondent's operating account on March 11, 2008. Vogel filed and served a partial satisfaction of judgment with regard to the judgments against both Barney and respondent.

45. During the period June 17, 2009, to January 11, 2010, respondent made additional payments to MeritCare from his own funds in complete satisfaction of the judgment. On March 4, 2010, Vogel filed and served a satisfaction of judgment with regard to the judgment against respondent.

46. Respondent failed to take action to ensure that the judgment against Barney was fully satisfied. In fact, a judgment, the principal amount of which is \$40,342.20, remains outstanding against Barney.

47. Respondent's conduct in failing to diligently resolve matters regarding disbursement of the C.B. and J.J. no-fault benefits prior to the granting of default judgments against Barney and respondent, failure to obtain separate signed written fee agreements on behalf of each client, charging an unreasonable contingent fee on uncontested no-fault claims, and failing to return his contingent fee into trust after

MeritCare disputed his entitlement to that fee, violated Rules 1.1, 1.3, 1.5(a) and (c), and 1.15(c), MRPC.

FOURTH COUNT

Bradley Hellesvig Matter

48. On January 27, 2007, Bradley Hellesvig retained respondent with regard to two separate automobile accidents: a February 17, 2006, accident (“February accident”), which involved both liability and workers’ compensation claims, and a March 22, 2006, accident (“March accident”), which involved only liability claims, including a claim for uninsured motorist benefits.

49. Hellesvig’s vehicle was insured through State Farm Insurance (“State Farm”). Hellesvig’s no-fault coverage included \$50,000 for medical expenses and \$20,000 for income loss, rehabilitation and household services.

50. Hellesvig was originally represented by another attorney, Rolf Ulleberg, who referred Hellesvig to respondent. On January 27, 2007, Hellesvig signed two written fee agreements. The first fee agreement set forth respondent’s fees with regard to Hellesvig’s workers’ compensation claim stemming from the February accident. Respondent was to receive his statutory attorney’s fees and reimbursement of his costs. The second fee agreement appears to be a contingent fee agreement covering Hellesvig’s personal injury claims. The second fee agreement is unclear, because it did not specify which accident or any of the potential claims arising from those accidents were covered. Respondent did not obtain separate signed fee agreements for both accidents as required by Rule 1.5(c), MRPC.

February Accident

51. By the end of 2008, State Farm had paid Hellesvig’s maximum amount of no-fault benefits, which was \$50,000 in medical expenses and \$20,000 for rehabilitation, for the February accident.

52. Respondent initiated litigation against the at-fault driver by serving a summons and complaint on October 8, 2007. Despite service, respondent did not file the complaint on Hellesvig's liability claim. On November 12, 2007, the defendant served a request for discovery, including interrogatories and request for production of documents. Respondent failed to respond and did not file the complaint with the court.⁴ Eventually the case was filed when the defendant filed an answer with the court in March 2008.

53. On May 19, 2008, a scheduling conference occurred and the court issued a scheduling order requiring that discovery be completed by February 1, 2009.

54. On June 6, 2008, opposing counsel, Owen Sorenson, served a notice for Hellesvig's deposition. By letter dated June 10, 2008, respondent informed Sorenson he was unavailable that date. Sorenson made numerous unsuccessful attempts to contact respondent by telephone to reschedule. On July 28, 2008, Sorenson wrote respondent "I've been unable to get a hold of you by phone. Accordingly, I've taken the liberty of just rescheduling your client's deposition . . ." and served an amended notice of deposition. Hellesvig's deposition was rescheduled to October 7, 2008.

55. On September 11, 2008, respondent served discovery on the defendant but still had not responded to the defendant's outstanding November 12, 2007, discovery requests. Sorenson answered respondent's discovery request on September 26, 2008. Respondent also continued Hellesvig's deposition to October 31, 2008.

56. On October 28, 2008, Sorenson faxed respondent to remind him that he would need Hellesvig's discovery response no later than October 30, 2008, the day before Hellesvig's deposition. Respondent failed to respond to the outstanding discover request; however, Hellesvig was still deposed.

⁴ The at-fault driver was originally represented by attorney Suzanne Wolbeck Kvas, who served discovery, but later Owen Sorenson took over the representation in March 2008.

57. On December 3, 2008, Sorenson sent respondent a stipulation to amend the scheduling order since discovery could not be completed by the time set forth in the court's scheduling order. Sorenson again noted respondent's failure to respond to discovery or otherwise complete requested authorizations, which necessitated the amended scheduling order. Respondent failed to sign and return the stipulation.

58. On December 5, 2008, respondent answered the defendant's discovery requests, more than a year after they were served.

59. On December 15, 2008, Sorenson answered respondent's interrogatories and also requested that respondent sign and return the stipulation for an amended scheduling order. On December 17, 2008, Sorenson again asked respondent to sign and return the amended scheduling order. Sorenson noted that respondent's failure to respond would necessitate bringing a motion before the court. Respondent failed to respond.

60. On January 13, 2009, Sorenson filed a motion with the court seeking an amended scheduling order. Sorenson submitted an affidavit in support thereof noting respondent's numerous failures to timely respond to discovery requests and provide signed authorizations for medical records. Only after Sorenson filed a motion did respondent sign the stipulation for an amended scheduling order on January 19, 2009. The court issued an amended scheduling order setting trial for July 7, 2009.

61. On May 26, 2009, the defendant made an offer of judgment pursuant to Rule 68, Minn. R. Civ. P., in the amount of \$10,000. Under the rule, such offer expires within ten days of being made. It is unclear whether the settlement offer was timely conveyed to Hellesvig; however, he ultimately rejected it as too low.

62. On June 15, 2009, the defendant made a new offer to settle in the amount of \$5,000. Hellesvig wanted to proceed to trial, but respondent offered to pay him an additional \$3,000 and pursue an underinsured motorist (UIM) claim in connection with

the February accident in order to persuade Hellesvig to settle the liability claim. Hellesvig accepted respondent's offer.

63. On July 17, 2009, respondent issued to Hellesvig his operating check no. 2952 in the amount of \$3,000. On July 20, 2009, respondent deposited the \$5,000 he received from the insurer into his trust account on Hellesvig's behalf. On July 23, 2009, respondent issued to Hellesvig his trust account check no. 2189 for \$5,000.

64. In July 2009, respondent gave notice to State Farm in order to preserve Hellesvig's UIM claim. By letter dated October 22, 2009, the insurer declined to pay underinsured motorist proceeds to Hellesvig, stating that it did not believe Hellesvig's damages exceeded the liability policy limits. Respondent's advice to Hellesvig to settle the liability portion of his claim for \$5,000 in exchange for respondent pursuing a UIM claim was incompetent.

65. Hellesvig thereafter became frustrated by respondent's failure to respond to his inquiries and, on March 18, 2010, demanded that respondent provide him with his entire file and other information. By letter dated April 7, 2010, respondent informed Hellesvig that he would no longer be representing him with regard to the UIM benefits.

March Accident

66. Prior to retaining respondent, Hellesvig had received from his automobile insurance carrier \$28,500 in uninsured motorist benefits based on the March accident. Respondent stated to Hellesvig that no additional uninsured benefits were available based on the March accident. Hellesvig, on the other hand, believed that, since his automobile insurance policy allowed for total uninsured motorist benefits of \$100,000 per accident, \$71,500 (\$100,000 minus \$28,500) in such benefits remained available to him with regard to the March accident.

67. Since he and respondent did not agree on the viability of any additional claim for uninsured benefits based on the March accident, Hellesvig understood that the second retainer agreement he entered into with respondent concerned his liability

claims only with regard to the February accident. Inasmuch as respondent paid himself a contingent fee from the March accident proceeds, *see* paragraph 70 below, it appears respondent had a different understanding of his fee arrangement with Hellesvig.

68. Respondent first discussed with Hellesvig's insurer payment of the remaining uninsured motorist benefits in late April or early May 2007. Thereafter, and into December 2008, respondent periodically communicated with the insurer regarding payment of uninsured motorist benefits. By January 26, 2009, the insurer had agreed to pay those benefits.

69. On approximately January 29, 2009, respondent received on Hellesvig's behalf the \$71,500 in remaining uninsured motorist benefits based on the March accident. Respondent deposited the funds into his trust account.

70. On February 5, 2009, respondent transferred \$32,495.83 of the uninsured motorist benefits from his trust account into his operating account. This \$32,495.83 was comprised of a \$23,833.33 contingent fee on the uninsured motorist benefits, and reimbursement for \$8,662.50 in out-of-pocket costs. During the period February 5 to April 30, 2009, respondent disbursed to Hellesvig the remaining balance of the uninsured motorist benefits.

71. At the time respondent paid himself the contingent fee, he did not inform Hellesvig that he had done so. Further, at no time did respondent present Hellesvig with a written settlement statement showing the total amount of the recovery, the remittance to the client and the method by which that remittance was determined.

72. Respondent's conduct in failing to clearly communicate to Hellesvig the basis and rate of his fee with regard to Hellesvig's liability claims, failing to provide Hellesvig with a settlement statement with regard to the uninsured motorist recovery from the March accident, failure to timely respond to discovery requests in connection with the February accident, incompetently advising a client on a settlement, and

remitting to Hellesvig \$3,000 of his own funds, violated Rules 1.1, 1.2(a), 1.4(a)(1), 1.5(b) and (c), 1.7(a)(2), 1.8(e), 3.2 and 3.4(a), MRPC.

FIFTH COUNT

Pattern of Client-Related Misconduct

Ed Grew Matter

73. On August 29, 2004, Ed Grew injured his right knee and left shoulder when he fell in a public restroom owned and operated by Murphy Oil Corporation (“Murphy Oil”).

74. On March 10, 2005, Grew retained respondent to represent him in recovering damages for his injuries. (Respondent also represented Grew regarding an unrelated automobile accident.) Also on or about March 10, 2005, respondent informed Murphy Oil of Grew’s slip and fall claim.

75. At the time he retained respondent on the slip and fall matter, Grew incorrectly informed respondent that the fall occurred on October 15, 2004. As detailed below, however, respondent soon became aware that the correct date of Grew’s injury was August 29, 2004.

76. On April 18, 2005, Liberty Mutual, insurer of Murphy Oil, wrote to respondent and requested information regarding Grew’s claim, including medical bills, records and authorizations. Respondent did not respond.

77. On May 2, 2005, Duluth-Superior Adjusting, an insurance claims adjuster for Liberty Mutual, wrote to respondent and stated, “I have been attempting to speak with you regarding Ed Grew’s claim.” Duluth-Superior Adjusting requested, among other things, Grew’s signature on medical authorizations and the names of all medical providers. Respondent did not respond.

78. In an inter-office memorandum dated May 24, 2005, respondent asked his legal assistant to “zero in on the date” of Grew’s fall. On June 4, 2005, respondent’s

legal assistant informed him in writing that based on Grew's medical records, the correct date of Grew's fall was August 29, 2004.

79. On June 6, 2005, respondent informed the Minnesota Department of Human Services ("DHS") of Grew's claim and requested whether it had paid any medical bills relating to Grew's fall. Respondent correctly cited August 29, 2004, as the date of Grew's injury.

80. On June 15, 2005, Liberty Mutual wrote three letters to respondent. In one letter, Liberty Mutual stated, "I have been trying to reach you to obtain an updated status regarding your client."

81. On June 16, 2005, DHS wrote to respondent and provided records reflecting the medical expenses it had paid in connection with Grew's fall. In its cover letter, DHS asked respondent to provide the names and addresses of the liable individuals and insurer. (DHS indicated the correct August 29, 2004, date of injury on its June 16, 2005, letter.) Respondent did not respond. DHS forwarded to respondent additional copies of its June 16, 2005, letter, thus renewing its request for the names and addresses of the liable individuals and insurer, on at least three subsequent occasions.

82. On July 6, 2005, in response to a June 22, 2005, request, respondent provided Duluth-Superior Adjusting with the names and addresses of Grew's medical providers. Respondent provided the same information to Liberty Mutual in a July 15, 2005, letter. Respondent again correctly cited the August 29, 2004, date of injury in this letter.

83. On July 15, 2005, respondent sent Grew a letter stating, "It looks like we have determined that your slip and fall actually occurred on August 29, 2004 based upon our review of your Orthopedic Associates medical records." Respondent again correctly cited the correct date of injury for a third time.

84. On October 19, 2005, a representative of the Minnesota Attorney General's Office ("AG") notified respondent that DHS had provided \$1,428.60 in medical

assistance on Grew's behalf for "injuries he sustained on or about August 29, 2004," and that DHS intended to intervene in any litigation in the matter to recover that amount. As is customary, the AG further wanted respondent to act as counsel to represent DHS's subrogation interest in the litigation. The AG requested respondent sign and return the October 19, 2005, agreement and provide copies of various documents. On information and belief, respondent did not sign and return the October 19, 2005, agreement to the AG.

85. On April 10, 2006, respondent finally responded to DHS's letters. Respondent confirmed that he continued to represent Grew in connection with the fall, but declined to arrange for an interview of Grew, as Liberty Mutual had apparently requested. Respondent indicated an incorrect date of October 15, 2004, as the date of injury for Grew's fall.

86. On April 17, 2006, Liberty Mutual sent respondent a second letter requesting information on Grew's claim, including medical reports and bills and signed medical authorizations.

87. On April 26, 2006, DHS sent respondent a letter enclosing records reflecting the medical expenses it had paid in connection with Grew's fall. In its cover letter, DHS advised respondent that Grew's medical expenses had increased to \$2,767.72 and again requested that he provide information concerning the liable parties and an update regarding the status of the claim. DHS cited the correct August 29, 2004, date of injury in its letter.

88. On July 24, 2006, Liberty Mutual informed respondent that it had considered Grew's claim and, based on its conclusion that "our insured is not responsible for this accident," denied Grew's claim. Liberty Mutual asked respondent to provide it within 30 days "a copy of medical expenses incurred as a result of this accident to consider under the medical payment policy."

89. On August 6, 2006, respondent sent Liberty Mutual Grew's medical bills totaling \$14,562.31 and requested a check in that amount made payable to respondent and Grew. Respondent cited for the second time an incorrect date of injury, October 15, 2004, for Grew's slip and fall.

90. On August 25, 2006, Liberty Mutual issued a \$10,000 check made payable to respondent, Grew and respondent's former law firm, as and for the medical expense policy limits of Murphy Oil's policy. Respondent did not inform DHS of his receipt of this check.

91. On April 13, 2007, Grew wrote respondent requesting that his slip and fall claim be resolved as quickly as possible.

92. On October 18, 2007, more than a year after he received it, respondent returned Liberty Mutual's August 25, 2006, check because it included respondent's former law firm as a payee. Respondent asked Liberty Mutual to issue a replacement check made payable to respondent and Grew. Respondent continued to cite the incorrect date of injury in this letter.

93. On November 2, 2007, respondent deposited Liberty Mutual's \$10,000 replacement check into his Beacon Bank business account. Respondent did not inform DHS of his receipt of this check. Respondent then issued business account check no. 1857 in the amount of \$6,266.67 in payment to Grew. Respondent retained the \$3,733.33 as his own. Respondent paid no portion of the \$10,000 in medical expense reimbursement to DHS as required by statute.

94. On June 1, 2010, Grew emailed respondent asking him to "check on the slip and fall case and let me know what the date of injury was and the status as I think the statute of limitations is approaching."

95. From August 2007 through September 2010, respondent neglected Grew's slip and fall case.

96. Respondent believed the statute of limitations was fast approaching on Grew's slip and fall claim so he served a summons and complaint on Murphy Oil on September 24, 2010. In the complaint, respondent incorrectly represented that the date of Grew's injury was October 15, 2004, when in fact it was August 29, 2004. Murphy Oil subsequently retained the Law Offices of Stilp & Grove ("S&G").

97. On October 11, 2010, S&G served an answer to the complaint, along with interrogatories, request for production of documents, request for production of statements and demand for medical disclosure.

98. On November 1, 2010, respondent forwarded copies of these materials to Grew. Respondent stated, "As you can see, the insurance company has completely denied your claim. As you know, insurance companies generally do deny claims and it will be our job to try and prove up your claim." Respondent thereafter failed to respond to S&G's discovery requests.

99. On November 12 and December 14, 2010, and January 14, February 16, and March 9, 2011, S&G wrote to respondent and requested responses to its discovery requests. Respondent did not provide discovery responses or any response whatsoever to S&G's letters.

100. S&G also wrote to respondent on February 28, 2011. In this letter, S&G advised respondent that the actual date of Grew's injury was August 29, 2004, and that his service of the complaint on September 24, 2010, exceeded the applicable statute of limitations. S&G asked respondent to voluntarily dismiss Grew's complaint. If respondent refused to do so, S&G stated that it would file a motion seeking dismissal, which would include a request for costs and fees. Respondent did not respond.

101. On March 15, 2011, S&G wrote again to respondent requesting that he voluntarily dismiss Grew's complaint. S&G reminded respondent that if he failed to dismiss the complaint, S&G would file a motion for dismissal and request an award of its fees and costs. Respondent did not respond.

102. On March 16, 2011, S&G served requests for admission on respondent. The requests sought Grew's admission that, among other things, his alleged fall in the Murphy Oil restroom occurred on August 29, 2004. Respondent failed to respond to the requests for admission. As a result, by operation of Rule 36.01, Minn. R. Civ. P., those requests were deemed admitted.

103. On April 14, 2011, S&G served on respondent and filed a notice of motion and motion for summary judgment, together with supporting documents. In these materials, S&G argued that Grew's claim was time-barred based on (a) myriad medical and other records, including respondent's own letters, that definitively established the date of Grew's injury to have been August 29, 2004, (b) respondent's service of the complaint on Murphy Oil on September 24, 2010, and (c) a six-year statute of limitations applicable to Grew's claim.

104. On April 28, 2011, respondent's associate wrote to S&G. The associate stated, "I find no good faith argument under the law to oppose this motion [for summary judgment]. I will, as you originally requested, voluntarily withdraw this Complaint. Said withdrawal, due to the tolling of the Statute of Limitations, is clearly with prejudice."

105. Also on April 28, 2011, respondent's associate wrote to Grew. The associate stated that respondent's office had "relied on your recollection of events indicating that this incident occurred on October 15, 2004," and prepared the complaint relating that fact. The associate continued, "In the course of pretrial discovery, information was obtained that indicated that the slip and fall actually occurred on August 29, 2004, some six weeks prior to your recollection." Finally, the associate informed Grew that Murphy Oil had filed a motion seeking dismissal of Grew's complaint based on service of the complaint more than six years after the actual date of injury, that there "is no good faith basis under the law for us to argue against this case," and that he was withdrawing Grew's complaint.

106. On April 29, 2011, S&G sent respondent's associate a stipulation for dismissal with prejudice. On May 2, 2011, respondent's associate signed and returned the stipulation, which S&G filed with the court on May 5, 2011. An order dismissing Grew's complaint, with prejudice, subsequently issued.

107. Respondent's conduct violated Rules 1.1, 1.3, 1.15(c)(4), 3.2 and 3.4(a), MRPC.

Janice Mattson Matter

108. On August 22, 2001, Janice Mattson (Janice) and her daughter, Samantha Mattson (Samantha), were injured when the vehicle in which they were traveling was rear-ended by another vehicle. The other driver's liability in the accident was not disputed. Janice's vehicle was insured by State Farm and she had health insurance coverage through Blue Cross. The other driver's vehicle was insured by USAA Insurance.

109. By March 2004, State Farm had paid its no-fault policy limits of \$20,000 for Janice's medical treatment. Thereafter, Blue Cross covered Janice's and Samantha's medical treatment.

110. On August 17, 2007, Janice and Samantha consulted with respondent about representation regarding the accident. Respondent agreed to undertake the representation of both Janice and Samantha. Respondent did not enter into a written fee retainer agreement with Janice until five months later on January 21, 2009. The fee agreement provided for a one-third contingent fee.

111. On August 22, 2007, a summons and complaint respondent had prepared on behalf of Janice and Samantha, who were named in the complaint as co-plaintiffs, were served on the defendants, Kathryn, Donald and Kathy Kundel ("the Kundels"). Respondent did not, at that time, file the summons and complaint with the court. The complaint asserted no actual claims on Samantha's behalf. The Kundels, who were

represented by attorney Richard Wright, served an answer to the complaint in September 2007.

112. On August 20, 2007, respondent informed USAA Insurance of Janice's claim. USAA Insurance sent respondent written requests for medical records and other information relating to Janice's claim by letters dated August 21, 23 and 28, 2007. Respondent failed to respond.

113. On September 6, 2007, respondent wrote to Duluth Clinic to request Janice's and Samantha's medical records. On information and belief, Duluth Clinic provided respondent with the requested records sometime in October 2007.

114. On September 19, 2007, Wright served discovery requests on respondent. Respondent failed to timely respond to those requests. On December 11, 2007, Wright wrote to respondent to request discovery responses. Wright stated, "Your discovery responses are now seriously overdue and we would appreciate receiving them as soon as possible." Respondent did not, at that time, provide discovery responses or otherwise respond to Wright.

115. On March 12 and July 14, 2008, Wright wrote again to respondent to request discovery responses. Respondent did not, at that time, provide discovery responses or otherwise respond to Wright.

116. By letter dated August 29, 2008, ten months after they were due, respondent forwarded Samantha's discovery responses to Wright.

117. On December 11, 2008, Wright wrote again to respondent to request Janice's responses to his discovery requests.

118. On January 5, 2009, respondent received State Farm's payment log, which showed the medical expenses State Farm had paid on Janice's behalf during the period September 2001 to March 2004. The log reflected the fact that by March 2004, State Farm had paid the full \$20,000 in no-fault coverage provided for under Janice's policy.

119. On January 22, 2009, fifteen months after they were due, respondent provided Janice's discovery responses to Wright.

120. During the period September 2007 to January 2009, respondent neglected Janice's and Samantha's personal injury claims.

121. On May 11, 2009, respondent wrote to SMDC Medical Center to request copies of Janice's medical bills. On information and belief, SMDC Medical Center provided respondent with the requested information in May and August 2009.

122. On May 29, 2009, Wright wrote to respondent requesting information about Janice's and Samantha's medical providers. Wright also asked "[w]hether there exists any liens and/or subrogation interests for benefits provided to or on behalf of Janice Mattson as a result of the August 22, 2001, motor vehicle accident and if so, please state with specificity the nature and extent of any liens that now exist and that your client claims are related to the accident in question." Finally, Wright asked respondent to provide him with a written settlement demand. On information and belief, respondent did not respond.

123. On June 8, 2009, Wright served respondent with offers of settlement pursuant to Rule 68, Minn. R. Civ. P., with respect to both Janice's and Samantha's claims. Respondent forwarded the offers to Janice, but did not thereafter respond to Wright regarding them.

124. On June 9, 2009, respondent's legal assistant stated in a file memorandum that she had attempted to reach Janice by telephone to discuss, among other things, "if anyone has paid for any bills or treatment from 8/22/01 to the present in relation to the auto collison [sic]." A notation on the file memorandum indicates that respondent was provided with a copy of the memorandum.

125. On June 11, 2009, respondent's legal assistant prepared a file memo memorializing a telephone conversation with Janice. In the memo, the legal assistant stated that Blue Cross had paid Janice's medical expenses "when State Farm stopped

paying.” Respondent did not at that time, or at any other reasonable time thereafter, contact Blue Cross regarding its possible subrogation claim.

126. On October 29, 2009, apparently as a result of respondent’s failure to respond to the June 2009 Rule 68 offer of judgment, Wright served notices of Janice’s and Samantha’s depositions. The depositions were scheduled for November 18, 2009.

127. On November 9, 2009, respondent wrote to Wright advising that he was unavailable for the November 18, 2009, depositions “that you unilaterally scheduled for our clients.”

128. On November 10, 2009, Wright wrote to respondent, stating the following:

Please be advised that I have contacted your office no less than 10 times to discuss this matter with you, [sic] the defendants’ offer of judgment and the scheduling of your clients’ depositions. I have never received a return phone call from your office in response to my many attempts to discuss this matter with you.

Wright asked respondent to contact him to reschedule the depositions.

129. On December 4, 2009, Wright served second amended notices of taking Janice’s and Samantha’s depositions. The depositions were scheduled for January 6, 2010.

130. On January 4, 2010, respondent, for the first time, informed Janice of her January 6, 2010, deposition. The depositions were later rescheduled for January 13, 2010. Respondent informed Janice of her January 13, 2010, deposition by letter dated January 7, 2010. In that letter, respondent requested that Janice arrive at respondent’s office one-and-one-half hour prior to the deposition to prepare.

131. On January 5, 2010, respondent wrote to Duluth Clinic and requested a narrative report regarding the injuries sustained by Janice in the August 2001 accident. On information and belief, Duluth Clinic provided the requested report sometime in April 2010.

132. During Janice's January 13, 2010, deposition, in response to a question posed to him by Wright, respondent stated that there were no outstanding subrogation claims. Respondent's response ignored information contained in his client file indicating that Blue Cross had covered Janice's and Samantha's medical expenses in the period after March 2004, which therefore created an outstanding subrogation claim.

133. On January 26, 2010, Wright wrote to respondent requesting, among other things, signed medical authorizations from Janice and Samantha. Respondent did not respond.

134. On February 2, 2010, Wright wrote to respondent and asked him to advise whether he would be agreeable to submitting the matter for mediation. On information and belief, respondent did not respond.

135. On March 8, 2010, Wright wrote again to respondent to request the signed medical authorizations. On April 1, 2010, respondent's legal assistant forwarded medical authorizations to Janice to sign. By April 19, 2010, respondent had not yet forwarded signed medical authorizations to Wright, prompting Wright to make another written request to respondent for the authorizations.

136. On May 27, 2010, respondent forwarded signed employment and tax authorizations to Wright. Respondent failed to respond.

137. On June 1, 2010, Wright wrote again to respondent to request medical authorizations signed by Janice and Samantha.

138. On June 1, 2010, following a scheduling conference in the matter, the court issued its scheduling order. Among other things, the order required completion of discovery by January 1, 2011, scheduled a pre-trial conference for March 1, 2011, scheduled a three-day trial beginning March 15, 2011, and required submission of all jury instructions, exhibit lists, witness lists and other trial information one week prior to the pre-trial conference.

139. On June 3, 2010, respondent wrote to Duluth Clinic to request Janice's complete medical records relating to the August 22, 2001, accident. On information and belief, Duluth Clinic provided the requested information later in June 2010.

140. On June 9, 2010, respondent forwarded to Janice medical authorizations from Wright and asked her to sign and return them.

141. On June 23, 2010, after receiving medical authorizations signed by both Janice and Samantha, respondent forwarded those authorizations to Wright. Janice, and perhaps Samantha, had made notations on the authorizations, limiting them to the period "Aug 22, 1994 to Present." Respondent did not question the notations.

142. On August 25, 2010, Wright served respondent with a notice of motion and motion and supporting documents. The motion sought an order compelling Janice and Samantha to provide complete, updated medical authorizations and awarding \$500 in attorney's fees to the Kundels. The hearing on Wright's motion was scheduled for November 9, 2010. Respondent did not serve or file any documents in response to Wright's motion, nor did he inform Janice or Samantha of it.

143. On November 1, 2010, Wright served on respondent Rule 68 "Total Obligation Offers of Judgment" directed to both Janice and Samantha. The offers were in the amount of \$10,000 each to Janice and Samantha. Wright reminded respondent of the November 9, 2010, hearing on his motion to compel medical authorizations. Respondent did not respond to Wright's offers.

144. On November 8, 2010, respondent agreed to provide Wright with medical authorizations signed by both Janice and Samantha within 48 hours. On the basis of respondent's agreement, Wright withdrew his motion to compel and cancelled the November 9, 2010, hearing. On November 9 and 15, 2010, respondent forwarded signed medical authorizations to Wright.

145. On November 30, 2010, Wright wrote to respondent stating that because respondent had not responded to his November 1, 2010, Rule 68 offers of judgment, he

was proceeding to schedule independent medical examinations (“IMEs”) of Janice and Samantha. Wright stated, “If your clients have any interest in trying to resolve this matter short of trial please contact me immediately. If additional expense costs are incurred, all previous offers for settlement will be withdrawn.” Respondent did not respond.

146. On December 1, 2010, Wright informed respondent that IMEs of Janice and Samantha had been scheduled for December 10, 2010.

147. Respondent and Wright thereafter discussed settlement. During the course of these discussions, Janice told respondent that, in order to appropriately evaluate the various offers of settlement, she needed to know the amount of Blue Cross’s subrogation claim. Respondent told Janice not to worry about any subrogation claim because, whatever the amount of the claim, he would negotiate it down to zero.

148. By December 6, 2010, respondent had agreed with Wright to settle Janice’s and Samantha’s claims for a total of \$30,000. On that date, Wright’s associate wrote to respondent confirming the settlement and requesting that respondent inform him “how much of the settlement sum will be allocated to Samantha and how much will be allocated to Janice.” Respondent determined and advised USAA Insurance that the settlement should be apportioned \$20,000 to Janice and \$10,000 to Samantha. Respondent told Janice and Samantha only that such an apportionment would protect more of their money.

149. In apparent connection with the settlement, respondent prepared an undated and untitled document directed “To Whom It May Concern,” in which he agreed, on behalf of Janice and Samantha, to indemnify the Kundels and USAA Insurance from any medical liens that may exist. Prior to signing this indemnification agreement, respondent had not contacted Blue Cross about its potential subrogation claim, nor did respondent discuss any subrogation claims with Janice or Samantha.

Respondent further signed the indemnification agreement without discussion or the consent of Janice or Samantha.

150. On December 22, 2010, USAA Insurance tendered to respondent the \$20,000 settlement check on Janice's claim and the \$10,000 settlement check on Samantha's claim. Respondent met with Janice and Samantha and obtained their endorsements on the settlement checks. At that time, Janice once again stated that she wanted to know the amount of Blue Cross's subrogation claim. Respondent told Janice not to worry and he would negotiate any claim down to zero.

151. Respondent deposited Janice's and Samantha's settlement checks into his trust account on January 17, 2011. On January 19, 2011, respondent disbursed his contingent fee on the settlements along with reimbursement for his costs.

152. At the time of settlement, Samantha had an outstanding chiropractic bill of approximately \$7,000. After respondent's contingent fee and costs were paid, only approximately \$5,900 of Samantha's settlement remained in respondent's trust account, *i.e.*, not enough to cover the chiropractic bill.

153. On or about January 21, 2011, Janice went to respondent's office to pick up the settlement proceeds. Respondent gave Janice a \$5,900 check payable to Samantha. Respondent informed Janice, on Samantha's behalf, that he would pursue no-fault arbitration with regard to the chiropractic bill and that the chiropractor, to whom respondent had referred Samantha, had agreed to accept whatever amount State Farm was directed to pay as a result of the arbitration.

154. During their meeting on or about January 21, 2011, respondent informed Janice that Blue Cross's subrogation claim, which he stated was in the amount of either \$800 or \$1,200, prevented him from disbursing to Janice any portion of her settlement proceeds. Respondent again told Janice not to worry about Blue Cross's claim, because he would negotiate the claim down to zero.

155. On February 2, 2011, Blue Cross informed respondent that its subrogation claim was in the amount of \$39,815.21. By March 1, 2011, Blue Cross had agreed to accept \$3,000 in complete satisfaction of its subrogation claim.

156. On March 3, 2011, respondent prepared a settlement statement reflecting payment of his attorney's fees and costs, Blue Cross's \$3,000 subrogation claim and a net balance to Janice of \$9,665.05.

157. When respondent informed Janice of Blue Cross's agreement to accept \$3,000, Janice stated that she would not agree to pay anything to them and directed respondent to waive their claim in its entirety. On March 23, 2011, respondent wrote to Janice and stated that he was negotiating with Blue Cross to waive their subrogation claim in its entirety. Respondent has not communicated further with Janice regarding this claim. Respondent continues to hold Janice's settlement funds in his trust account.

158. Respondent's conduct violated Rules 1.1, 1.3, 1.4, 1.15(c)(4), 3.2 and 3.4(a), MRPC.

Shawn Evenson Matter

159. On September 25, 2008, Shawn Evenson retained respondent to represent him on a personal injury claim stemming from an accident that occurred on September 8, 2008, when a vehicle he was driving was rear-ended by another vehicle. The other driver's liability in the accident was not disputed.

160. Following the accident, Evenson received regular, ongoing chiropractic treatment for his injuries. Initially, those services were covered by Evenson's insurer, Western National Insurance Company ("Western"), through Evenson's no-fault coverage.

161. On January 20, 2009, the results of an independent medical examination ("IME") of Evenson were provided to Western. On January 26, 2009, based on the IME report, Western informed Evenson that it was discontinuing no-fault coverage of his chiropractic treatment.

162. In a February 6, 2009, letter, respondent advised Evenson to continue with his treatment. When Evenson asked respondent how continued treatment would be paid, respondent stated that he would pursue no-fault arbitration on Evenson's behalf. In actuality, respondent failed to do so.

163. On April 4, 2009, Evenson wrote to respondent stating, "I am ready to settle with Progressive." On April 30, 2009, respondent wrote to Evenson's chiropractor and requested a narrative report. On or about May 21, 2009, Evenson's chiropractor provided respondent with his narrative report.

164. Evenson discontinued chiropractic treatment in June 2009. By that time, Evenson had accumulated \$1,032 in chiropractic charges that Western had declined to cover.

165. At or about the time he discontinued chiropractic treatment, Evenson asked respondent about the status of the no-fault arbitration. At that time, respondent stated that Evenson should simply pay the accrued chiropractic charges from his eventual liability settlement.

166. On June 10, 2009, after receiving Evenson's treating chiropractor's narrative report, respondent made a settlement demand to Progressive Insurance Company ("Progressive"), the other driver's insurer.

167. On June 14, 2009, Progressive responded with a settlement offer of only \$1,000. Progressive requested additional information from respondent, including Evenson's social security number and additional medical reports.

168. On June 19, 2009, respondent forwarded at least some of the additional medical records requested by Progressive, but did not specifically respond to Progressive's settlement offer.

169. Progressive wrote to respondent on July 10 and 21, 2009, requesting a response to its settlement offer. Respondent did not respond.

170. On October 6, 2009, respondent wrote to Progressive. Respondent enclosed additional medical records and asked Progressive to “make an appropriate offer that reflects this new information.”

171. On October 12, 2009, Progressive responded with a settlement offer of approximately \$2,500. By letter dated October 27, 2009, respondent informed Evenson of the offer. Respondent later discussed the offer with Evenson, who rejected it. Respondent did not inform Progressive that Evenson had rejected the offer.

172. On October 21, 2009, November 13, 2009, November 30, 2009, and April 8, 2010, Progressive wrote to respondent and requested his response to its October 12, 2009, settlement offer. Respondent did not respond.

173. Respondent did no meaningful work on Evenson’s case during the period of October 2009 to May 2010.

174. On May 11, 2010, at respondent’s suggestion, Evenson was examined by a medical doctor, who recommended ongoing treatment, but no surgery, for Evenson.

175. On June 1, 2010, respondent provided Progressive with the medical doctor’s report and asked that its settlement offer be increased. In response, Progressive offered to settle Evenson’s claim for \$4,500, an offer that apparently later increased to \$4,600.

176. On July 1, 2010, respondent wrote to Evenson and advised that, if the offer was unacceptable, the “only other choice we would have is to initiate the lawsuit.” Evenson rejected the settlement offer and directed respondent to initiate a lawsuit.

177. During the period July 2010 through January 2011, despite Evenson’s repeated calls asking that he do so, respondent failed to initiate the lawsuit on Evenson’s behalf. Further, at no time during this period or any other did respondent provide Evenson with his honest assessment of the strengths and weaknesses of Evenson’s claims to enable Evenson to make a fully informed judgment regarding the

case. In particular, respondent never discussed with Evenson whether proceeding to trial was an advisable option.

178. On February 10, 2011, Evenson wrote to respondent and advised that he was terminating respondent's services.

179. Respondent's conduct violated Rules 1.3, 1.4 and 3.2, MRPC.

WHEREFORE, the Director respectfully prays for an order of this Court imposing appropriate discipline, awarding costs and disbursements pursuant to the Rules on Lawyers Professional Responsibility, and for such other, further or different relief as may be just and proper.

Dated: 8-1-11, 2011.



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This amended and supplementary petition is approved for filing pursuant to Rule 10(e), RLPR, by the undersigned.

Dated: 8/11, 2011.



JUDITH M. RUSH
CHAIR, LAWYERS PROFESSIONAL
RESPONSIBILITY BOARD