SUPREME COURT OF NEW JERSEY
Disciplinary Review Board
Docket No. DRB 09-172
District Docket No. XIV-2002-0676E

IN THE MATTER OF	:
ROBERT C. DIORIO	:
AN ATTORNEY AT LAW	:

Decision

Argued: September 17, 2009

Decided: December 3, 2009

Lee A. Gronikowski appeared on behalf of the Office of Attorney Ethics.

Gregory J. Lawrence appeared on behalf of respondent.

To the Honorable Chief Justice and Associate Justices of the Supreme Court of New Jersey.

This matter was before us on a recommendation for discipline (reprimand) filed by the District XII Ethics Committee ("DEC"). It stems from respondent's deposit of personal injury protection ("PIP") payments in his trust account and failure to promptly release funds to medical providers in

nineteen personal injury matters. We determine to censure respondent.

Respondent was admitted to the New Jersey bar in 1975. He has no prior discipline.

I. The Potter Matter (Count One)

Count one of the complaint charged respondent with having violated RPC 1.1(a) (gross neglect), RPC 1.3 (lack of diligence), RPC 1.15(b) (failure to promptly deliver funds to a third party), RPC 5.3(a), (b), and (c) (failure to supervise non-lawyer staff) and RPC 8.4(c) (conduct involving dishonesty, fraud, deceit or misrepresentation).

Respondent represented Willard Potter, the grievant, in connection with personal injuries sustained in a November 12, 1995 motor vehicle accident. At the time of the accident, Potter was driving a taxi insured by AIG Claims Services, Inc. ("AIG"). The other driver was insured by General Accident Insurance Company ("General").

In 1998, Potter received a $15,000 settlement from General. On June 7, 1999, he received a $20,000 settlement from AIG.

Pursuant to letters of protection between respondent and two of the medical providers, Dr. Steven Nehmer and HealthSouth, respondent was responsible for ensuring that they receive payment. According to the complaint, respondent failed to pay Dr. Nehmer ($4,400), HealthSouth ($3,840), and RSC Anesthesiologist ($520).

In his answer, respondent stated that Potter had directed him not to pay the medical providers and, instead, to attempt to negotiate a reduction of their bills. Respondent held $6,500 in his trust account, pending the outcome of his efforts.

Potter's grievance alleged that a) he did not receive all of the funds that he was due; b) his credit was damaged, when respondent failed to pay the medical providers; and c) respondent told him that David Pohida, Potter's cousin and a former employee of respondent, might have stolen and cashed some of Potter's settlement checks.

Both in his answer and before the DEC, respondent countered that it was Potter, not he that had implicated Pohida in a stolen settlement check scenario. According to respondent, when Potter raised the issue, he showed Potter the settlement checks in question; Potter then identified his own signature on the back

of all but one or two of the checks. According to respondent, Potter was unsure whether he had signed the remaining checks.

Respondent also testified about a bank notation, apparently made by the bank teller, when one of the suspect checks had been cashed. The bank had telephoned respondent's office and had asked Pohida, who was working for respondent at the time, to verify the authenticity of that check, which had been endorsed by Potter. Respondent concluded that Pohida could not have simultaneously cashed the check at the bank and been present at respondent's office to take the bank's call.

Respondent testified that the Potters and the Pohidas owned the two largest taxi cab companies in the City of Elizabeth. He had been fortunate to count both of those family businesses as clients for about thirty years. He had represented the cab companies, as well as many Potters and Pohidas, cab drivers, cousins, and other relatives. He had attended christenings and weddings over the years and knew the families very well. Therefore, respondent stated, although he believed that Potter had likely endorsed all of the checks, he had decided to pay Potter $12,000, the amount Potter thought was missing, out of his own funds.

The OAE investigator, Mary Jo Bolling, testified that she found no irregularities in respondent's disbursements in Potter's matter or that Potter was due any funds from the case.

According to respondent's records, as of October 31, 2007, he still held $6,500 in his trust account for the medical providers.

II. The Rivera Matter (Count Two)

Count two of the complaint charged respondent with having violated RPC 1.1(a) (gross neglect), RPC 1.3 (lack of diligence), RPC 1.15(b) (failure to promptly deliver funds to a third party) and RPC 8.4(c) (conduct involving dishonesty, fraud, deceit or misrepresentation).

In May 1997, Cynthia Rivera was struck by an automobile driven by a Zurich Insurance Company ("Zurich") insured. Rivera retained respondent to represent her in connection with injuries sustained in the accident.

On November 19, 1999, after the matter was settled, Zurich issued fourteen checks, totaling $22,661.20. The checks were made payable to various medical providers, care of respondent.

One of the medical providers, Dr. Boris Lipovsky, filed an ethics grievance against respondent, claiming that respondent had wrongfully withheld PIP payments made by Zurich, totaling $1,863.30, representing his award for medical services provided to Rivera.

Respondent admitted that he deposited the checks in his trust account and withheld the funds, but he claimed to have done so at Rivera's direction. Just prior to a five-day trial on the PIP issues, respondent had learned that Lipovsky, who was supposed to assist him at trial by testifying as Rivera's treating physician, had been criminally convicted of Medicare fraud. Due to that conviction, Lipovsky could not testify. Therefore, respondent was forced to retain another expert witness at a cost of $3,000.

Respondent claimed to have spent an additional $6,600 of his own funds trying the case, for a total out-of-pocket expense of $9,600, an amount he never recouped. It is uncontroverted that the Rivera PIP funds remained intact in respondent's trust account, even after Rivera lost the case. In fact, respondent still held the funds at the time of the DEC hearing, because Rivera had refused to authorize their release.

Respondent also recalled warning Rivera, after the trial, that Lipovsky might attempt to collect the debt and that, if he did so, respondent would have to sue him to protect Rivera's creditworthiness.

Neither Rivera nor Lipovski testified about the case. Respondent's was the only version of the events.

III. The Other Matters (Count Three)

Count three of the complaint charged respondent with having violated RPC 1.1(a) (gross neglect), RPC 1.3 (lack of diligence), RPC 1.15(b) (failure to promptly deliver funds to a third party), RPC 8.1(b) (failure to cooperate with ethics authorities), and RPC 8.4(c) (conduct involving dishonesty, fraud, deceit or misrepresentation).

OAE investigator Bolling testified that an OAE audit of respondent's trust account revealed that, between January 2002 and November 2003, he held $189,831.57 in PIP benefits in his trust account on behalf of numerous clients, including Rivera.[1] As of October 31, 2005, respondent had disbursed $96,473.45 of

[1] There was no allegation that respondent knowingly misappropriated any of the funds in question in these matters.

that amount, leaving a PIP fund balance of $93,358.12 in his trust account.

In addition to Rivera's, respondent withheld PIP funds in eighteen other client matters, including Lopez, Montgomery, Evans, Polynice, Mendosa, Picado, Sine, Sadykhob, M. Torres, N. Torres, Spruiel, Yorski, Cervants, Brazona, Brooks, Kozak, R. Medina, and Shamis. As of the DEC hearing, respondent had disbursed the PIP funds in all of the matters, save Rivera, Picado, and Medina.

Respondent testified that, in Rivera, Picado, and Medina, his clients had prevented him from releasing the PIP funds. His own records showed that, as of October 31, 2007, in Medina, he had disbursed $15,042 of $18,221, leaving a balance of $3,179; in Picado, he had disbursed $89,353.47 of $103,000.14, leaving a balance of $13,646.67; and in Rivera, he had disbursed none of the $22,661 received as PIP award funds.

According to respondent, in Rivera and the three other PIP matters, the insurance company had sent him PIP award checks payable to the medical providers. The checks were then deposited into his trust account. Respondent's practice had been to explain to the client that the PIP award might be sufficient to

pay the PIP providers, but not other remaining medical providers who had not been awarded PIP funds. Once the clients understood that they would be personally liable to pay the non-PIP bills, they would authorize him to withhold the PIP funds from all of the medical providers. Respondent would then contact the providers who had been awarded PIP funds and negotiate a compromised or discounted bill for services.

If respondent was successful in compromising a bill, he would use the savings to pay providers that had not been awarded PIP funds. According to respondent, his intent was to minimize the client's overall liability for medical services.

When asked why he had not simply turned over the PIP awards to the medical providers, given that they were the named payees on the checks, respondent replied that his only "fealty" was to his client, not to the medical providers involved.[2] His position was that he could only release PIP funds with his clients' authorization. He claimed that every client in these matters had

---

[2] The checks were made payable to the medical providers, care of respondent. Copies of the checks in the record do not include the back of the checks. Thus, no endorsement or deposit information is available. Respondent was not charged with any wrongdoing by the manner in which the checks were deposited into his trust account.

authorized him to withhold the PIP funds, pending his negotiations with the medical providers. Respondent furnished no evidence that any of the clients authorized him to withhold the PIP funds from the providers, despite the DEC's repeated requests for such evidence, the last request occurring at the conclusion of the fourth hearing day.

Respondent used the Picado matter to illustrate his handling of a typical PIP award:

> Some of the providers when we – after we got the award, after we – me and [Picado], discussed a game plan, for want of a better plan, I would start to write, and would not get responses from some, some would respond, so the complexities are – is that if I'm writing, and I do a diligent inquiry on if they went out of business, did they change or merge with somebody, you have to do all of that to at least call your client, Hey, there's a six-year Statute of Limitations, meaning the time that a provider can sue you for services rendered or from the date of the last payment, if the provider doesn't make a claim, then he can't sue you, and if he does, then we have a defense called the Statute of Limitations, he sued you past that time.
>
> [3T32-11 to 25.][3]

[3] "3T" refers to the May 28, 2008 DEC hearing transcript.

When asked what would happen to the PIP funds if the client never authorized their release, respondent answered:

> They're still there, [the medical providers] didn't respond, we're waiting for the Statute of Limitations, and what that effectively does in these type of situations, it gives me a bigger pool to maybe give a little bit more to other people in this instance because, again, if a person has a $3,000 bill, and you only want to give them $500, they're not going to be too happy, so it's just negotiating back and forth.
>
> [3T33-7 to 14.]

When questioned about compensation for negotiating the bills, respondent stated that he had an agreement with the client for the additional time that he would spend on the case:

> I don't have a formal billing procedure like you would if you were working on an hourly rate. So what I would generally do is sit down with the client and say, Here, this was what our discussion was, and our updates, this is what has been saved, and in a lot of instances I just say, Here, God bless you, go spend the money.
>
> [3T53-14 to 20.]

Other times, respondent would

> work it out, I could take a straight third, as I do on the bodily injury, but, again, if I get lots of referrals from this person or it's a repeat, you know, you got to be just

> a real person and work with them too, I take a reduced fee. Sometimes, again, the goal is they're happy, to put as much into it as I can, they can — and hopefully, I can make a living and pay my staff and bills, and stuff like that.
>
> [3T56-14 to 21.]

Thus, if respondent performed additional legal work after the PIP arbitration award, he was sometimes compensated, depending on the circumstances. In some extreme instances, if the client experienced a problem after the PIP balance had been zeroed out, he resorted to spending his own money to file motions and appeals, if necessary.

None of the other eighteen clients named in the complaint testified about their matters.

At the DEC hearing, the presenter withdrew the charge that respondent failed to cooperate with ethics authorities in the investigation of the matter. The presenter noted that, shortly after the complaint was filed, respondent complied with the OAE's requests for documents.

Respondent presented expert testimony on the propriety of his handling of the PIP arbitration awards. Aldo Russo, a certified civil trial attorney specializing in insurance

defense, testified that, in PIP matters, medical providers are "incidental beneficiaries" of the PIP policy. Citing Parkway Ins. Co. v New Jersey Neck & Back, 330 N.J.Super. 172 (Law Div. 1998), Russo stated that a medical provider has no legal right to PIP awards, unless an assignment of benefits from the patient or a letter of protection from the attorney has been obtained. There were no such agreements in these matters. According to Russo,

> [w]hen you file an arbitration on behalf of your client to obtain the medical benefits and you get an award, the money then comes to you. You put it in your trust account. You have to discuss with your client that you are going to make certain disbursements to these doctors pursuant to their bills. What discussions flow from that from the client could be, I don't want you paying this doctor.
>
> Now, the attorney, as long as the money is still sitting there, has to keep the money there and negotiate pursuant to his clients [sic] wishes.
>
> [2T-7 to 20.][4]

Russo also testified about the statute of limitations:

> A. [The] Statute of Limitations for contract actions are [sic] six years, provided you've complied with all the notice

[4] "2T" refers to the February 5, 2008 DEC hearing transcript.

> provisions. If notice was given to the doctor six years ago and there is money and it is six and a half years later and [sic] the money reverts back to the insured who paid for the benefits.
>
> Q. So if there's a dispute with the medical provider and it cannot be resolved and if the monies are held for longer than six years and the doctor hasn't moved on the money, it reverts back to the insured?
>
> A. Yes, [the client] paid for the benefits. She paid a premium for that money.
>
> [2T48-9 to 22.]

Russo opined that, during the six years leading up to the statute of limitations, the attorney is also obligated "to negotiate a settle [sic] or compromise between the patient and the doctor." The following colloquy took place between Russo and one of the panel members:

> MR. WOODRUFF: Let's assume I try that and there is an impasse, my client says he didn't do anything, don't pay him [the PIP award]. The doctor says it was awarded, I want my thousand dollars but the doctor fails to initiate a suit against my client slash his patient, I, in your opinion are [sic] under no obligation to do anything then until six years plus goes by and then release the funds?
>
> THE WITNESS: Yeah, because you can't jeopardize your client's position. You can't prosecute a case you — you can't file a lawsuit against the doctor because that would be putting not [sic] in the best

> interests of your client. Your client is the patient. Your client is your client. So other than strategically, you just wait, you advise your client to [sic] statute of limitations is six years, if he files a lawsuit within that time period, we will make a court make the decision, but other than that you can't jeopardize the interest of your client. You can't alert the doctor to what the law is. You alert the doctor, hey, the statute of limitations is running out. That would be not in the best interest of your client.
>
> [2T50-3 to 19.]

The OAE's expert, Cynthia Craig, also testified about the propriety of respondent's handling of the PIP funds. According to Craig, a twenty-nine year practitioner in the area of PIP law, and author of New Jersey Auto Insurance Law, Gann Books (1990), respondent mishandled these PIP cases.

Craig testified that, ordinarily, insurance companies make PIP payments payable to the medical provider and send them directly to the provider, not to the attorney. Craig stated that, even though the checks were made payable "care of" respondent in these matters, "it is my understanding the checks were made payable to the medical providers as a result of the [PIP] arbitration, were deposited into one of [respondent's] accounts, where they still remain or were [sic] they remained at

the time of my opinion." Thus, she stated, the funds belonged to the providers. Neither Craig's written opinion nor her book is included in the record.

Craig took issue with respondent's assertion that the PIP awards in these matters were the property of the insured. She asserted that they belonged to the medical provider:

> Well, first of all [respondent] filed a PIP arbitration. He would have been paid a fee to file the fee arbitration to get the doctors paid. So he was paid a fee to collect the money for the doctors, then he kept the money. He didn't release it to the doctors.
>
> It is a matter of convenience for insurance companies to mail the PIP checks as a result of an arbitration, which has either been won by the claimant or settled with the claimant, to the claimant's attorney to distribute. Because number one, then the insurance company doesn't have to run around and find addresses.
>
> Remember, these checks were issued for a '97 accident. Who knows if the doctors are at the same address.
>
> Secondly, it tells the attorney I have complied with the terms of the settlement or the arbitration award. It gives him a copy of the checks for his file.
>
> I've never seen a case in which anything was done with the checks other than mail them to the providers.
>
> . . . .
>
> Whether there has either been a PIP

> arbitration or a settlement of a PIP arbitration and checks are sent to the attorney, the attorney is supposed to send them to the doctor, period. That's all.
>
> [1T121-11 to 1T124-7.][5]

Respondent's claim that he negotiates the providers' bills was illogical to Craig, because the PIP statute is "no fault" legislation. The provider is paid according to a statutory schedule of fees. The provider must agree to accept the fee schedule in order to be a participating provider and, by statute, may not bill the patient an amount greater than the schedule allows. Thus, because a provider's fee is fixed by statute, there is no reason for the provider to discount services that have been scrutinized in an arbitration proceeding and approved for payment.

On cross-examination, Craig concurred with Russo's interpretation of Parkway Ins. Co. v. New Jersey Neck & Back, 330 N.J. Super. 172, opining that medical providers in PIP matters do not have any legal right to PIP awards, absent an assignment from the patient. Craig also admitted that she so

---

[5] "1T" refers to the February 4, 2008 DEC hearing transcript.

stated in her book, when discussing the Parkway case. When asked, Craig admitted that there was "a legal dispute amongst the experienced attorneys over this issue." She believed, however, the reason there is a "dearth" of case law discussing the rights of medical providers to receive payments of PIP awards is that the statute inherently provides for them to be paid.

Craig testified that, despite Parkway, it is "implicit" in the PIP statute (N.J.S.A. 39:6A-1 et seq.) that PIP funds belong to the medical provider, not to the client and that, when sent to the plaintiff's attorney after an arbitration award, they must be turned over to the provider.

In its brief to the DEC, the OAE sought the imposition of a three-month to a one-year suspension.

The DEC dismissed the Potter matter (count one) for lack of clear and convincing evidence, stating that "the OAE was unable to meet its burden to sustain the allegations of wrongdoing."

In the Rivera matter, the DEC found that "respondent's conduct with respect to the PIP funds" violated RPC 1.3, RPC 1.15(b), and RPC 8.4(c). The DEC did not address the RPC 1.1(a)

charge and did not tie any of its findings to the facts of the case.

With regard to the other matters (count three), the DEC found, without further elaboration, that "respondent's conduct with respect to the PIP funds" violated RPC 1.15(b) and RPC 8.4(c).

The DEC recommended a reprimand, without supporting case law.

Upon a de novo review of the record, we are satisfied that the DEC's conclusion that respondent's conduct was unethical was fully supported by clear and convincing evidence.

Count one of the complaint charged respondent with grossly neglecting and otherwise mishandling a personal injury matter for Willard Potter. The DEC ultimately dismissed all of the charges. Although it was alleged that respondent's handling of the case damaged Potter's credit, there was no evidence in the record that his credit was damaged as a result of respondent's action or inaction. Likewise, there was no testimony about respondent's alleged failure to promptly deliver funds to his medical providers or about the charge that Pohida had stolen the funds.

Respondent was the only witness to testify in the Potter matter, stating that Potter had been mistaken about the theft of settlement checks and that he had paid Potter $12,000 of his own funds so as not to lose "important" clients.

Without Potter's and Pohida's testimony, the charges against respondent were not proven by the clear and convincing evidence standard. We, therefore, dismiss the charges in the Potter matter.

The Rivera matter, too, charged respondent with gross neglect and lack of diligence in a personal injury matter. Once again, however, there was no testimony from the client about the alleged neglect and no evidence in the record that respondent failed to prosecute Rivera's claims. To the contrary, it appears that respondent obtained satisfactory results for Rivera, including settlements from AIG and General.

We are unable to agree with the DEC's finding, in Rivera, that respondent lacked diligence only, in not releasing PIP funds to medical providers, including the grievant, Dr. Lipovsky. Respondent's actions with respect to the PIP awards were intentional, not dilatory. He purposely withheld the PIP funds in Rivera and in the other matters. As discussed more

fully below, this conduct falls more properly under RPC 1.15(b) and RPC 8.4(c). Because there is no clear and convincing evidence that respondent either neglected or lacked diligence in the case, we dismiss the charged violations of RPC 1.1(a) and RPC 1.3 in Rivera.

The remaining charges in counts two and three address the claim that, in Rivera and in eighteen other matters, respondent violated RPC 1.15(b) and RPC 8.4(c), by failing to promptly deliver PIP funds to third party medical providers.

The issue is whether respondent's failure to deliver checks made payable to them and his deposit of those checks in his trust account constituted unethical conduct. For the reasons stated below, we find that respondent acted unethically.

Respondent and his expert, Russo, urged a finding that respondent's conduct was proper because PIP awards belong to the client. That being the case, if a client instructed respondent to withhold the payment to a medical provider, respondent was obligated to do so. The basis for this argument rested in the Parkway case, which, according to respondent, holds that, absent an assignment from the patient, a medical provider has no legal right to PIP funds. Therefore, respondent asserted, because he

was acting on the client's direction, he should not be held accountable for failing to promptly deliver funds to the medical provider. Respondent's alleged authority to withhold payments and to negotiate the awards stemmed from putative authorizations obtained from each of his nineteen PIP clients. These authorizations were respondent's main defense to the charge that he failed to deliver funds to third parties.

Significantly, however, there is not a shred of evidence in the record, beyond respondent's bare assertion, that he sought, let alone obtained, authorizations from Rivera or from the eighteen other clients to withhold the PIP funds. Respondent was given ample opportunity to elicit testimony from his clients and to furnish documentary evidence in support of his position. Yet, even after the DEC allowed him to submit evidence of the authorizations, he elected not to do so.[6]

---

[6] In his brief to us, respondent's counsel suggested that he was prevented from providing evidence of such authorizations, once the record was closed, at the end of the DEC hearing. Respondent made no objection to the closing of the record. When the panel chair asked respondent if he sought to provide any additional documents, he replied, "No."

It is logical to infer from respondent's failure to substantiate his claims that he had no client authorization or instruction to withhold PIP funds in these matters.

Even if he had received such instructions, however, his conduct would still have been improper. We agree with the OAE's expert, Craig, that clients have no authority to withhold medical providers' PIP payments. It is implicit in the PIP statute that such payments belong to the medical provider, not to the client. Here, respondent was simply a conduit to the provider. He had no legal right to deposit PIP funds in his trust account. Further, as Craig stated, it made no sense for a medical provider to negotiate a statutorily fixed fee with respondent, once the insurance company had paid the scheduled amount as contained in the periodically updated table that is part of the statute.[7]

We agree with Craig's conclusion that, in effect, respondent held the medical providers' money hostage, demanding discounted fees for their release. Failing a compromise, the provider risked expensive litigation with respondent to collect

---

[7] Even if a medical provider were to agree to discount a bill, any windfall would belong to the insurer making the payment, not to the insured or to other parties.

the funds, additional legal work for which respondent would seek payment.

Respondent's expert reached the opposite conclusion, based on his interpretation of the Parkway case, an interpretation with which Craig agreed. Citing Parkway, Russo claimed that a medical provider has no legal right to PIP awards, absent an assignment of benefits from the patient or a letter of protection from the attorney. Our independent review of the Parkway case, however, reveals a far different interpretation from Russo and respondent's. Our interpretation supports Craig's overall position, notwithstanding her concession.

In that case, the insurer, Parkway, sought a declaratory judgment that medical-provider assignees had no standing to file for PIP arbitrations in matters where the underlying Parkway policies contained a clause requiring Parkway's written consent as a condition precedent to an insured's valid assignment of benefits to a medical provider. The Law Division judge found for the insurer and held only that the non-assignment clause in the policies was valid. Thus, the medical providers' assignments were void and unenforceable. The providers had no standing to sue the insurer, based on the void and unenforceable

assignments. Parkway Ins. Co. v. NJ Neck & Back, supra, 330 N.J.Super. at 188. To support this conclusion, the judge noted that the medical providers were merely incidental beneficiaries of the underlying policies and, as such, had no standing to pursue their claims under those contracts. The judge nowhere stated, as respondent urged, that an assignment of benefits from the insured in favor of the provider is required for a medical provider to have a right to its own PIP awards.

Parkway does not speak to the issue of PIP fund "ownership" but, rather, addresses only the issue of PIP medical providers' standing to sue the insurer, based on contracts of assignment with the insured. As such, the decision has no bearing on the question in this case, that is, whether respondent could withhold PIP payments made to PIP providers by the insurer pursuant to its contract/PIP policy with the insured, whether or not the client/insured directed the withholding. Because Russo's opinion that respondent acted properly was based on Parkway, we find that it must be discounted. We concur with what remains – Craig's opinion, based on the PIP statute, that PIP funds are always the property of the medical providers. We conclude, thus, that respondent was obligated to promptly deliver the funds to

the medical providers in all nineteen matters and that his failure to do so violated RPC 1.15(b).

We also conclude that respondent's conduct in this regard was dishonest and, thus, a violation of RPC 8.4(c). His motivation was to deprive the medical providers of funds that they were entitled to receive under the PIP statute.

Respondent's conduct was aggravated by his improper deposit of checks that had been made payable others. Although the backs of the checks are not in evidence, it is undeniable that the payees, that is, the medical providers, did not endorse the checks or authorize respondent to deposit the checks on their behalf.

There remains the question of the appropriate degree of discipline for respondent's unethical behavior.

Ordinarily, failure to promptly deliver funds to clients or third persons will lead to an admonition, even when that violation is accompanied by other, non-serious infractions. See, e.g., In the Matter of David J. Percely, DRB 08-008 (June 9, 2008) (for three years attorney did not remit to the client the balance of settlement funds to which the client was entitled, a violation of RPC 1.15(b); the attorney also lacked diligence in

the client's representation, failed to cooperate with the investigation of the grievance, and wrote a trust account check to "cash," violations of RPC 1.3, RPC 8.1(b), and R. 1:21-6(c)(1)(A); significant mitigation presented, including the attorney's unblemished twenty years at the bar); In the Matter of Anthony Giampapa, DRB 07-178 (November 15, 2007) (attorney did not promptly disburse to a client the balance of a loan that was refinanced; in addition, the attorney did not adequately communicate with the client and did not promptly return the client's file); In the Matter of Walter A. Laufenberg, DRB 07-042 (March 26, 2007) (following a real estate closing, attorney did not promptly make the required payments to the mortgage broker and the title insurance company; only after the mortgage broker sued the attorney and his client did the attorney compensate everyone involved; violations of RPC 1.1(a) and RPC 1.15(b)); In the Matter of Gordon Allen Washington, DRB 05-307 (January 26, 2006) (for a seven-month period attorney did not disburse the balance of escrow funds to which a party to a real estate transaction was entitled; the attorney also lacked diligence in addressing the problem once it was brought to his attention); and In the Matter of E. Steven Lustig, DRB 02-053

(April 19, 2002) (for three-and-a-half years, attorney held $4,800 in his trust account earmarked for the payment of a client's outstanding hospital bill; the attorney also practiced law while ineligible and violated the recordkeeping rules).

But respondent's withholding of the funds was not merely a failure to timely distribute them to legitimate recipients, or inadvertent, or based on reasonable, but mistaken beliefs, as it typically occurs when violations of RPC 1.15(b) are found. It was deliberate and deceitful. It was intended to deprive the medical providers of at least a portion of the funds that rightfully – indeed, by statute – belonged to them. Therefore, an admonition would be woefully inadequate to address the seriousness of respondent's behavior. At a minimum, a reprimand, if not more severe sanction, would be in order for respondent's knowing, improper motives guiding his actions.

There are additional factors to consider, however, factors that aggravate respondent's conduct and that, therefore, require even stronger discipline, notwithstanding that he does not have an ethics history. The amount that respondent withheld was considerable ($200,000), in a great number of cases (nineteen), and for an extended period (sometimes in excess of six years);

in three matters, he still has not released the funds, many years after the conclusion of the matters; and he improperly deposited checks that listed other individuals as payees, without first obtaining their endorsement or their authorization for the deposit. We, thus, determine that the suitable form of discipline for respondent is a censure.

Member Baugh did not participate.

We further determine to require respondent to reimburse the Disciplinary Oversight Committee for administrative costs and actual expenses incurred in the prosecution of this matter, as provided in R. 1:20-17.

Disciplinary Review Board
Louis Pashman, Chair

By: Julianne K. DeCore
Julianne K. DeCore
Chief Counsel

SUPREME COURT OF NEW JERSEY
DISCIPLINARY REVIEW BOARD
VOTING RECORD

In the Matter of Robert C. Diorio
Docket No. DRB 09-172

Argued: September 17, 2009

Decided: December 3, 2009

Disposition: Censure

Members	Disbar	Suspension	Censure	Dismiss	Disqualified	Did not participate
Pashman			X			
Frost			X			
Baugh						X
Clark			X			
Doremus			X			
Stanton			X			
Wissinger			X			
Yamner			X			
Zmirich			X			
Total:			8			1

Julianne K. DeCore
Chief Counsel