J. D. Peacock II
Clerk of the Circuit Court and Comptroller
Okaloosa County, Florida

OPPG Investigation
Case Number 19-064

Date:	**July 9, 2019**
Subject:	**Rebecca Fierle**
Case Number:	**19-064**
OPPG Complaint:	**00285**
Reference:	**Investigative Report**
Disposition:	**Closed**

The Okaloosa County Clerk of Circuit Court and Comptroller, Department of Inspector General and the Clerks' Statewide Investigations of Professional Guardians Alliance was created to provide independent, objective, and expert investigative services to the Florida Department of Elder Affairs, Office of Public and Professional Guardians. Our investigation was performed in compliance with the Quality Standards for Investigations found within the Principles and Standards for Offices of Inspector General as published by the Association of Inspectors General. The standard or degree of proof required to establish a conclusion of fact is at least "by a preponderance of evidence", which indicates evidence that establishes the fact sought to be true is more probable than not.

Investigations by the Clerks' Alliance will reach one of the following three conclusions of fact per allegation: substantiated, unsubstantiated, and unfounded. ***Substantiated*** *means there is sufficient information to justify a reasonable conclusion that the allegation is true.* ***Unsubstantiated*** *means there is insufficient information to either prove or disprove the allegation.* ***Unfounded*** *means there is sufficient information to indicate the allegation is false*

A. Introduction and Scope

The Office of Public and Professional Guardians (OPPG) submitted a complaint regarding Rebecca Fierle to the Palm Beach County Clerk and Comptroller's office, which serves as the Administrative Coordinator for the OPPG and the Clerk's Statewide Investigations Alliance. It was determined by the OPPG that there was a legally sufficient basis to believe that Rebecca Fierle, a state registered Professional Guardian, may have violated Florida Guardianship Law, Florida Criminal Code, or OPPG Standards of Practice. On May 15, 2019, the complaint was forwarded to the Okaloosa County Clerk of Circuit Court and Comptroller, Department of Inspector General (OCCIG) to investigate.

B. Summary of Investigative Finding

Allegations:

There were three legally sufficient complaints about the state registered professional guardian:

1. The guardian has moved the Ward to multiple ALFs that do not meet the Ward's needs for care or supervision, which has resulted in multiple hospitalizations.

2. The guardian did not contact either of the Ward's children regarding initiation of the guardianship.

3. The Ward has communicated that he wishes for life-saving actions to be taken should they be required, but the guardian has a DNR *[Do Not Resuscitate order]* and has not agreed to remove it per the Ward's wishes.

Background

On May 9, 2019, F.S. 744.2111(1) the daughter of ward F.S. 744.2111(1) filed a complaint with the Florida Department of Elder Affairs, Office of Public and Professional Guardians F.S. 744.2111(1) alleged that Fierle moved her father to multiple ALFs that were unable to care for him, that she did not reach out to family members during the initiation of the guardianship, and that even though the Ward expressed a desire to live, Fierle refused to remove a Do Not Resuscitate order (DNR) she had placed. According to court records, Rebecca Fierle served as the Ward's court appointed guardian from F.S. 744.2111(1) until his death on F.S. 744.2111(1) F.S. 744.2111(1)

Investigative Narrative

Our office conducted a review of guardianship court case proceedings in the Florida 9th Judicial Circuit Court in and for Orange County. Additionally, we reviewed medical records for the Ward that had been provided pursuant to a court order.

We conducted an interview with the complainant, F.S. 744.2111(1) on July 2, 2019. She reiterated details forwarded to our office from the Office of Public and Professional Guardians (OPPG). She also expressed confusion as to why her father kept being released from the hospital to facilities lacking the ability to treat his chronic condition. F.S. 744.2111(1) stated that in the week prior to the Ward's death, Fierle had agreed to give up guardianship of him. When she asked Fierle about the DNR order, Fierle told her that her decision was a "quality of life, rather than quantity" matter. F.S. 744.2111(1) said that she believed that if not for Fierle's actions, her father would still be alive. She also forwarded an email that she received from Fierle in the days after her father's death, which she characterized as callous and disrespectful (Attached as **EXHIBIT A**).

We conducted an interview with F.S. 744.2111(1) a friend of the Ward who had previously held a durable power of attorney for him and acted as his healthcare surrogate. She stated that Florida Hospital contacted her to ask if she wanted to be his guardian and she said no at the time. She was unaware that the hospital had already petitioned for a guardian to be appointed. F.S. 744.2111(1) confirmed that the Ward was hospitalized several times due to chronic health conditions that the facilities Fierle placed him in where unequipped to manage. She said that the Ward required a procedure known as an EGD periodically to enable him to eat solid foods. The Ward had another EGD scheduled a few weeks after the day he died. F.S. 744.2111(1) was in regular contact with the Registered Nurse/Case Manager at St. Joseph's Hospital in Tampa, Florida, where the Ward was receiving inpatient care from early F.S. 744.2111(1) until his death. She said that the case manager told her that Fierle planned to let the Ward die. F.S. 744.2111(1) confirmed that she and F.S. 744.2111(1) had retained an attorney and were planning to petition for guardianship.

We conducted an interview with Kirtikumar Pandya, MD, a licensed psychiatrist who examined the Ward at St. Joseph's Hospital. He stated that he was concerned about the DNR filed for the Ward by Fierle. While he acknowledged that the Ward did not have the capacity to make all decisions, Dr. Pandya believed that he had the ability to decide that he wanted to live. Dr. Pandya said that the Ward wanted to be resuscitated

and wanted to be alive. Dr. Pandya said that, in his opinion, Fierle's reasons for the DNR were not rational, also noting that she does not have a healthcare background. Dr. Pandya also stated that the Ward's medical condition is not generally considered terminal. In both our interview and his psychiatric progress note in the Ward's medical records (Attached as **EXHIBIT B**), Dr. Pandya requested that the hospital rescind the DNR and order an ethics consult.

We conducted an interview with Rebecca Fierle, court-appointed guardian of F.S. 744.2111(1) She said that became associated with the guardianship when Florida Hospital contacted her after filing a guardianship petition. She said that she understood the Ward to be estranged from his children, but that she believed that Florida Hospital reached out to them when they petitioned for guardianship. Fierle said that it was difficult to find facilities that would accept the Ward due to his sex offender status. She knew that F.S. 744.2111(1) and F.S. 744.2111(1) were planning to petition for guardianship and confirmed that she would be willing to give up the guardianship if the petition was granted. When asked about the DNR, she gave the same response that F.S. 744.2111(1) F.S. 744.2111(1) mentioned: that it was an issue of quality of life rather than quantity. Fierle stated that she discussed life-saving care with the Ward and that he agreed to the DNR being in place. She also stated that this was common for her and that she files DNR for Wards regularly. She acknowledged that she attended an ethics counsel meeting at St. Joseph's Hospital. The meeting determined that because she was the court-appointed guardian, she had the authority to decide on end of life care and life-saving procedures, and the DNR remained in place. Fierle stated that, to her knowledge, the Ward had been dealing with his medical condition for many years.

We attempted to interview both the RN case manager and the physician who pronounced the Ward dead, but the case manager was told by hospital management not to speak with us and the physician did not return a message left with his office staff. However, our review of the Ward's medical records confirmed what F.S. 744.2111(1) told us, as well as what she said the case manager told her. The note in the records written upon the Ward's death, and digitally signed by the pronouncing physician, indicated that they did not perform life-saving procedures due to the DNR in place (Note attached as **EXHIBIT C**). The records also confirmed the upcoming EGD.

Findings of Fact, Observations, and Recommendations

Allegation 1: That the guardian has moved the Ward to multiple ALFs that do not meet the Ward's needs for care or supervision, which has resulted in multiple hospitalizations is **SUBSTANTIATED**. Even though it was difficult to find a facility willing to accept him due to his sex offender status, as court-appointed guardian, it remained Fierle's responsibility to ensure the Ward's medical care needs were met. The Ward's particular medical condition indicated that an assisted living facility was likely not the most appropriate environment for his care.

Allegation 2: That the guardian did not contact either of the Ward's children regarding initiation of the guardianship is **UNFOUNDED**. Fierle did not petition for guardianship in this case. Section 744.334, Fla. Stat. requires the petitioner to list next of kin and to state whether a willing and qualified guardian can be located. As Fierle was not the petitioner, she was not responsible for providing notice to next of kin for the petition. Fierle stated that she believed the Ward to be estranged from his children. F.S. 744.2111(1) even acknowledged that because of his past issues, she kept her father "at a distance." Further, once she was appointed as guardian, Fierle remained in regular contact with both the Ward's daughter and F.S. 744.2111(1).

Allegation 3: That the Ward has communicated that he wishes for life-saving actions to be taken should they be required, but the guardian has a DNR and has not agreed to remove it per the Ward's wishes is **SUBSTANTIATED**. Fierle's statement that the Ward agreed with the DNR is directly contradicted by statements made by the Ward's daughter, his friend, and his psychiatrist based on their discussions with the

Ward. Fierle also acknowledged that Ward had been dealing with his condition for many years, while also citing a quality of life concern. The Ward had never previously expressed a desire to die, and it seems unlikely that, as soon as he was appointed a guardian, he would suddenly be unwilling to tolerate a condition that he had been dealing with for many years. Additionally, Fierle knew that a relative and friend of the Ward, both of whom had serious concerns about the DNR, would be petitioning for guardianship (and acknowledged that she would willingly give up the guardianship), and she remained unwilling to consider removing the DNR even temporarily. Fierle acknowledged that members of the hospital staff had ethical concerns related to the DNR, and that she attended an ethics conference at St. Joseph's Hospital, but she failed to submit this ethical dilemma to the court for direction pursuant to OPPG Standard 15.

Pursuant to Section 744.3215(1)(d), Fla. Stat., a person who has been determined to be incapacitated retains the right "to be treated humanely, with dignity and respect, and to be protected against abuse…"

Pursuant to OPPG Standard 2(a), the "Professional Guardians shall know the extent of the powers and the limitations of authority granted to them by the court and all their decisions and actions shall be consistent with applicable court orders and Florida law. Any action taken by a Professional Guardian pursuant to a court order shall not be deemed a violation of this rule." Standard 2(b) states, "Professional Guardians shall obtain court authorization for actions that are subject to court approval in advance except for emergency situations." Standard 2(c) states, "Professional Guardians shall clarify with the court any questions that the professional guardian has about the meaning of orders or directions from the court before taking action based on the orders or directions."

During our interview, Fierle stated that placing DNR orders for her Wards is common and something that she does frequently. Because she did not petition the court for approval to place the DNRs, and these records are not generally maintained in the guardianship case files, we do not currently know the extent to which Fierle's current or former Wards may be affected.

Fierle's decision to place a DNR order, against the Ward's stated wishes, constituted the removal of care necessary to maintain the Ward's physical health. Section 825.102(3)(a)1. Fla. Stat. states that Neglect of an elderly person or disables adult means "A caregiver's failure or omission to provide an elderly person or disabled adult with the care, supervision, and services necessary to maintain the elderly person's or disabled adult's physical and mental health, including, but not limited to, food, nutrition, clothing, shelter, supervision, medicine, and medical services that a prudent person would consider essential for the well-being of the elderly person or disabled adult." The removal of this necessary care directly resulted in the Ward's death. Section 782.07(2), Fla. Stat. states "A person who causes the death of any elderly person or disabled adult by culpable negligence under s. 825.102(3) commits aggravated manslaughter of an elderly person or disabled adult, a felony of the first degree."

Additional Observations – Origination of the Guardianship

During our investigation, we noted two issues that, while not directly related to Fierle's performance as guardian, are concerns:

In the Florida Hospital petition for guardianship, they state that the Ward's daughter's F.S. 744.2111(1) whereabouts were unknown. However, her contact information was listed on the Advance Directive on file with the hospital, and our office found her contact information with a quick Google search. During our interview, F.S. 744.2111(1) stated that she was not asked if she wanted to be guardian until after the petition had already been filed. Even then, she said that she was not given details or made aware of the situation and was only asked if she wanted to be his guardian.

F.S. 744.2111(1) a friend of the Ward, was his designated health care surrogate and held a durable power of attorney for him. Soon after she began to question the need for a guardian to be appointed, she discovered that she was under investigation by the Florida Department of Children and Families, Adult Protective Services on suspicion of elder abuse or exploitation. She was later cleared of any wrongdoing by the investigation. This is the second investigation involving Rebecca Fierle that our office has worked recently where a friend or family member who questioned the need for a guardian found themselves under DCF investigation. In both instances, the subjects were cleared by the investigation. In both cases, the complaints were submitted anonymously.

Recommendations

The Clerk's Inspector General is responsible for establishing and maintaining independence so that the inspector general opinions, conclusions, judgments, and recommendations will be impartial and viewed by others as impartial. A cornerstone and guiding principle for inspectors general is the essential and fundamental boundary of independence; independence both in appearance and in fact. As a professional standard, the Clerk's Inspector General should make necessary and appropriate recommendations to the OPPG in the body of an investigative report. The Clerk IGs' recommendations are based on the scope, observations, and findings of the investigation. The recommendations are suggestions of professional opinions. The scope of the Clerks IG's investigation may not necessarily include information derived from administrative proceedings such as interrogatories, subpoenas, discovery, or hearing testimonies. The investigation reports are issued prior to the completion of the administrative and entire investigative process.

The Clerk IG suggests that the OPPG has an obligation to reasonably consider the recommendations and take all necessary actions pursuant to statute and rules to satisfactorily resolve any and all issues. The OPPG's actions or inactions are made at its sole discretion, and may correctly differ to the Clerk's recommendation.

Since Section 744.2004(2), Fla. Stat. delineates the actions that the OPPG must take, additional recommendations for OPPG action would be redundant and potentially contradictory to Florida statute. Therefore, no additional recommendations are suggested.

C. Investigative Methods

Our office conducted interviews with the complainant and the subject. We reviewed case file documents and court documents.

D. Status of Investigation

This investigation is **complete**. The Okaloosa County Clerk of Circuit Court and Comptroller, Department of Inspector General, on behalf of the Clerk's Statewide Investigation Alliance, continues to be available for further consultation and direction.

Andrew Thurman
Digitally signed by Andrew Thurman
Date: 2019.07.10 15:33:02 -05'00'

Andrew Thurman, CIGI
Auditor/Investigator
Okaloosa County Clerk of Court
Department of Inspector General

EXHIBIT A

From: Rebecca Fierle <rebecca@geriatricllc.com>
Subject: Re: My father is dead
Date: May 15, 2019 at 9:56:24 AM EDT
To: F.S. 744.2111(1)

F.S. 744.2111(1)

It was my understanding that you were in close contact with the hospital case manager so I assumed she let you know.

Any final arrangements can be handled by you and your brother. That is not a task I handle if there is family.

The funeral home of your choice can send an invoice to my office for payment from funds I have in the Guardianship account.

Rebecca Fierle
PO box 568625
Orlando, FL 32856
407-895-0504
888-858-7871 fax
Rfierle@gmail.com

On May 15, 2019, at 8:45 AM, F.S. 744.2111(1) wrote:

Rebecca,

Were you even going to tell me?

My family wants to know what is being done with my father's remains. He had specific instructions and preparations made, which you will no doubt ignore.

F.S. 744.2111(1)

Sent from my iPhone

EXHIBIT B

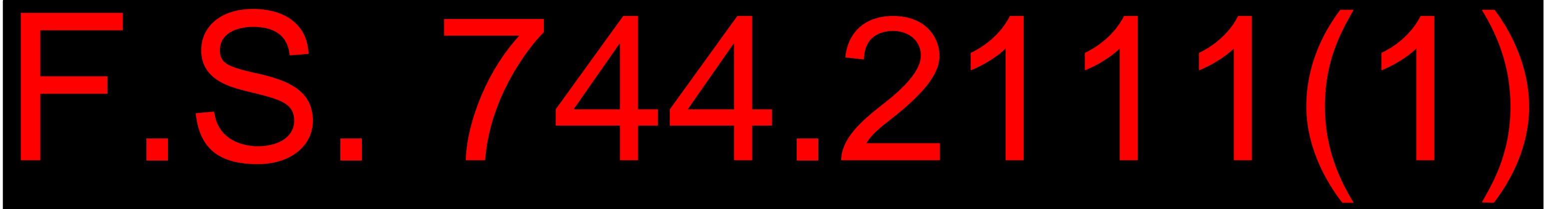

EXHIBIT C