Jeannette Marino, M.S., LLC
75 South Main Street, #7, PMB 616
Concord, NH 03301
603-226-6004
Fax# 603-226-7152

Guardian • Guardian ad Litem • Payee Services • Mental Health Consulting

October 24, 2014

HAND DELIVERED

Honorable Edwin W. Kelly
Administrative Judge
State of New Hampshire Circuit Court
45 Chenell Drive, Ste 2
Concord, NH 03301

Judge Kelly:

Please accept this correspondence and attachments, consistent with your letter dated September 30, 2014 referencing Judge Leonard's findings in the case, to demonstrate my position that at no time were my actions with respect to Mrs. guardianship improper. The attachments are as follows:

A. Judge Leonard's August 15, 2014 Decision.
B. Letter of Meg Miller dated June 25, 2014
C. Notice of Hearing dated July 1, 2014 (received by me on July 3, 2014)
D. National Guardianship Standards
E. Model Code of Ethics for Guardians
F. Care Plan and Ward Visit Notes
G. Evaluations of ward
H. Physician's Clearance Form
I. June 16, 2014 email chain with Peabody Home
J. July 9, 2014 post-hearing submission to Court including excerpts from Dr. Robert Santulli's *The Alzheimer's Family, Helping Caregivers Cope.*
K. June 23, 2014 email chain with Peabody Home
L. Rule 7 Notice of Mandatory Appeal

On July 3, 2014, I received from the court a notice of hearing scheduled for July 7 and further notice (See Appendix C) of a letter sent to the Court by Meg Miller, Executive Director of Peabody Home ("Letter") (See Appendix B). As reflected in the Court Notice, a copy of the Letter was not forwarded to me by Ms. Miller.

A hearing was conducted on July 7, 2014 lasting approximately 90 minutes. Due to the short notice of hearing and late receipt of a copy of the Letter, there was little time over a long-holiday weekend to obtain an attorney to represent me and address the numerous issues and allegations contained in Ms. Miller's Letter. Nonetheless, the hearing went forward, and the ward did not attend.

Although Ms. Miller complained in her Letter that I was in violation of 12 NGA Standards, Judge Leonard in her decision of August 15, 2014 ("Decision") (See Appendix A) found me to be in violation of ~~eight~~ **8**NGA standards in connection with the circumstances surrounding my decision to move Mrs. from Peabody Home to the Birches of Concord ("Birches"). The decision was based upon ~~six~~ **6** specific complaints by Ms. Miller:

Failure to attend care plan meetings;
Failure to visit the Ward;
Failure to include the Ward in the decision making process;
Failure to consult the team regarding the proposed move to the Birches;
Failure to consider the Ward's relationship with her friend and care providers; and
Failure to act in the best interest of the Ward.

Judge Leonard's findings appear to be largely based on the Letter (Appendix B) and testimony by Ms. Miller.

I respectfully disagree with the findings of Judge Leonard. I did not violate NGA standards and in fact acted in accordance not only with NGA Standards noted in the Decision (See Appendix D) but also the Model Code of Ethics for Guardians (See Appendix E). The Court's reliance on Ms. Miller's hearsay statements was improper and not supported by the record. I further submit the following explanation and clarification of the circumstances, along with supporting documentation, addressing each contention.

I. **Failure to attend care plan meetings**

A. Allegation

In her Letter, Ms. Miller states "Jeannette Marino has not been present via phone or in person at 's care plans for over two years".

Judge Leonard states in her order "Ms. Marino failed to visit with Mrs. or participate in her care team meetings to the degree that was required have [sic] as her guardian"

B. Response

Since my appointment in August 2011, I have attended care plan meetings with the team at Peabody Home on:

August 23, 2011
May 2, 2012
October 24, 2012
May 20, 2013
October 16, 2013

I also attended 3 additional meetings with staff on December 18, 2013, January 24, 2014 and April 22, 2014. These meetings were held at my request in response to reports by Peabody Home staff of increased difficulties with Mrs. mental status. My notes documenting my attendance at these meetings and the staff present at these meetings are contained in Appendix F. It should also be noted that at the July 7 hearing, I testified I did attend the care plan meetings and offered notes in my possession at the time of the hearing. There was no first hand testimony to dispute my representations, and Ms. Miller's statement to the contrary were hearsay.

II. Failure to Visit the Ward:

A. Allegation

In her Letter, Ms. Miller states "Jeannette has only physically visited on two occasions since her appointment of [sic] guardian, August 2, 2011."

Judge Leonard in her order states "Ms. Marino failed to visit with Mrs. ".

B. Response

In addition to visits with the Ward conducted prior or after the time of each care plan meeting noted above, there were several other informal visits that occurred at times when I was in the Franklin, NH area to visits other Wards. There were also several visits with Mrs. Payan during the time surrounding her estate planning in 2012.

III. Failure to include the Ward in the decision making process; and Failure to consult the team regarding the proposed move to the Birches

A. Allegation

Ms. Miller stated in her Letter that "Jeannette Marino never included the resident or the care team in this decision", "Jeannette Marino never once asked what she would like" and "Jeannette never maximized the participation of ". The Letter contained several other statements reiterating Ms. Miller's belief that I did not include Mrs. , her treatment providers or others, in the decision making process.

Unfortunately, as with almost all statements made by Ms. Miller in her Letter and at the July 7 hearing, these statements are untrue.

Judge Leonard stated in her Decision:

> "Ms. Marino failed to treat Mrs. with dignity in that (1) she failed to consult with her or her care team about relocating to The Birches";
>
> "Ms. Marino failed to meaningfully consult with and consider the opinions of Mrs. care team regarding a transfer";
>
> "Ms. Marino failed to maximize Mrs. participation in the decision to relocate and failed to obtain meaningful input from her care team in making such a decision"; and
>
> "Ms. Marino violated Mrs. right to self-determination".

B. Response

Since 2011 Mrs. has suffered from significant symptoms of dementia, including anxiety, depression, poor insight, memory loss and poor judgment, all of which were carefully monitored by me as her guardian over the course of my appointment and reflected in psychiatric evaluations (See Appendix G). Mrs. condition was further complicated by both behavioral disturbances and symptoms of a delusion order.

On April 11, 2014, I received a call from, Blanche Lund, LNA the primary staff person for Mrs. at Peabody Home. Ms. Lund advised Mrs. level of functioning has deteriorated to the point where staff believed she could no longer reside in the assisted living residence at Peabody Home. I requested and scheduled with Ms. Lund a meeting with the team on April 22, 2014.

On April 22, 2014, I appeared for the team meeting and was advised that only Ms. Lund would be available to meet with me. At the conclusion of my meeting with Ms. Lund, it was determined and agreed upon that Mrs. could no longer continue in an assisted living environment and now required the full assistance, services and supervision available in a nursing home or dementia care facility. This determination was based on reports as to Mrs. deteriorating condition and careful review of the medical chart going back several months for the purpose of again reviewing if there were any other factors contributing to the deterioration which could be resolved and enable Mrs. to continue in her residence.

As reflected in my note dated April 22, 2014, I then visited with Mrs. to discuss the need for increased care and the associated move to another environment. The discussion with Mrs. was complicated by her inability to recall any of the difficulties she was having, her lack of insight into her limitations and marginal ability to cognitively follow the conversation. I also note that based upon the ward's condition,

including immediate and significant short term memory loss, how could Peabody Home offer any information as to what, if anything, I discussed with the ward. No Peabody Home staff were present during my visit and discussion with the Ward and, therefore, cannot testify as to what was discussed.

The Model Code of Ethics for Guardians extensively addresses the concept of substituted decision making versus best interest decision making. (See highlighted portions in Appendix E). Due to Mrs. significant memory loss, poor insight into her condition and circumstances and complete lack of judgment in connection to her abilities, I determined that best interest decision making was not only the required course of action under NGA Standards (See Standard 7), but also under the Model Code of Ethics (A:1 and A:2).

Between April 22 and May 27, I reviewed Mrs. Payan's medical and psychiatric records, history, case notes and options for placement. On May 27, 2014, I contacted Judy Mrs. daughter, to advise her of her mother's condition and the need for a move to a higher level of care. We discussed options for placement, which included a transfer to the Peabody Home upper level nursing facility, the specialized dementia care facility at the Birches or return to Long Island to an available nursing or dementia care facility. Ms. was supportive and approved of the need for a higher level of care.

Also during this time, I continued to speak with Ms. , the executive director of a facility in Long Island, the executive director of the Birches and eventually with John Roe, Esq., Mrs. ; long time attorney for both she and her deceased spouse. I concluded, with Ms. ; agreement that Mrs. remaining in New Hampshire and her transfer to the specialized dementia unit, as opposed to Peabody Home's nursing home residence, was in the best interest of Mrs. as it would offer the best care for Mrs. condition and level of needs.

Of significant consideration in the decision to move Mrs. , was my previous discussions with her where she clearly stated she did not want to reside in a nursing home as she believed those patients were ill and elderly and she viewed herself as being much more healthy and independent that the residents she observed in the nursing home wing of Peabody Home.

The process of transfer to the Birches was started on June 9, 2014 when I telephoned Peabody Home to advise of the physician clearance form necessary for transfer to the Birches and faxed it over the form the following day (See Appendix H). On June 10th I spoke with the director of the Birches who scheduled the intake assessment for June 17 at Peabody Home. On June 11, I spoke with Peabody Home staff in response to receipt of the Birches forms sent on June 10. On June 16th, I received a telephone message from Meg Miller and an email from Cheryl Barnes, RN from Peabody Home. It was explained to Ms. Barnes in my responding e-mail and subsequent telephone conversation with Ms. Miller that the risks and benefits of all options had been considered and with the support of her daughter, the move to the Birches was determined to be in Mrs. best interest and. (See Appendix I for documented communications with Peabody Home).

At the conclusion of the discussion with Ms. Miller, she simply stated she would be pursuing a complaint with the Ombudsman and writing a letter to the court. At no time did Ms. Miller request I meet with the team, who had previously not been available for the April 22 meeting as I had requested. Additionally, between June 9 and June 16, none of the Peabody Home staff involved in the conversations and transfer paperwork requested a meeting at any time.

As required by NGA Standards and the Model Code of Ethics for Guardians, my actions reflected inclusion of Mrs. in the decision making process to the best of her ability. My actions also reflected inclusion of the team to the extent they were willing and available to meet and who had already expressed were in agreement with the need for a higher level of services, treatment, care and supervision.

In light of the serious allegations by Ms. Miller in her Letter of June 25, 2014 and the awareness of more than one staff person at Peabody Home of the planned move to the Birches, it is noteworthy that at no time during the process between April 22 and June 17, did anyone from Peabody Home request a meeting to discuss concerns. Rather, I only received a telephone call from Ms. Miller on June 16, 2014, at which time she expressed her concerns. Prior to this telephone call I had not spoken with Ms. Miller since my appointment in August 2011, nor was she in attendance at any care plan meetings. I was first advised of a request for a meeting on June 17, 2014 – as testified to in Court by Ms. Miller – when I arrived to pick up Mrs. for the transfer.

IV. Failure to consider the Ward's relationship with her friend and Care Providers

A. Allegation

Ms. Miller in her letter stated:

"The Guardian shall promote social interactions and meaningful relationships consistent with the preferences of the person under guardianship;

The guardian shall encourage and support the person in maintaining contact with the family and friends as defined by the person, unless it will substantially harm the person The guardian may not interfere with established relationships unless necessary to protect the person from substantial harm;

The guardian shall make reasonable efforts to maintain the persons established social and support networks during the person's brief absences from the primary residence;

The guardian may maintain communication with the person's family and friends regarding significant occurrences that affect the person when that communications would benefit the person; and

The guardian may keep immediate family members and friends advised of all pertinent medical issues when doing so would benefit the person. The guardian may request and consider family input when making medical decisions."

"Jeannette Marino violated most of the above statements."

Judge Leonard in her Decision stated;

> "Ms. Marino failed to consider Mrs. physical and mental well-being was directly related to her inseparable relationship with Don [sic] and the trust she had with the care team in changing her residential setting".

B. Response

Mrs. friend Dot was present for at least two of the visits I had with Mrs. Although in prior years, their relationship was mutual, it was clear that the nature of the relationship changed due to Mrs. significant decline. I observed and assessed their relationship to be one of primarily dependence by Mrs. who relied upon Dot to act as her "memory". This observation was also reflected in reports by Peabody Home staff at the time of team meetings. The successor guardian noted in her report that "when asked about the Peabody Home and her friend Dot, Mrs. . . . was unable to engage in a meaningful conversation about either."

When reviewing the risks and benefits of a transfer, the importance of Mrs. relationship with her friend Dot was considered. Prior to transfer I contacted the personal care service I utilize with other wards, to inquire as to the availability of services to transport Mrs. for visits with her friend Dot. Additionally, as reflected in my June 23, 2014 e-mail to Ms. Barnes (Appendix K), I requested to be provided with contact information for Dot and her family in order to maintain the relationship between the two women. The proximity of Concord to Franklin, an approximate 30 minute ride, was considered and determined to not create a hardship for Mrs. , who has no medical issues that would prevent her from riding in a vehicle, nor was the distance so far that Mrs. could not frequently visit with her friend.

With regard to Mrs. 's relationship with her team, it was one of many factors reviewed when weighing the risks and benefits of the impact of a facility transfer on the health and welfare of the ward. In this instance, although I found the staff at Peabody Home to have provided good care and a supportive environment, Mrs. expressed attachment to staff or her relationships with them primarily reflected the typical relationship with facility staff and not the deep attachment expressed by Ms. Miller. The April 22, 2014 visit note, in fact reflects Mrs. statement "I have been in one place so long" in response to my question about consideration for moving. In my opinion, this statement is reflective of Mrs. 's ambivalence towards relationships with staff at Peabody Home, rather than a secure attachment that would have appropriately been given more weight in the decision making process.

Other factors to be considered, such as disruption of relationships with peers or family, must be considered and mitigated to the extent most possible, but ultimately cannot be more meaningful than the health and welfare of the patient.

I would also like to comment here, that in my experience, it is not uncommon for facility, treatment and support staff to develop affectionate attachments to patients. This is especially common with a ward such as Mrs. , who has essentially been abandoned by her family and suffered some degree of exploitation at the hands of those to whom she was entrusted prior to her admission to Peabody Home. In fact, Ms. Miller was the petitioner for guardianship in 2011 with her allegations against the former Power of Attorney being the basis for my eventual appointment by the Court.

Without exception, all professionals in any treatment or care-giver practice are cautioned and receive on-going supervision and education on the matter of developing personal attachments to patients as it is understood the risks of these relationships often result in significant damage to the patient and the provider and, more commonly, impact objectivity when difficult decisions must be made about care and treatment.

Although I appreciate and desire the providers to work with and care for my wards to genuinely care for them, I continually monitor for inappropriate attachments and behavior which have in the past resulted in an undermining of treatment, care and the Ward's willingness to cooperate with other providers and care givers. There have been a number of times in my role as guardian, where I have had to request otherwise good staff to be removed from my ward's treatment due to the development of an inappropriate attachment that has been to the detriment of my ward. There are other times when I must also consider a dissatisfied or complaining party have other interests, such as business, familial or financial, which are negatively impacted on conflicted with the interests and welfare of my Ward.

V. **Failure to act in the best interest of the Ward**

A. Allegation

Ms. Miller in her letter stated:

"The Guardian's professional Relationship with the Person- The Guardian shall treat the person under guardianship with dignity."

"Jeannette Marino lied to about leaving Peabody Home."

"Informed consent. Clearly in violation of section I-V. A witnessed meeting that was ever informed of this move. The care team indirectly notified but never consulted as to how this might effect ."

"Self-Determination of the Person-Jeannette never allowed the opportunity to exercise any individual rights. Moving at this time in her life will clearly will cause her condition to deteriorate."

"Jeannette Marino has not been present via phone or in person at l care plans for over two years."

As with many other statements in Ms. Miller's letter, these statements are untrue, inflammatory, not based on any direct interaction Ms. Miller had with me, nor are they substantiated with clinical or staff records from Peabody Home.

Judge Leonard in her order states:

"Ms. Marino failed to treat Mrs. with dignity in that (1) she failed to consult with her or her care team about relocating to The Birches and (2) she removed her from Peabody Home under the false pretense of going to lunch when the true intention was to admit her to the Birches."

"Ms. Marino failed to maximize Mrs. participation in the decision to relocate and failed to obtain meaningful input from her care team in making such a decision."

"Ms. Marino violated the standards for decision –making by failing to act in Mrs. best interest."

"Ms. Marino violated Mrs. right to self-determination."

B. Response

As a guardian there are two standards by which I am guided when making decisions regarding a Ward:

Substituted decision making; and
Best Interest decision making.

It seems that of most concern to the Court was the allegation I did not included Mrs. in the decision making process involved with the move to the Birches. The Court found specifically I violated Mrs. right to self-determination, I failed to maximize Mrs. participation in the decision to relocate, I failed to treat Mrs. with dignity and failed to act in her best interest.

I respectfully disagree with the conclusions of the Court.

As described previously and as affirmed in Court by both Ms. Miller and me, Mrs. suffers moderate dementia. The clinical assessment standard for moderate dementia (Cleveland Clinic: Stages and Treatment of Alzheimer's Disease), reflects the individual's almost complete loss of short-term memory. Additional symptoms may include:

- Seeing or hearing things that aren't there
- Suspecting people of lying, cheating, or stealing from you
- Be depressed or anxious
- Becoming angry or violent
- Not always knowing family and friends
- Losing track of the day of the week or where you are
- Forgetting details in your life, like your address, phone number, or where you went to high school or college
- Trouble putting clothes on in the right order or picking the right clothes, and later bathing and using the toilet
- Jumbling words
- Poor judgment about your health, finances, or safety.

As far back as 2011, when Mrs. was assessed for incapacity prior to appointment of a guardian and again assessed in 2012 in connection with estate planning and as reflected in the clinical notes from her treating psychiatrist, Mrs. was found to be suffering all of the above symptoms. Her condition was further complicated by behavioral disturbance and suspected delusional disorder. As dementia is a progressive disease, these processes continued to deteriorate over time. By the time it was determined by both Peabody Home staff and me that Mrs. required increase care, treatment and supervision, her ability to participate meaningfully in the decision making process was severely impaired.

On April 22, 2014 I met with Mrs. to discuss a potential move and options. As reflected in my notes contained in Appendix F, I did attempt discussion with Mrs. but she was unable to meaningfully participate in the decision making process due to her inability to understand her limitations, tangential thought process about her current residence and options and almost complete inability to follow the conversation due to significant immediate and short term memory impairments and confusion.

Based on both NGA Standards and Ethical Standards for Guardians, I determined Mrs. incapacity prevented her from participating in the decision regarding placement and that I would apply the best interest standard.

Guardianship certification in the State of New Hampshire requires I keep current my certification as a guardian with the National Guardianship Association. Certification requires I pursue approved continuing education related to various competencies related to the duties of a guardian.

In November 2013, I attended a continuing education presentation by Robert Santulli, MD, a geriatric psychiatrist and Associate Professor at Dartmouth Medical School and Director of the Dartmouth Memory Clinic. At the time of the presentation, I purchased Dr. Santulli's book, The Alzheimer's Family: Helping Caregivers Cope, and additionally had the opportunity to speak with him individually.

As reviewed by Dr. Santulli at the November presentation and as outlined in his book (See Appendix J, pages 174-176 & 179-180), specialized memory care units are preferable over traditional nursing home facilities for the care and treatment of patients with advanced dementia for numerous reasons, all of which are intended to provide the best care, treatment, environment and opportunities for engaging activities and socialization. (Note: Appendix J was provided to the Court and other parties, subsequent to the hearing.)

The setting at Peabody Home is that of a generic nursing care facility which does not offer any specialized programming, therapies, activities or services designed specifically for patient's suffering from dementia. Published literature reflects that admission to these type of facilities can actually hasten progression of the disease and often exacerbates psychiatric conditions such as depression and anxiety.

As a guardian with more than 15 years' experience and education, I am very familiar with the assessment, placement, treatment and residential options for wards suffering from the various stages of dementia.

The determination that Mrs. was best served in a facility specializing in the care and treatment of patients with dementia is well supported by physicians, clinical providers, basic standards of care and a common sense assessment of options. By any medical or psychiatric standard, placement of a dementia patient in a specialized dementia care facility is in the best interest of the patient. My decision to relocate Mrs. to the Birches of Concord was by any medical or clinical standard, in her best interest.

As reflected in the comments in Ms. Miller's Letter to the court and the court's decision, of tremendous concern to both was my actions with the transition of Mrs. to the Birches of Concord without first discussing the pending move. Again, as a professional guardian with 15 years' experience, I have participated in the transition of dozens of clients in varying stages of mental capacity and in each case sought to engage the participation of the ward to the best of their abilities, while being sensitive to the impact of their limitations and dignity, for what is - even under the best of circumstances- an anxiety provoking process.

With regard to my decision not to inform Mrs. of the move, I again ask you refer to excerpts from Dr. Santulli's book located in Appendix J, pages 180-183). Specifically Dr. Santulli recommends that "on moving day, [you] simply invite the person out to lunch to avoid the often difficult reaction by an otherwise anxious and confused patient." As is further recommended, I also put in place 1:1 staff care to assist Mrs. with any difficulties during the initial transition and checked in on and visited her almost daily for the first week of transition.

The Model Code of Ethics for Guardians, also addresses a guardian's decision to withhold information from a ward:

> "The guardian shall use common sense and tact in sharing information, and shall be mindful of the fact that certain sensitive information by his or her manner of presentation and shall anticipate the potential need for support and counseling for the ward who reacts adversely to such information." (Appendix D, page 13)

My decision not to tell Mrs. was based not only on my extensive experience over 15 years, but on sound clinical reasoning, guidance and advice and is the very definition of treating her with dignity.

Summary

The Model Code of Ethics for Guardians Rule 1- Decision Making General Principles, I believe, best outlines the guidelines for understanding and applying the duties and responsibilities of a guardian when making any decision:

Rule 1 - Decision-Making: General Principles:

1.3 When the preferences of the ward cannot be ascertained, a guardian is responsible for making decisions which are in the best interests of the ward.

1.4 The guardian shall be cognizant of his or her own limitations of knowledge, shall carefully consider the views and opinions of those involved in the treatment and care of the ward, and *shall also seek independent opinions when necessary.* (italics added for emphasis)

1.5 The guardian must recognize that his or her decisions are open to the scrutiny of other interested parties and, consequently, to criticism and challenge. *Nonetheless, the guardian alone is ultimately responsible for decisions made on behalf of the ward.* (italic added for emphasis).

My decision was made with consideration of many factors, including, but not limited to, medical and psychiatric considerations and history, my own experience with the ward, extensive investigation of the ward's history prior to incapacitation, consultation with her daughter, consultation with her long-time attorney, examination and knowledge of the care, treatment and services available in different settings and discussions with the ward herself at earlier times when she was able to offer an opinion of her preferences.

The decision before me was not whether Peabody Home could provide basic and necessary services for Mrs. , but whether Peabody Home was the best environment to provide for the care and treatment of persons suffering moderate stage dementia. Although I appreciate and understand the connection between a patient and caregivers, the consideration of their opinion is but one of many factors to be considered when making a decision with regard to the placement of any ward. In this instance, the benefits of a specialized dementia facility and the available care, treatment and services, far outweighed the impact of any losses associated with a transition from one facility to another.

I am at a loss to explain why Judge Leonard based her decisions solely on the statements by Ms. Miller at the hearing and those contained in her Letter, and chose to disregard my response to the allegations as being untrue. On its face the allegations and statements in Ms. Miller's Letter are disturbing and rightfully raised concerns by the court who requested a hearing. Unfortunately, Ms. Miller's Letter was inflammatory and contained numerous misstatements and baseless allegations which are unsupported by documentation, medical records or the testimony of any of the parties for who she made representations during the court hearing. In fact, upon listening to an audio of the hearing, my attorney, the ward's attorney and the judge herself all commented that it would have been helpful if the individuals for who Ms. Miller made representations would speak themselves, including at least one staff member who was in the courtroom.

Ms. Miller presented no evidence, other than her own hearsay testimony, to support her allegations. With the exception of the submission of a single note to which I objected as hearsay, no documentation of the allegations were submitted. Ms. Miller's hearsay statements should not have been considered by the Court, as neither Mrs. nor Peabody Home staff testified to their truthfulness or validity, and my testimony directly contradicted the representations by Ms. Miller. Cheryl Barnes, Peabody Home Director of Nursing, was present at the hearing but did not present testimony. Despite Ms. Miller's statements that I never attended a care plan meeting, my notes reflect that Ms. Barnes was present for at least two of the meetings.

I believe the contents of this correspondence and the supporting documentation provided reflect that I did not violate my NGA standards in this matter and in fact reflect that I took great care to thoughtfully and appropriate meet the needs of my ward ultimately acting in her best interest.

At all times I acted in accordance with my responsibilities as Mrs. guardian and did not violate my professional standards. The code of ethics, in several sections, reaffirms that ultimately decisions regarding the ward are the responsibility of the guardian. There are times this is no easy task. Conflicts with the ward, outside parties and care-givers often interfere and undermine the decision making process. It is up to the guardian to find a balance through careful consideration of all factors and eventually make a decision in the best interest of the care of the ward.

I respectfully disagree with the findings of the court and I have appealed Judge Leonard's decision to the New Hampshire Supreme Court with the expectation that the Order will be reversed. (See Appendix L).

Based on the explanation I have provided in connection with Judge Leonard's conclusion I violated my NGA standards and referral for further sanctions, I request that you issue a decision that no further action is warranted. In the alternative, I request that you await an Order from the New Hampshire Supreme Court, as I expect the Probate Court Order to be reversed thereby becoming moot.

Lastly, as a professional guardian, who frequently is involved in high conflict matters, I am very concerned that the serious consequences in this matter will have a chilling effect on guardian's willingness to put their ward as a priority over their own professional welfare. The decision in this matter, made after a 90 minute hearing for which I had four days notice over a holiday weekend, has put at risk my professional reputation, career and livelihood. I recognize that the courts need to oversee guardians to ensure proper treatment of their wards. However, it is my fear that a decision such as this may have a significant impact on the willingness of guardians to act independently and with priority for the needs of the ward first.

I would be happy to discuss these issues with you further, if you would like to schedule a meeting.

Sincerely,

Jeannette Marino, M.S.