

## **MARGARET BACH'S RESPONSE TO THE STATE BOARD OF BAR EXAMINERS**

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### **Introduction**

This is not a case of an overprotective mother so embroiled in the fight to protect her son that she has lost sight of her responsibilities as guardian. The current bitter relationship with Milwaukee County and extended litigation is because I am a good guardian and have tried to hold all parties to the law to keep my disabled child safe. But Milwaukee County's power has so corrupted the system, the disabled in Milwaukee County are not safe. Many families move to other counties just to gain basic needed services. Judges, guardian ad litem, and corporation counsel lie to save Milwaukee County money and protect their job ignoring their professional and ethical responsibilities. This is what this case is about. It is an abuse of government power, a violation of numerous constitutional, civil rights, and state laws. Wisconsin law should have protected my son and I these last three years, but the law is being ignored.

I appreciate this opportunity to present a defense to the charges against me, and only hope with so much at stake you will all take the time to read the evidence I have assembled. I realize I have a complicated case, and it is a significant time investment to read the briefs and transcripts. But if I am to be denied admission to the bar on the ramifications of my fight for my disabled son, I need a full and fair adjudication. A review of all the evidence will show my actions have not only been appropriate, they have been brave and necessary.

The bottom line is I have a disabled child with such extreme needs his care is very expensive, and Milwaukee County doesn't want to pay for it. The state paid for the care my son needed and kept him safe until he turned 19 and Milwaukee County took over. Milwaukee County arbitrarily downgraded his care, as Judge Dwyer stipulated in the first hearings in 2008. When this led to increased dangers and injury instead of increasing the care to correct the abuse Milwaukee County again downgraded his care leading to further dangers and injuries. My only single-mindedness has been to ensure my son was safe.

No parent of a disabled child should have to lose so much to gain the protections the law provides for the disabled. I have lost my job, the company car and excellent insurance benefits it provided. I have lost all my savings and 401K. I am on the verge of declaring bankruptcy and losing my home. I have suffered tremendous emotional and physical stress. On one particular occasion both my son and I were bleeding in the street with no help. We could have been killed. Still Milwaukee County did nothing. One attack caused such a severe injury I required surgery. Still Milwaukee County did nothing. I learned about foreseeable harm in my Torts class increasing my outrage at County's actions.

## **Aaron's Medical Condition**

It is important to understand what my son's medical condition is to realize what he needs to be safe. Aaron is one of only 200 cases in the world with a rare type of brain tumor called a hypothalamic hamartoma. This disability does not require a wheelchair or ramps. It requires adequate staffing to safely manage the seizures and violent, aggressive behavior.

I have tried everything to help my son medically and legally, as any good mother would. I have consulted with physicians all over the world who have some limited experience with this type of tumor. I have taken him to neuro-surgeons in New York, Boston, Phoenix, and Cleveland. We have consulted by mail with experts in France and Australia. No one has an answer. His tumor is the worst of the worst; larger, more diffuse borders, and in a more difficult location than others.

I have made myself an expert in his medical condition, even attending the medical lectures physicians attend. My close oversight and medical knowledge have saved his life on numerous occasions. I will highlight three.

First, was when Aaron has placed at Lakeview Neuro-Rehab. Aaron had failed two residential placements prior to Chileda and Lakeview was one of those. After a surgery left him with a PICC line in order to be administered antibiotics, I reminded their staff of the dangers Aaron's behaviors presented since he had pulled out IV's before and was more fragile now with a PICC line. They assured me they could manage his care. Thankfully, I went there every day after work so I was there when he got angry one night with the nurse changing his bandage and pulled out the PICC line. The staff planned on taking no immediate action, intending to wait for a doctor to arrive the next morning and examine him. I called my son's pediatrician's after hours line and a nurse told me if part of the PICC line was still inside Aaron it would slide into his heart and lungs, likely lead to an arrhythmia and he would die. It took further insistence on my part, and two calls to the doctor in charge at Lakeview to get agreement to transport Aaron to Children's Hospital. The PICC line had slid into his heart and lungs and he nearly needed open-heart surgery to get it out.

Second, was an occasion in LaCrosse while Aaron was at Chileda and I was visiting for the weekend. Aaron had a generalized tonic clonic seizure, but didn't come out of it after 10 minutes so needed to be rushed to the emergency room. Once there the ER doctor said he would do a spinal tap on Aaron to check for meningitis as a possible cause for the status seizure; normal protocol that would have caused Aaron's brain tumor to bleed out, killing him. I explained this to the young doctor and gave him the number for my son's neuro-surgeon in Milwaukee. He came back 20 minutes later and thanked me for the valuable information, saying I was right, and they would not be doing a spinal tap.

Third, was the recent hospitalization when Aaron was admitted to the ICU at Froedtert after a seizure in our unsafe bathroom caused a fall and life-threatening aspiration

requiring a breathing tube. Normal protocol in the ICU provides blood thinners to all patients to prevent blood clots due to the patient's inactivity. Again, this would have caused his brain tumor to bleed out and kill him. But because I was at his bedside 24-7, asked what pills they were giving him and why, and was well-informed about my son's rare condition, I kept him safe.

Yet, Milwaukee County and Mr, Linhart want to put Aaron back in a group home with no medically trained staff. Again, this is foreseeable harm. Chileda offered a registered nurse at all times. The nurse manager, BJ Lenz usually managed all the care for any residents, but not in Aaron's case. Because of Aaron's unique high needs and my specific competence, she had me direct all his care. This did not come at my request or insistence, but developed over time as optimal for Aaron's care.

The state recognized Aaron's severe medical condition and provided for an ambulance to transport Aaron home for weekend visits once a month and holidays. After one dangerous drive when I was alone with Aaron and he had a stroke, they realized the foreseeable harm and did the right thing. They met Aaron's needs. The state was willing to increase costs to keep a child safe, while Milwaukee County has demonstrated adults are disposable.

I have repeatedly testified that only a medically fragile group home would meet my son's needs, and the former group home supervisor agreed. But medically fragile group homes are much more expensive, so they have never been offered. It is not that I refuse to consider other options, but that every option presented did not meet Aaron's needs and would put him in danger. A guardian has a duty to object. I have not been unreasonable and single-minded as the Bar's summary concluded. My only single-mindedness was for ensuring Aaron's safety, insisting his needs be met, and the law followed.

Aaron has between one and three partial complex seizures a day. The more serious generalized tonic clonic seizures occur four to six times a month. They usually occur at night, but he can fall over anytime without warning making physically close one-on-one care imperative. During the nighttime generalized tonic clonic seizures he has incontinence frequently. So the care is significant. He must be closely monitored to ensure he is not in a status seizure that requires emergency treatment. He must have time to recover to then be able to safely move into the bath to clean up, which is very difficult because he cannot lift his leg over the side of the tub or have the balance and muscle strength to sit down in the tub. And he is very unsteady standing. He then has to be dressed and clean sheets put on his bed. This can occur one to three times during one night. It is physically exhausting.

Margaret provided this care alone for 14 months while working full time and going to law school at night as a single working mother. Milwaukee County would not provide any night care providers because it was too expensive, not because there was no need. All parties testified Aaron required 2 people 24 hours a day to be safe; they just refused to provide it for three years. The appendix contains a page listing all of the written requests Margaret made to gain this 24-hour care. (Appendix, 8e) Not a minute of care

was ever refused. Judge Flanagan continued to give Milwaukee County complete discretion in spite of the obvious dangers and hardship this severe understaffing caused.

In addition to seizures, the other medical complication of Aaron's tumor is violent, aggressive behavior. This is more frightening and possibly fatal than his seizures. This is what prompted me to file a CHIPS petition in 1999, (Appendix, 6, p. 32) and search out residential placement. My judgment is clear. I know when the situation is too unsafe and removal from my home is necessary. No parent can know how agonizing a decision this is until they hear their child say, "Please Mom, don't make me go back there, I promise I'll be good this time". Especially, when he can't help the behavior.

All of Aaron's doctors, and all the published literature on this rare tumor agree the violent behavior is uncontrollable. (Appendix, 5, p. 28; 8c, p. 95) It is organic; caused by the tumor. The staff at Chileda where Aaron lived for 7 years agreed. Aaron's teachers have all agreed. Aaron's family and care providers agree. All the people who know him best agree with the medical literature and physicians.

So who doesn't agree? Mr. Linhart, Karen From, and Dr. Mooney, the court appointed "expert" disagree Aaron's behavior is caused by the tumor and uncontrollable. Their expertise and judgment have to be questioned when they all have an economic incentive to lie and disagree with all the medical authority. Both Mr. Linhart and Dr. Mooney are old friends with Milwaukee County Disability Services having worked with them for years. Dr. Mooney said she has worked with them for 15 years and trusted their decisions implicitly. Mr. Linhart used to be employed by Milwaukee County Disability Services until he left to start his guardianship business with referrals from his old friends. Both rely on Milwaukee County for their income.

Karen From had no past with Milwaukee County running her own small agency out of her home, but was also hoping to gain their lucrative business and be paid to supply services to Aaron, so has questionable credibility. Also making her opinion questionable is the fact that Karen has testified she only provides non-medical care, has personally not been able to control Aaron herself, does not provide the 24 hour back-up required, and yet had agreed to provide care for Aaron until Margaret's e-mail exposed these concerns. More on her specific allegations will be detailed below, but any good guardian would object if the contract provider could not provide the services they were contracted to provide, putting the disabled client at risk. This objection to Karen's agency was not evidence I had lost objectivity, was embroiled in a fight and not seeing clearing, or "blocking efforts on Aaron's behalf". It was being a good guardian.

Dr. Mooney stated she got her information to conclude Aaron could control his behavior from past care providers of Aaron's I had fired for misconduct, and the agency managers who did assessments of Aaron. Fired care providers cannot be trusted to give honest, accurate information. Agencies who only met Aaron for one to two hours for an assessment cannot know him as well as his teachers, doctors, aids and family who care for him. They have a financial incentive to lie because they rely on Milwaukee County

for their livelihood. They also do not have the skill and training of a medical professional to comment on such a rare medical disorder.

The agencies' actions support my consistent position that appropriate staffing is a critical need to safely manage Aaron's violent, uncontrollable behavior. For two years Milwaukee County, and Mr. Linhart's testimony maintained Aaron could be safely cared for at \$213 a day. Yet, contrary to that, every agency that evaluated Aaron gave estimates of \$840-\$1200 a day, not including room and board. So who made up the difference? Margaret was forced to, in violation of Wisconsin Statute Section 49.90 that states no parent can be forced to support their child over 18 years old. In fact, in the initial hearings both Mr. Linhart and Judge Flanagan recommended exactly that, asking Margaret to pay for the extra care her son needed to be safe.

Judge Flanagan removed my guardianship because the home was so unsafe and she concluded it was my fault for not being more cooperative and agreeable with Milwaukee County. So they appoint their friend to be corporate guardian and easily work to move Aaron to one of these agency group homes. History proved them wrong. They have had complete control since giving Mr. Linhart guardianship September 9, 2009, but Aaron is still at home.

Aaron is still home because it is a cheaper option for Milwaukee County. No group home would have a mother there like Margaret willing to give her entire income to pay for Aaron's needs. I am only paid as a lower paid aid, but I provide all the services of an aid, a supervisor, and a nurse. If an agency could keep Aaron safe and make a profit, he would have been moved to one by now. The fact that he is still home proves Margaret was not the problem in not "objectively reviewing all options".

I was just never given safe options that met Aaron's needs.

Margaret actually found new options to fund Aaron's care, but because Aaron needs are so extreme these options were infeasible. Through extensive networking Margaret found out Medicare would pay for four hours of care a day, so Milwaukee County would not have that expense. I alerted Milwaukee County Disability Services and it was thoroughly investigated. But because these programs pay such a low reimbursement once the providers heard about Aaron's extreme needs, both medically and behaviorally, they declined to provide this care.

The only service ever declined by Margaret was the behavior consultant Milwaukee County offered to come to the home for a one to two hour visit to give tips on managing basic behavior difficulties. Margaret did speak to the representative arranged through Mr. Linhart for this service, but when Aaron's details were explained they declined the offer because they said they had no solutions for behaviors caused by brain tumors. Incredibly, County will pay someone to come to my house and talk about setting limits and using positive reinforcement for minor behavior issues, but the extreme danger and injury necessitating a surgery on my elbow is left unaddressed. A clear explanation of

Aaron's medical condition is not "stonewalling, obfuscating or outright opposing" supportive services Aaron needs.

Perhaps it would be helpful at this point to explain these violent behaviors Aaron has no control over. There is often no antecedent. He can go from laughing happily one second to throwing the TV a second later. He will hurt himself and others. Self injury has included cutting his wrists, pulling off fingernails and toenails, running into a busy street to try and get hit by a car, banging his head into walls, putting his fist through glass windows, trying to throw himself down the stairs, and gouging at his eyes. Attacks are often directed at others. He has stabbed his mother in the face with a knife, kicked, bitten, scratched, pulled hair, and knocked heavy furniture over on people causing injury. Attacks can also be directed at property causing significant damage. Even at the group home for only one month Aaron managed to throw the TV three times.

Included in the appendix are the West Allis Police reports that support the dangers I describe, refute Karen From's reports I decline help when needed, and further explain why no agency has offered to take Aaron even when pressured by Milwaukee County and approved by Mr. Linhart. (Appendix 8a, p. 55) After so many dangerous 911 calls in 2008 West Allis police called to ask who the agency was responsible for Aaron's care because they saw the constant dangers due to understaffing as more than negligent. They were planning to criminally prosecute the agency responsible. Sadly and surprisingly once they learned no agency was responsible, but it was Milwaukee County controlling the level of care, they checked with a supervisor and then declined assistance saying it was a civil matter, and they were very sorry. How can criminal behavior be allowed if it is Milwaukee County doing it?

Any agency would likely decline understaffed underfunded care if it put them at risk of criminal charges. That explanation is more logical than County's explanation I was just difficult to work with, and that was why no agency would take Aaron.

One dangerous behavior deserves extra emphasis. It was even documented in Milwaukee County Disability Service's files. Sandra Butts stated Aaron would be unsafe for community placement due to his history of running into the street. It happened consistently at his prior placement at Chileda, a locked facility with three staff. Yet, they moved him to a group home on a busy street with less staff, and much lower quality staff. Within one week he was in the street; just lucky no cars were going by at the time. Nothing was done after this incident to prevent further occurrences. I bring up foreseeable harm, speak up to unsafe care, and they take away my guardianship.

Aaron's violent behaviors have occurred consistently in every place he has lived: school, home, group home, Chileda, other residential placements. The only reprieve came after a gamma knife surgery in 2003, but it did not last. He has failed 29 medications and 5 surgeries tried to control his violent behavior and seizures. Any medication choice is made cautiously because most behavior medications make seizures worse, and many seizure medications make behavior worse. Frequently, a new medication appears effective but then three or six months later the efficacy is gone and increased doses do not

restore the initial effect. Having said that, two recent behavior medications have helped significantly: Propranolol and Sertraline.

All of Aaron's physicians, teachers and staff agree his behavior has improved since returning home from Chileda. Neither Mr. Linhart nor Karen From have personal knowledge having no personal contact with Aaron. Mr. Linhart did one assessment of Aaron in 2008, saw him in court, and twice for school meetings in three years. He has no idea if Aaron's behavior has improved or not. Karen From has not worked with Aaron in years. Even when her agency provided Aaron's care she had Bev McCarthy supply 90% of that care, so she herself had no knowledge of Aaron's changes in behavior. Only after challenged by Margaret with her incompetence and inability to provide the care Aaron needed did she claim Aaron's behavior had become worse.

Dr. Mooney made this claim of worsening behavior in court, which Judge Flanagan relied on although it was impeached by Margaret's testimony, all the physician reports, and the teacher's testimony. Judge Flanagan never gave any reasoning in her decision why all this evidence and testimony was not credible, only stating she found Karen From credible. While a circuit court has discretion to determine the credibility of witnesses, in cases as here where there is clear error the Court of Appeals can overrule. Anderson v. City of Bessemer City, N.C., 470 U.S. 564, 575, 105 S.Ct. 1504, 84 L.Ed.2d 518 (1985) Clear error is defined as when "[d]ocuments or objective evidence may contradict the witness' story; or the story itself may be so internally inconsistent or implausible on its face that a reasonable fact finder would not credit it." Kidd III v. Illinois State Police, 167 F.3d 1084, 1095 (1999).

Dr. Mooney's claim of worsening behavior was proven wrong in six ways. 1.) It was contradicted by those who know Aaron best, and had personal knowledge of his behavior: his physicians, care providers, teachers, and family. (Appendix 8c, Transcripts) 2.) Dr. Mooney skewed the measurement of Aaron's behavior by not including the first four months of Aaron's time at home when his school behaviors were bad but his home behavior was excellent. (Appendix 8d, p. 143) 3.) Dr. Mooney used only one graph of Aaron's Physical Aggression and Severe Physical Aggression from Chileda when they had five different graphs for other bad behaviors, and compared this to Margaret's journals reporting all bad behaviors together on one graph. (Appendix 7, p. 50-54) 4.) It inaccurately claimed the graph represented two bad months before behaviors at Chileda improved when it was two years. 5.) It ignored the obvious likely cause of the improvement in behavior: Aaron's brain surgery in 2003. Instead Dr. Mooney concluded the improvement in Aaron's behavior was due to the institutional setting working to control Aaron's aggression after two years. 6.) It is easier to keep behaviors in check with adequate staff, which Chileda offered but Milwaukee County denied Aaron in his home.

This is clear error. All the points above were made in court except number 3 because in violation of Evidence Rule 907, we were not allowed to take a deposition of Dr. Mooney and had very limited time for cross examination.

## **Mr. Linhart's Allegations**

Addressing Mr. Linhart's inaccuracies from his interview the first is shown on the last paragraph of page one. Aaron did not "age out" of the juvenile facility as Mr. Linhart knows from information I shared with him at our first meeting and the testimony in court October 21, 2008. Lynn Kay, the director of Chileda where Aaron resided for seven years testified Aaron could have stayed at Chileda until he was 21 years old. (Transcript 10-21-08, p. 139) It was Milwaukee County who forced a move when Aaron turned nineteen because they said they could not afford the cost of care at Chileda, and insisted on a reduction in care and services moving Aaron to a group home. Judge Dwyer stipulated to this at the hearing June 12, 2008. (Transcript, p. 5) Judge Flanagan also stated additional care was not approved for Aaron for financial reasons. (Transcript 1-20-09, p. 20)

The report of Aaron's sexual abuse is also inaccurate as compared to the record in the tort lawsuit filed against Mr. Linhart January 11, 2010, my past testimony on this topic, and the information I shared directly with Mr. Linhart at our first meeting. First it was not the only reason I removed Aaron from the group home. The group home had failed to meet Aaron's needs and keep him safe; the sexual assault was just the last straw. Even the supervisor from the group home admitted Aaron was too severe both medically and behaviorally for them to manage. In the one month Aaron spent at the group home twice I arrived for a visit and found him in such a medical crisis their staff had not recognized that I took him to the emergency room and he was severe enough to be admitted.

In addition to the inadequate medical oversight, there was also a previous assault documented by the group home. Aaron was upset refusing to go up the stairs at the group home, so a staff tried to physically move him and Aaron hit him in the face. The staff retaliated in anger by dragging Aaron up the stairs causing a severe abrasion. When I arrived it was weeping with pus, and had gotten no medical attention. The staff defended the action stating Aaron was being difficult. I took a photo, admitted in evidence to the court of the wound still visible five months later.

In the one month time Aaron was at the group home he had consistent staff turnover with staff assaulting him as described above, or staff too frightened to care for him that they walked off the job. On one occasion I stayed alone with Aaron until the next shift came in. One staff specifically hired to monitor Aaron after one of the hospital stays admitted to me she had not even read his file and knew nothing about what to watch for in managing his care. She left after I called the supervisor, and he admitted this was unsafe.

In summary, the group home failed for a variety of reasons: inadequate medical care, danger having run into the street once already with no available remedy, Aaron's difficulty navigating their stairs, the uncontrollable behaviors making him unsafe with available staffing/funding, and the sexual assault. Still, today Mr. Linhart argues this is the best option for Aaron.

Aaron was not seen at both Froedtert and Children's Hospital for the sexual assault. Having called Aaron's pediatrician the night I discovered the injury, he recommended I take Aaron to Children's Hospital in the morning because their staff has experience communicating with children of his functional level for these matters. So we went to Children's Hospital where Aaron repeated to them what he had told me: "Donald was mean to me, hurt me, and it's hard to explain." While some of the physical findings I had seen the night before were gone, the trained staff at Children's Hospital were concerned enough they called the police and tested for sexually transmitted diseases. The night before Aaron told me his butt hurt when he tried to wipe it while on the toilet. He asked me to wipe it and when I did I saw red abrasions all around his anus.

The circumstances that day were also suspicious. He had been alone all day with one staff, a big man named Donald. I met Donald and Aaron at Froedtert that afternoon for a physical therapy appointment. Donald was acting strangely. In the past when Aaron would get agitated, Donald would intercede to keep me safe. That afternoon Aaron attacked me in the Froedtert lobby and Donald just stood back and watched. Then that night when I arrived to give Aaron a bath and tuck him in, instead of staying around to talk like usual, Donald gave me a guilty, nervous look and made some excuse why he had to rush off.

Another suspicious factor that supported my conclusion Aaron was sexually assaulted was the chilling comment Donald's co-worker made to me a few days afterwards. She was there that morning and admitted seeing Donald kneel on top of Aaron's legs in a restraint in retaliation for Aaron throwing the TV. She said she yelled for him to stop because he was 300 pounds and Aaron was screaming it hurt. When informed of Aaron's abrasions around his anus that I observed she said, "I left at 8:00 am, what happened after I left, I don't know nothing about."

One final suspicious factor indicating Aaron was sexually assaulted was his new onset of rectal bleeding since arriving at the group home. Aaron never had this symptom at Chileda. I was doing his laundry and noticed a lot of blood stains in his underwear. I followed up with Aaron's physicians but the gastroenterologist who scoped Aaron made no definitive findings. Once Aaron moved home the blood stains in his underwear disappeared. My conclusion is not unreasonable.

My conclusion was even supported by Corporation Counsel, (Transcripts 7-22-08, p. 14) and Kevin Madson of Milwaukee County Disability Services, (Transcripts 10-21-08, p. 48-66). Corporation counsel and Mr. Madson both denied their statements in subsequent trials.

Aaron's needs are far beyond any one person's education and knowledge. No one person is safe managing Aaron's aggressive behavior. Aaron is just physically too strong. Mr. Linhart seemed to indicate Margaret was uniquely unqualified on page two. There was never any evidence introduced that I let Aaron get away with things he should not be allowed to do. No example was provided here.

Dr. Fischer did do some formal training on how to safely restrain Aaron and manage his aggression for Margaret and her family when she requested it. Chileda found Margaret uniquely qualified to manage Aaron's care, approved of monthly home visits and vacation weeks. The state ensured another staff was there at all times to be safe. Staffing is the key, as Mr. Linhart testified to himself, Aaron needs two people at all times to be safe. (Transcripts 10-21-08, p. 103, and Transcripts 4-8-10, p. 77)

Aaron's consistent organic aggression has lead to injuries for staff at every place Aaron has ever been placed. Margaret is not uniquely unqualified as Mr. Linhart asserts. Aaron's Children's Court Record, and the Chileda record confirm this. (Appendix 6-7) This is Aaron's disability. Aaron's first placement at St. Aemelians only lasted three days when they called and told me to come and pick him up because they could not manage him.

Mr. Linhart complains of my communication delay in informing him of Aaron's recent hospitalization, but doesn't tell the whole story. I told Mr. Linhart I provided the staff with his information in the ER as I always did knowing they notify him to gain consent for treatment. I usually follow up sooner to notify him, but I didn't for two reasons this time. First, this was a frightening life and death ER visit. I never saw doctors and nurses move so fast. We never even got all the way checked in before they whisked us to a room, and a CAT Scan within ten minutes. The concern for stroke and then aspiration provided an urgency I had not seen with past admissions. I explained this severity to Mr. Linhart. I was physically exhausted up the whole night suctioning him in the ICU as he gagged on the breathing tube all that first night. Even the second night I was only given a hard chair and got very little rest. Knowing the hospital contacted him I saw no urgency for calling him to provide additional detail.

Especially because Mr. Linhart has been historically bad at communicating with me at all, in court complaining my two questions per week were too much so he saw no obligation to respond. (Transcripts 4-13-10, p. 93) Even with medical matters. As my Argument noted after the trial to remove him as guardian he refused to get HIV results for Aaron after a significant blood-on-blood exposure for months. It took 7 months in all and a court order to get Mr. Linhart to make the phone call necessary to get these results. Not to mention repeated requests from Margaret, Aaron's physicians, and the staff at Disability Rights Wisconsin.

Mr. Linhart also never responded to Margaret's request if he wanted certain medical reports. (Transcripts 4-8-10, p. 105) He took 15 days to respond to a physician's request for approval of a medication change that was causing bad side effects for Aaron. (Appendix 8g, p. 153, E-mail from 10-10-09; Transcripts 4-8-10, p. 104) Mr. Linhart took four months and needed a second request from Aaron's psychiatrist, Dr. Barthel to authorize his ability to communicate with Aaron's new neurologist; essential for Aaron's medication management. (Dr. Barthel's letters from 12-18-09 and 3-5-10; Transcripts 4-8-10, p. 104-105, 61-62) Therefore, Mr. Linhart's poor communication in the past and inattention to medical urgency lead me to believe an e-mail two days later with the additional detail of Aaron's recent hospitalization was sufficient. (Appendix, 12, p. 180)

Mr. Linhart claimed I did not notify him of this hospitalization, but the e-mail proves I did. Additionally, the hospital always has to call him for consent so I knew he was informed immediately. Finally, Mr. Linhart provides no reason why this communication was a difficulty, or not in Aaron's best interests.

The final full paragraph on page six of Mr. Linhart's interview is completely false. There is no evidence I have "blocked all efforts on Aaron's behalf". In fact there is no evidence I have been anything but a passionate advocate for Aaron's needs. Mr. Linhart provides no specific example. I agree consistent treatment is important, but strict treatment would be inappropriate and only escalate Aaron's behaviors and dangers. Even in the group home they tried to placate Aaron if at all possible. My history of having a positive, close working relationship with Childea and Aaron's school prove I do not feel I am the only one that understands and can handle him. I placed him in residential care when necessary.

Mr. Linhart states I allow him too much freedom, placing others in dangers of injuries, but provides no examples. Aaron's disability is what places him and others in danger of injuries, especially if understaffed. I have been the only one consistently and persistently arguing for the adequate staffing he needs to be safe, even though all parties have agreed what that adequate staffing is: two people 24 hours a day. (See Appendix 8e, p. 146 and Transcripts cited below)

Mr. Linhart has no personal knowledge of Aaron's behaviors having only brief exposures to him. While as a guardian he was required by law to do monthly visits, (Wis. Stat. § 54.25(1)(b)) he has not. Since gaining guardianship 17 months ago, Mr. Linhart only saw Aaron briefly at two school meetings, and was at our home once just last month for ten minutes to introduce Mr. Bill White from the Weisman Center who was there to do an assessment. He has no personal knowledge on if Aaron is manipulative, and cites no reference or example.

While the statement I have been injured numerous times is accurate, the key causation of Aaron's disability and being dangerously understaffed is left out. It is only logical that a care provider is safer with two people when a 225-pound man full of adrenaline is attacking them. Of course there will be injuries. Everywhere Aaron has lived or gone to school people have been injured due to his disability. The injuries are just more frequent and more severe when he is understaffed.

The statement "Aaron has the ability to control his outbursts" is contradicted by a mountain of evidence. As I reported earlier, everyone who knows Aaron best and has personal knowledge of his behavior would disagree with that statement. Aaron's physicians report the opposite, (Appendix 8c, p. 95; Transcripts 4-8-10, p. 61-67) his staff at Childea that kept him safe for seven years reported the opposite. His teachers from Fairview South where he went the last two plus years report the opposite. All of his current and most past care providers report the opposite, as does his family. Also on this

mountain of evidence is the medical literature on Aaron's rare type of brain tumor. (Appendix, 5, p. 29) Mr. Linhart's contrary conclusion is not credible.

Mr. Linhart cites the Chileda comparison as provided by Dr. Mooney and used by Judge Flanagan, but I have addressed above why this is not accurate. Dr. Mooney even contradicted herself in her report stating Aaron still exhibited dangerous behaviors at the end of his stay at Chileda. (Appendix 8vi, p. 128, Mooney Report, p. 4) Specifically, "[a] 2006 summary stated, 'when behaviors occur they typically are easily ignorable and redirectable but can escalate quickly in their severity'. He still tended to 'perseverate and/or aggress if things aren't going as planned', and he still exhibited 'opportunistic revenge' toward peers." Aaron was not cured by the seven years of expert treatment at Chileda or the brain surgery. He still needed adequate staffing to insure the safety of himself and those around him.

Mr. Linhart seems to infer he does not believe Aaron requires two people 24 hours a day to be safe on the bottom of page two in his interview. But Mr. Linhart has testified that Aaron does need two people 24-hours a day, and more skilled than average care providers. Every other party agrees this is the level of care Aaron needs to be safe:

Judge Dwyer	6-12-08 Hearing Transcript R. 100, p.15-16
Kevin Madson	10-21-08 Hearing Transcript R. 127, p.48-63
Richard Linhart	10-21-08 Hearing Transcript R. 127, p.98-103
Geri Lyday	10-21-08 Hearing Transcript R. 127, p.10-17
Alexa Tatalovich	10-21-08 Hearing Transcript R. 127, p.140-143
Judge Flanagan	10-28-08 Hearing Transcript R. 128, p.124-131
GAL Ruthmansdorfer	7-22-08 Hearing Transcript R. 102, p. 15-16
Mr. Linhart	10-21-08 Hearing Transcript, p. 102-103; and 4-8-10 Hearing Transcripts, p. 77

The law requires Aaron's needs be met. Wisconsin's protective placement statute reads:

The legislature recognizes that many citizens of the state, because of serious and persistent mental illness, degenerative brain disorders, developmental disabilities, or other like incapacities, are in need of protective services or protective placement. . . . allow the individual the same rights as other citizens, and at the same time protect the individual from financial exploitation, abuse, neglect, and self-neglect. This chapter is designed to establish those protective services and protective placements, to assure their availability to all individuals when in need of them, and to place the least possible restriction on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, financial exploitation, neglect, and self-neglect.

Wis. Stat. § 55.001

The second relevant statute is the Wisconsin Patient Bill of Rights. Disabled individuals “[h]ave a right to receive prompt and adequate treatment, rehabilitation and educational services appropriate for his or her condition, under programs, services and resources.” Wis. Stat. § 51.2(f).

Therefore, it is irrelevant if Mr. Linhart knows of other wards who need two people 24-hours a day, or if the County provides this level of service for anyone else. What the law requires is that Aaron gets what he needs to be safe. No one has ever denied that he has very high needs, or that it requires two people 24-hours a day. So it is not just as Mr. Linhart claims, that “Ms. Bach insists there is no other way to handle Aaron’s angry outbursts.”

History has proven this need. Chileda had three staff to safely manage Aaron’s aggressive behaviors, and in seven years there he was never assaulted once. The group home Aaron was placed in for that one month had two people for all daytime hours. The day Aaron was assaulted was an exception because they kept him home from school unexpectedly. In that one month Aaron was assaulted twice. Aaron has been home for over three years now, with one assault. One care provider used an overly aggressive restraint leaving severe bruising. Aaron was traumatized, refusing to work with him. That man has since been fired. Aaron was alone with me 16 hours a day for over a year. We did not get the adequate care of two people 24-hours a day approved until November 19, 2010 when I had three limbs unusable. It took a broken foot, surgery to my left elbow, and an attack on my right wrist to get this adequate level of care.

Mr. Linhart seems to falsely claim Milwaukee County does not provide such a high level of care to any other disabled resident. Evidence was introduced in the hearing October 28, 2008 (Transcript, p. 96), and never challenged, that Milwaukee County pays \$1500 a day for one person’s care. Aaron’s care is below that with two workers earning \$15 a day coming to \$720 a day. To be precise, that was reduced to a lower pay of \$12 an hour for seven hours a day, so the total is \$699. No money is currently allowed for any activities, day program, transportation, room and board, medical expenses, or workers compensation as initially promised by IRIS. These additional supports are supplied to other disabled citizens.

Mr. Linhart claims he “strongly feels Aaron should be placed outside the home”. First of all, if that is true why has he not done so having had complete control for over 17 months now? I submit it is due to financial constraints and liability from understaffing the care as detailed earlier in this document. Second, he testified to the opposite in the hearing October 21, 2008, “[home] is the least restrictive placement, and it could be, with a -24-hour support, could be the most appropriate place for Aaron. (Transcript, p. 106) So what changed? Aaron’s condition has not gotten worse. But I have sued Mr. Linhart to make him accountable for the harm he has caused.

I have never attempted to overbill my time to the Department of Health Services. No one has ever accused me of this. The time sheets I turn in have been complicated at times because IRIS reduced the hours of care they would cover after five months without any notice. So I turned in time sheets with hours for myself plus two aids as I had without problems for five months, but in July of 2010 they simply didn't pay the amounts because they had reduced the level of care to only two (me and one aid), but never notified me to schedule accordingly. Mr. Linhart approved of this reduction, but also never notified me.

In an effort to keep my valued, good workers for Aaron I instructed the IRIS staff to pay my workers first, and then pay me whatever was left. So while my time sheets had a greater number of hours submitted than I was paid for, I worked every hour I submitted.

Another complication with the time sheets occurred when Mr. Linhart authorized a reduction in pay from \$15 an hour to \$12 an hour for seven hours a day in order to take advantage of federally funded "personal care" hours made available. For six months these personal care hours paid \$15, but then changed. Mr. Linhart approved of this change even though he testified Aaron needs above average workers to be safe because of his high needs, and that average workers make \$10 to \$12 an hour. This change led to some initial math errors in calculations, but no time sheet was ever fraudulent, and no one ever accused me of overbilling my time.

Mr. Linhart tendered his resignation in July, as his attorney threatened would be a result of my tort complaint. He claims he was at the ARC assessment and I "was fighting the change at every chance". This is not true. He was not at the assessment as evidenced by written statements of the people who were there. (Appendix 10, p. 176-177) ARC never said they planned to reduce Aaron's level of care. In fact, when I followed up with them after reading Mr. Linhart's claim they said they had not agreed to be Aaron's guardian yet, and that their agency strongly supports and advocates for the services the disabled need to be safe. And as I have mentioned before, there is a mountain of evidence and all parties agree Aaron needs two people 24-hours to be safe.

Mr. Linhart's nod to his 30 years experience should not be given much weight. Experience does not equal competence or ethical values as the recent case of Estate attorney Leonard Brady proves. This man was a respected professional practicing for 57 years before being caught stealing from clients. The evidence of lies Mr. Linhart told in court prove he is no better. The Argument I wrote for a closing statement in the hearings to remove Mr. Linhart as guardian detail the specific examples of his perjury. (Appendix, 8f, p. 147) No court should allow lies. Corporation counsel violated her ethical responsibilities by first calling Mr. Linhart to lie about \$213 a day being adequate to meet Aaron's needs in the October 21, 2008 hearing.

I strongly disagree with Mr. Linhart's statement I "made an effort to stop or alter every plan he tried on behalf of Aaron." There is no evidence of this. Reading the transcripts from the hearings will prove this statement untrue. The only complaint County made in this regard was that by my supplying agencies assessing Aaron with copies of the 911 calls and West Allis Police information it was thwarting their chance to place Aaron more

cheaply outside the home. But this is exactly the proper information to supply to any care provider so they don't repeat the mistakes of understaffing that led to those dangers. Providing complete information of a ward's needs is the duty of a guardian.

If there are "proper and adequate facilities and personnel available to care for Aaron" why has the all-powerful Milwaukee County with Mr. Linhart in approval as legal guardian not moved Aaron to one of these facilities in the last 17 months?

Margaret has not "run out of advocates". Lisa Foley with Disability Rights Wisconsin argued passionately as Aaron's adversary counsel that Margaret was a fine guardian and did not deserve to have her guardianship removed. Jeanne Welcenbach wrote a compelling brief in support of the same conclusion. Catey Doyle with the Legal Aid Society of Milwaukee has argued the tort lawsuit is valid and should not be dismissed.

Advocates or not, I will prevail. I fight a just cause, Marquette Law School provided me the tools to wage this battle, and I always remember being inspired by Gideon's Trumpet when I read it in high school. This will be a landmark case that will stop the abuse of thousands of disabled citizens in Milwaukee County.

**MARGARET BACH'S SUPPLEMENTAL RESPONSE**

## TO THE STATE BOARD OF BAR EXAMINERS

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### Introduction

I appreciate the opportunity to supply additional information to the Board before any decision is made on my character and fitness to practice law in Wisconsin. In an effort to comply with the Board's request I focus on my character alone and not discuss my son's court case I did not include much detail to support my allegations against Judge Flanagan, the Guardian ad Litem Elizabeth Ruthmansdorfer, ("GAL") or the Corporation Counsel Jeaneene Dehring. The only detail was found in my briefs, Exhibits 3 and 4.

But it was obvious from the questions on May 20, 2011 and Professor Blinka's comments about Judge Flanagan that a real question is still outstanding. Am I being reasonable in my accusations against Judge Flanagan, the GAL, Corporation Counsel, Dr. Mooney, Mr. Linhart, Ms. From, and Mr. Madson? I believe I am and I would like to take this opportunity to prove my case as succinctly as possible.

The undisputed historical facts of this case, where Aaron and I are today, are proof of misconduct by all involved. I say this because all lawyers and judges are required to take an oath to support the Constitution of the United States and Wisconsin's Constitution. (SCR 40.15, Wis. Stat. § 757.02) No judge or lawyer is above the law.

The fact is Aaron was brought home to live with me November 2007. He was under protective placement and I was his guardian. He did not get 24-hour care at all until January 20, 2009 when I filed a Motion for Enforcement of Order and a hearing was held. He did not get the 2 people 24-hours a day all parties agreed Aaron needed to be safe until November 2009. The court has continually acknowledged Aaron was unsafe in the current placement, year after year. Judge Flanagan, the GAL and Corporation Counsel advocated moving Aaron from his home from the start, took away my guardianship to facilitate that move, but he is still in my home understaffed. These are undisputed facts.

Numerous laws and constitutional protections had to have been violated for this outcome to occur. There was no error in communication about Aaron's needs or situation. Page 146 in your binder provides a list of all the formal efforts made to secure the adequate two people 24-hours a day all parties agreed Aaron needs to be safe. The following laws should have prevented all the damage and injury that were forced upon Aaron and myself:

1. Wis. Stat. § 49.90 provides no parent can be forced to pay for the support of their children over 18 years of age. Judge Flanagan's orders required Margaret to pay hundreds of dollars a day for her son's care.
2. Wis. Stat. § 51.61(1)(f) provides patients protectively placed like Aaron are due prompt and adequate treatment. Aaron has not gotten adequate treatment for over three years now, even by the admitted level of care all parties agreed to.

3. Wis. Stat. § 55.001 provides the disabled like Aaron the same rights as other citizens to be free from abuse, neglect and self-abuse. Numerous 911 reports, and hospitalizations Aaron required due to under-staffing are undisputed facts proving he has not been safe from abuse, neglect, and self-abuse.
4. Wis. Stat. § 104.02 provides all Wisconsin employers must pay a living wage. Every agency that accessed Aaron quoted it took \$840-\$1200 a day, not including room and board, to keep Aaron safe. Yet Judge Flanagan and Milwaukee County only approved \$213 a day for years. They have forced an unlivable wage upon the only place agreeing to care for him: his mother in their home.
5. Wis. Cons. Art. I §2, and U.S. Cons. Amend. XIII provide involuntary servitude is illegal. Judge Flanagan's order January 20, 2009 required Margaret work 24-hours a day seven days a week without pay. She was reminded of this injustice in subsequent hearings, but did not change the order.
6. U.S. Cons. Amend. VIII provides cruel and unusual punishments are forbidden regardless of the crime. Not being adept at trial advocacy and rules of evidence as a law school student, not being personally likeable in court when acting pro se as a mother fighting assertively with her son's life at risk, are not deserving of cruel and unusual punishment. Being under constant physical attack without adequate resources to avoid assaults and injuries for her and her son is cruel and unusual. The emotional stress of her son being moved to a group home any day when that placement had failed to protect him in the past from medical emergencies and assaults by poorly trained staff is cruel and unusual. Taking away a mother's guardianship in retaliation for speaking up against inadequate care for her disabled son is cruel and unusual. Taking away the family's only source of income, their health insurance, car, savings, retirement, forcing them to use food stamps and energy assistance for basic needs is cruel and unusual punishment.
7. The purpose of the Watts Review is to provide a yearly impartial judicial review for our disabled citizens in need of protective placement to ensure their needs are being met, because in many situations the department of health & social services may be influenced in its decision making by economies of placement. State ex. rel. Watts v. Combined Cmty. Serv.s Bd., 122 Wis.2d 65, 362 N.W.2d 104, 107 (Wis. 1985). Aaron's case had a review for three years, but he is still without adequate services.

All parties have agreed Aaron was unsafe.

Judge Flanagan reported:

- "Well, the testimony of the county employees each said that they felt that there was major safety issues and aggression problems. I haven't heard anybody testify to the contrary." (Transcript, 10-21-08, p. 178)
- "The school bus driver, the - other school personnel that have been bit or hurt, the throwing of the furniture and picked up a knife on April 26<sup>th</sup>, 2008, examples of serious rages and major damage, as I go through all your documents; and frankly, I got all of this from you." (Transcript 10-28-08, p. 133; Bar Response, Bar Response Exhibit 17, p. 17))

- “You’re, I’m sure, financially, professionally, personally suffering a lot more than just sleep deprivation.” (referring to Margaret) (Transcript 10-28-08, p. 129; Bar Response Exhibit 17, p.17)
- “I would agree, with no doubt, that he presents significant dangers, as related by the police reports and the photos that you provided, and that no other agency has been willing to provide care for Mr. Bach at any price.” (Transcript 1-20-09, p. 6)
- “[Y]our son is still a danger, . . . you very likely could have been seriously hurt or killed.” (Id. at 22)

The GAL, Elizabeth Ruthmansdorfer reported:

- “I am a little nervous about for herself as well as being so tired without 24-hour care available, which I’m not sure in which context it exists or doesn’t, but without it it is not in his best interests to be there.” (Transcript 7-22-08, p. 16)
- “There continue to be safety issues with Aaron.” (Transcript 9-2-09, p. 147-148)

Corporation Counsel Jeaneen Dehring reported:

- “It’s a safety issue too, and obviously the determination of whether he can be safely kept at home, you know, is an issue too.” Then Judge Dwyer said “Well, right, but it’s my belief that, if Miss Bach got additional staffing, that safety would not be an issue . . . I’d like to have a stipulation to that effect.” Ms. Dehring answered, “Yes”. (Transcript 6-12-08, p. 13)
- “There was some testimony, and I’m sorry. I can’t remember if it was from the woman from Chileda or the - Aaron’s teacher, who stated that sometimes Aaron needs up to three people at the same time to take care of him.” Then after my response, Ms. Dehring asked. “But aren’t you concerned, as his guardian, to ask for less than three people?” (Transcript 10-28-08, p. 100)

Milwaukee County Supervisor Kevin Madson reported:

- “Aaron’s safety is clearly at issue . . . each time there was a report of an incident, after I discussed it with my supervisor, we would follow up and call Mrs. Bach and discuss the situation. I can’t say there was an offer every time of increased funding, but we would discuss the situation.” (Transcript 10-21-08, p. 54-55, Exhibit 6)
- “Aaron had attacked the bus driver . . . Aaron has run out of the home, and Mrs. Bach had to chase after him and restrain him on the sidewalk . . . just simply wasn’t safe for him.” (Id. at 56)

For over three years all these responsible parties have not lived up to their duty, denying even interim relief as they made plans to move Aaron from his home. During the hearings to have me removed as guardian, a delay was imposed when Judge Flanagan requested a comprehensive, independent evaluation be done by Dr. Mooney after four hearings concluded, so my attorney, Melanie Alberts asked for the adequate care all parties said Aaron needed to be safe: 2 people 24-hours a day. Judge Flanagan denied this request stating she didn’t have the authority to make that order, and the GAL and corporation counsel were silent. (Transcript 7-8-09, p. 59-60)

## Judge Flanagan

I am not unreasonable to believe Judge Flanagan lied, is unethical, and should not be a judge. I could go on for pages with supporting evidence, and have begun a detailed report for the Wisconsin Judicial Commission, but for purposes of this response will highlight just two examples. Additional detail can be found in the briefs I submitted to the Board, Exhibits 3 and 4.

The first example was Judge Flanagan's statement in her Decision and Order after the hearings to review Mr. Linhart's guardianship: "Each witness, other than Ms. Bach, testified that Mr. Linhart was available to them as needed and did respond to their inquiries." (p. 2) The following testimony by four witnesses contradicts this finding of fact and support it was "clear error":

- 1.) Testimony from Dr. Barthel, Aaron's psychiatrist. He requested Mr. Linhart sign a letter authorizing him to communicate with Aaron's neurologist, which was essential to Aaron's medical care because the behavior medications he prescribes can cause seizures and the seizure medications the neurologist prescribes can cause behavior problems. It took 4 months and additional requests to get this signature. Dr. Barthel also requested Mr. Linhart get HIV results for Aaron and his case worker on December 18, 2009, but never got an answer. (Transcript 4-8-10, p. 61-63, 67; Exhibit 2) No one else asked any questions of Dr. Barthel or impeached his testimony in any way.
- 2.) Liz Ford with Disability Rights Wisconsin. She asked Mr. Linhart in November 2008 to arrange for alternative transportation home from school when Aaron's disability made the usual bus transport unsafe, but never got an answer. (Transcript 4-13-10, p. 59; Exhibit 5) This testimony was never challenged, in fact, Mr. Linhart admitted he had never responded to Ms. Ford in court on April 8, 2010. (Transcript 4-8-10, p. 136; Exhibit 2)
- 3.) Tanya Fredrich, Aaron's school principle. She also requested Mr. Linhart arrange for alternative transportation home from school in October 2009. (Transcript 4-13-10, p. 42-43; Exhibit 5 and Transcript 4-8-10, p.136; Exhibit 2) Ms. Fredrich testified she did not get prompt response from Mr. Linhart to her request for authorization to give Aaron over-the-counter medications while in school, having to send two e-mails and still not getting a response. (Transcript 4-13-10, p. 49-52; Exhibit 5) The e-mail evidence in support of these requests and Mr. Linhart's lies that he did not know Aaron needed over-the-counter medications, or that the school needed his authorization are in the binder, Exhibit 1, p. 161-163, 165. No one challenged Ms. Fredrich's testimony or discredited the e-mails. Mr. Linhart admitted getting numerous notifications about Aaron's fingernail injuries and the need for over-the-counter medications. (Transcript 4-13-10, p. 73-79; Exhibit 5)
- 4.) Alexa Tatalovich, Aaron's teacher. She testified she never met Mr. Linhart or had ever spoken to him. (Transcript 4-13-10, p. 13; Exhibit 5) This is important because every guardian has a duty to make regular inspection, in person, of the ward's condition, surroundings, and treatment, (Wis. Stat. § 54.25(1b)(1)) and Mr. Linhart admitted never being to Aaron's home. (Transcript 4-13-10, p. 79; Exhibit

5) So if he never visited the school or home, he did not fulfill his duty as guardian.

A second example of unethical conduct by Judge Flanagan was the hearing held January 20, 2009 in response to my Motion for Enforcement of Order I filed after Milwaukee County refused to provide the 24-hour coverage the prior order required. I have enclosed the full transcript because it is short, and reading it in its entirety is helpful to understand my claim of misconduct. No ethical judge would deny an incompetent child their statutory protected right to adversary counsel, (Wis. Stat. §§ 55.16(3)(c), 55.10(4)(a)) and threaten them with institutionalization.

The discussion about adversary counsel was off the record before the hearing. Judge Flanagan asked me where Mr. Buffum was and I explained I did notify him of the hearing and asked him to be there. He declined saying he had filed the paperwork for an appeal so he could no longer represent Aaron. Judge Flanagan decided to proceed regardless. There were no objections from the guardian ad litem or corporation counsel.

Jeanen Dehring admitted they had not provided 24-hour care, (Transcript 1-20-09, p. 9-10; Exhibit 11) but in the end the court gave only two options. I could accept the home conditions dictated by Milwaukee County (Id. at 20) or Aaron will be moved to an institution. (Id. at 13) No room for compromise. No option that met Aaron's needs and would keep him safe.

A few background facts would be helpful to understand before reading the January 20, 2009 transcript. First, a live-in care provider is not physically possible in my small home. Second, Milwaukee County had previously agreed to pay me, as they pay other parents who care for severely disabled children. These payments went on from November 2007 until April 16, 2009, two days after Milwaukee County learned I was fired as a pharmaceutical representative. Finally, institutionalization was never presented as an option in any prior hearing, and Hilltop institution did not provide even one-on-one care much less the two-to-one care Aaron needs.

These two examples of misconduct by Judge Flanagan in addition to the detail discussed in the introduction above are enough to consider my view reasonable, if not correct.

### **GAL Elizabeth Ruthmansdorfer**

Similar to Judge Flanagan's claim Mr. Linhart was available to everyone as needed and responded to their inquiries, Ms. Ruthmansdorfer stated "Every witness indicated Mr. Linhart was timely and responded to their requests." The same four witnesses listed above on this issue apply here as well to contradict Ms. Ruthmansdorfer's conclusion. This is "clear error".

The second issue I will highlight in evidence Ms. Ruthmansdorfer was unethical is her response to Aaron's HIV threat. Ms. Ruthmansdorfer breached her fiduciary duty by not advocating for Aaron's best interests in getting HIV results after a second significant exposure. Ms. Ruthmansdorfer was continually notified of the dangerous situation, but

refused to do anything to help until August 2010 when Aaron's adversary counsel pleaded for assistance in front of Judge Flanagan. Then Ms. Ruthmansdorfer offered to write an order requesting Mr. Linhart get HIV results. I had submitted three written requests to Mr. Linhart and copied Ms. Ruthmansdorfer over five months, but they were ignored.

The first significant HIV exposure occurred December 12, 2009. Repeated requests to Mr. Linhart went unanswered. I was finally able to access the records myself when my son bit me in February of 2010. I was possibly infected then, not just a mother without guardianship, so the hospital shared the results with me. It only took 3 days and 3 phone calls to get the results shared for both parties. (Aaron and his aid) When it happened again May 25, 2010 I made repeated requests to Mr. Linhart, Ms. Ruthmansdorfer, Disability Rights Wisconsin, IRIS managers, Aaron's adversary counsel (when he was finally appointed), and requested Aaron's physicians contact Mr. Linhart. The court order was finally written in August 2010. I did not get the results until December 2010.

In her concluding statement to the court on the review of Mr. Linhart's guardianship, Ms. Ruthmansdorfer argued it was unclear there was any real threat to Aaron so it was excusable that Mr. Linhart did not follow-up. There is significant evidence this HIV exposure was a real threat. In addition to common sense that it would be in one's best interests to know if they had a life-threatening, contagious disease and get treatment if necessary, is the following:

- Aaron's psychiatrist, Dr. Barthel testified and had it in his clinic notes that he notified Mr. Linhart that this was a true threat to Aaron's health and directed him to follow-up to obtain the results.
- The tort complaint I filed against Mr. Linhart, which Ms. Ruthmansdorfer was copied on, clearly stated this was a serious blood-on-blood exposure when Aaron was bleeding from his mouth and bit an aid causing their arm to bleed as well.
- The hospital emergency room physician would not let Aaron and I leave until he was sure the results of this public health concern were shared. Even after speaking with Mr. Linhart he was not satisfied and called Judge Flanagan to get her promise she would ensure the results be shared before he let us leave.
- Wisconsin law provides HIV results be shared. (Wis. Stat. §§ 48.371, 938.296 and Syring v. Tucker, 174 Wis.2d 787, 498 N.W.2d 370 (1993).

Ms. Ruthmansdorfer's conclusion Mr. Linhart acted appropriately in Aaron's best interests is contrary to the evidence, and another misrepresentation to the court. Additional details of her misconduct are found in my complaint, and supplement to the Office of Lawyer Regulation. (Appendix, p.1) It all supports I was not unreasonable to challenge her ethics.

### **Corporation Counsel Jeaneen Dehring**

Jeaneen Dehring submitted a Motion to Review the Conduct of Guardian to remove Margaret as guardian on three grounds. First, "Margaret's failure to cooperate with

offered services and her refusal to allow services for the ward in her home at the discretion of Milwaukee County has prevented the ward from receiving 24-hour supervision in his home.” Second, “Margaret’s actions demonstrate her inability to make appropriate decisions with respect to the ward’s safety and placement.” Third, “Margaret now refuses to allow the ward to be accessed for placement at Hilltop ICFMR”.

The evidence showed two of these three grounds to have been known falsehoods at the time the complaint was filed, in violation of Wisconsin Statute Section 802.05(2)(c). First, Kevin Madson, the supervisor with Milwaukee County who signed the complaint, admitted knowing Aaron did have 24-hour care. (Transcript 5-28-09, p.32-33; Exhibit 12) Second, Mr. Madson testified knowing the assessment was done by Hilltop, (Id. at 35) as verified by Kristine Evans who did the assessment. (Id. at 81-83)

“Section 802.05, STATS., was patterned after Federal Rules of Civil Procedure 11 . . . to impose sanctions upon counsel who file documents with the court without conducting an adequate investigation of the issues or with improper motives behind the filing.” Belich v. Szymaszek, 224 Wis.2d 419, 430, 592 N.W.2d 254, 260 (Ct. App. 1999). Jeaneen Dehring violated this law. Not only did she fail to conduct an adequate investigation, she knowingly filed false claims. (Id. at 18, 32-33) In order to make an inadequate, cheaper placement easier, she filed false claims to remove a conscientious mother as guardian.

For a more minor violation of a less than diligent investigation of a claim, the attorney is cautioned, “this court will not tolerate the making of unsubstantiated factual allegations by attorneys in papers filed with this court” In re Kelly, 808 F.2d 549 (7<sup>th</sup> Cir. 1986). “When [attorney] Curl chose to state as a fact what was at best a guess and a hope, he engaged in misrepresentation.” In re Disciplinary Action Curl, 803 F.2d 1004, 1006 (9<sup>th</sup> Cir. 1986). Ms. Dehring’s conduct was even more egregious because she knowingly filed false claims, and the dates prove she actually wrote the Order for Assessment at Hilltop after she wrote Margaret had violated that order. (Brief, p. 9, ¶ 5; Exhibit 4)

The court had a duty to address this ethical violation, but instead condoned it by letting a fraudulent, malicious prosecution proceed. SCR 60.04(3)(b).

Jeaneen Dehring denied opposing counsel a simple discovery request in violation of Wisconsin SCR 20:3.4 on Fairness to Opposing Party and Counsel. Melanie Alberts represented Margaret and contacted Ms. Dehring prior to the hearing requesting a list of witnesses to prepare for. Ms. Dehring withheld the name of her key witness, Karen From. A reasonable inference is this was a lie because the contact was shortly before the hearing, and Ms. From’s e-mail they used for evidence was sent long ago on February 6, 2009. Simply to ensure Ms. From’s availability for the trial date, Ms Dehring would have had to plan for and know she was calling Ms. From to testify. This was bought out in the hearing, but Judge Flanagan made no response. (Transcript 5-29-10, p.51; Exhibit 14)

Jeaneen Dehring also violated SCR 20: 3.3 on Candor Toward the Tribunal. The Statement of Facts in the brief, (Exhibit 4) document numerous examples of perjury by Milwaukee County witness Kevin Madson, (¶ 7, p. 9) that Ms. Dehring had a duty to prevent, discourage, and if that failed, to disclose to the tribunal. She did not. She also made contradictory statements herself, at first agreeing before Judge Dwyer that Aaron was brought home for good reason, the sexual assault. (Transcript 7-22-08, p. 14; Exhibit 10) Then denying she ever admitted the sexual assault happened before Judge Flanagan. (Transcript 1-20-09, p. 16; Exhibit 11) and (Brief at 10, ¶ 7b; Exhibit 4)

For all these reasons, it is not unreasonable that I believe Ms. Dehring lied and violated her ethical, professional responsibilities.

### **Dr. Mooney**

My initial response to the Board, exhibit 17, contains much of the evidence supporting my contention that Dr. Mooney lied. (p. 4, 7) Additional detail is in my brief, exhibit 4, on pages 16-20. Rather than repeat this information here, I ask that you read those few pages to see the factual reasons I doubt Dr. Mooney's integrity. I realize I have no black and white proof she lied, as I explained in the last hearing when she told me perjury was OK because "everybody lies", but then denied it in court. But all the errors detailed in my brief, and the new evidence I describe below is suspicious enough to make my contention reasonable.

I enclosed new additional evidence Dr. Mooney distorted the facts on page 178 of the binder I submitted. (Exhibit 1) This is a statement from one of Aaron's care provider's at Chileda who Dr. Mooney quoted in her report on page 8: "Ms. Carlson of Chileda stated to this examiner that there are dynamics with Aaron and his mother- she did a lot of things to placate. He would be more violent with her." My attorney and I wanted to have her testify as a rebuttal witness, but the court would not allow it. Ms. Carlson states in her letter how her comments were edited and taken out of context to change their meaning. She was trying to state how dangerous Aaron's placement is at home without help. It was not that as his mother I was unable to handle him and they were, as Dr. Mooney and then later Judge Flanagan, and Mr. Hopkins conclude.

Dr. Mooney is an experienced court expert, an educated intelligent woman. I do not believe this was a mistake.

Ms. Carlson stated I was a "deeply caring parent and a well-educated advocate." She would not have supported there was cause to take away my guardianship, and would support me as an individual with the character and fitness to be a fine attorney.

Dr. Mooney also told me to move out of Milwaukee County. Two other rebuttal witnesses would have contradicted the statements Dr. Mooney attributed to them. (Aaron's teacher, Alexa Tatalovich and his school principle, Tanya Fredrich) But Judge Flanagan would not allow the time for these testimonies. I believe I am reasonable in doubting Dr. Mooney's ethics and honesty.

### **Guardian Richard Linhart**

My documentation of Mr. Linhart's numerous lies are obvious from the transcripts and detailed in my initial response to the Board, exhibit 17 on pages 3-15; in my brief, exhibit 3; and in the evidence in the binder, exhibit 1 on pages 152-177. I will highlight just one that was new from the interview Mr. Linhart gave Mr. Hopkins as reported in the February 11, 2011 memorandum.

Mr. Linhart claimed he was present during the short observation period when the ARC staff (Advocates for Retarded Citizens of Milwaukee) came to interview Aaron in his home. (Feb. 11 Memorandum, p. 3) He said I was "fighting the change at every chance". (Id.) But he was not even there. All the parties who were there have stated Mr. Linhart was not there. In addition to my statement, enclosed in the binder were the statements by the ARC staff and Aaron's aid, Jerrel Thomas. (exhibit 1, p. 176-177)

I do not lie. Mr. Linhart does.

### **Karen From**

The evidence Ms. From lied is detailed extensively in my initial response to the Board, exhibit 17 on pages 4, 6-7, 15-22 and in my brief, exhibit 4 on pages 11-15. I will not repeat all the detail here. The only new allegation she made while being interviewed by Mr. Hopkins as reported in the February 11, 2011 memorandum was that I was fired for "padding my company expense account". (p. 5) Once this memorandum was shared with me by Jacquelynn Rothstein I reached out to my former employer to gain the documentation they had to clear me of this accusation.

It took a little persistence as evidenced by the first response they sent to my inquiry on page 13 of the binder, exhibit 1. The follow-up request I made produced the necessary exculpatory letter (Appendix ) and is also evidence of why I believe I need to challenge authority at times. Those in positions of power do not always follow the law and do the right thing.

I would have gotten this information to Mr. Hopkins sooner, before he wrote his summary and conclusions if he would have communicated with me. I appreciate the chance to respond to it now. The letter from my former employer proves Ms. From made a false accusation and my character should not be questioned by her claims. It is reasonable I believe she lied.

### **Kevin Madson**

I will not further detail Mr. Madson's lies here as they are contained succinctly in my brief, exhibit 4 on pages 9-10. My claim of his dishonesty is reasonable. His own testimony contradicted itself. No one offered any defense or explanation for his contradictions.

