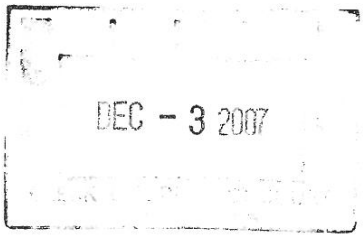
IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

THE COMMONWEALTH OF VIRGINIA, VIRGINIA OFFICE FOR PROTECTION AND ADVOCACY,	:	
Plaintiff,	:	CASE NO. 3:07CV734(REP)
v.	:	
JAMES S. REINHARD, in his official Capacity as Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, of the Commonwealth of Virginia, DENISE D. MICHELETTI, in her official capacity as Director, Central Virginia Training Center, and CHARLES M. DAVIS, in his Official capacity as Director, Central State Hospital,	:	
Defendants.	:	



COMPLAINT AND MOTION FOR PRELIMINARY INJUNCTION

PRELIMINARY STATEMENT

1. Plaintiff, Virginia Office for Protection and Advocacy (VOPA), brings this action against the Defendants, James S. Reinhard, Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) (in his official capacity only), Denise D. Micheletti, Director, Central Virginia Training Center (CVTC) (in her official capacity only), and Charles M. Davis, Director, Central State Hospital (CSH) (in his official

Va. § 37.2-707.

FACTS

13. On or about October 18, 2006, an individual with mental retardation and mental illness hereinafter referred to as "Resident A", died while a resident of CVTC. Resident A had a decades-long documented history at CVTC of ingesting non-edible items. During October 2006, Resident A began to show symptoms of bowel obstruction. He was transported to the hospital. On October 10, 2006, an exploratory laparotomy was performed and two latex gloves were discovered in his intestines. The gloves were surgically removed. Resident A died on October 18, 2006.

14. On or about November 13, 2006, after receiving a report of resident A's death while he was in the custody of DMHMRSAS, VOPA initiated an investigation of the death to determine whether or not the death was a result of abuse or neglect.

15. On November 16, 2006, VOPA requested, in writing, that CVTC provide VOPA with all records related to Resident A's death including any risk management review, baseline analysis review, or mortality review.

16. On June 5, 2007, VOPA renewed its request, in writing, for the report of the baseline analysis review.[1]

17. On July 12, 2007, VOPA renewed its request in writing for the baseline analysis review and risk management review.

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1. DMHRSAS Departmental Instruction 401 defines an "event BAR" as follows:
> This means a Baseline Analysis and Review (BAR) of an event, which involves a fundamental and substantial examination of all surrounding facts and elements of the event, with a focus on constructive criticism and correction of any/all related systems and processes.

18. Defendants have refused to provide records related to Resident A's death requested by VOPA. As a result, VOPA is unable to complete its statutorily authorized investigation into Resident A's death.

19. On or about January 11, 2007, an individual with mental retardation hereinafter referred to as "Resident B" was assaulted at CVTC by another resident. Resident B was observed by CVTC staff running from Resident B's room covered in blood. One staff member went to Resident B's room where she found multiple pieces of human ear tissue and a large amount of blood on the floor.

20. On or about May 24, 2007, VOPA opened a formal investigation into the incident to determine whether or not the injuries sustained by Resident B were a result of abuse or neglect.

21. On June 8, 2007, VOPA requested, in writing, records regarding the injuries to Resident B including any risk management review or baseline analysis review conducted regarding the incident.

22. On July 12, 2007, VOPA renewed its request, in writing, for the baseline analysis review and risk management review.

23. Defendants have refused to provide records related to Resident B's injuries requested by VOPA.

24. As a result of the denial of the requested records, VOPA is unable to complete its statutorily authorized investigation into the incident which caused Resident B's injuries.

25. On, or about March 22, 2007, an individual with mental illness hereinafter referred to as "Resident C" died while a patient at CSH. Resident C had been held in some form of

restraints for a period of approximately 33 hours before being released. About thirty minutes after Resident C was released from restraints, several CSH staff entered Resident C's bedroom to attempt to place Resident C into restraints. During the restraint incident, Resident C complained of being unable to breathe. Attempts to revive Resident C failed and Resident C was transported to a community hospital and was pronounced dead.

26. On, or about April 5, 2007 after receiving the report of the death of Resident C while in the custody of DMMHRSAS, VOPA initiated an investigation of the death to determine whether or not the death was a result of abuse or neglect.

27. On, May 31, 2007, VOPA requested in writing records relating to the death of Resident C, including the root cause analysis, mortality review, and risk management analysis.

28. On or about August 13, 2007, counsel for Defendants informed VOPA that its requests for records was denied by the Commissioner, DMHMRSAS, on the basis of the peer review privilege.

29. On August 29, 2007, VOPA renewed its request, in writing, for the mortality review, root cause analysis, and risk management review regarding Resident C.

30. Defendants have failed to provide records related to Resident C's death requested by VOPA.

31. As a result of the denial of the requested records, VOPA is unable to complete its statutorily authorized investigation into Resident C's death.

32. By letter dated September 14, 2007, VOPA sought to determine whether further discussion of the issue with Defendants would be productive.

33. On or about September 19, 2007, counsel for Defendants requested additional time to consider the issue.