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No. 09-529

IN THE
SUPREME COURT OF THE UNITED STATES

COMMONWEALTH OF VIRGINIA,
BY ITS OFFICE FOR PROTECTION AND ADVOCACY,
Petitioner,

v.

JAMES W. STEWART, III, IN HIS OFFICIAL CAPACITY AS COMMISSIONER, DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES OF THE COMMONWEALTH OF VIRGINIA, DENISE D. MICHELETTI, IN HER OFFICIAL CAPACITY AS DIRECTOR, CENTRAL VIRGINIA TRAINING CENTER, AND VICKI Y. MONTGOMERY, IN HER OFFICIAL CAPACITY AS ACTING DIRECTOR, CENTRAL STATE HOSPITAL,

Respondents.

On Writ Of Certiorari
To The United States Court of Appeals For the Fourth Circuit

BRIEF FOR PETITIONER

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Warner, Governor of Va., to Heidi Lawyer, Acting Director, Dep't for Rights of Virginians with Disabilities, at 1 (July 1, 2002), http://tinyurl.com/2002-07-01-Gov-Ltr.

B. Factual Background

This case arises from VOPA's attempt to investigate the deaths of two individuals, and injuries to a third, that occurred while the individuals were residents of institutions operated by the Commonwealth of Virginia. The facts discussed below are drawn from VOPA's complaint and its motion for a preliminary injunction.

Resident A. The first of these individuals, "Resident A," was a person with mental illness and retardation. He died while a resident of Central Virginia Training Center (CVTC). Respondent Micheletti runs CVTC under the supervision of respondent Stewart, as Commissioner of the Department of Behavioral Health and Developmental Services. J.A. 12-13.

Resident A had a decades-long history at CVTC of ingesting non-edible items. After exhibiting symptoms of bowel obstruction, Resident A was transported to a community hospital for surgical removal of two latex gloves from his intestines. Resident A died eight days after the surgery. J.A. 13.

VOPA initiated an investigation to determine whether Resident A's death resulted from abuse or neglect. As part of this investigation, VOPA repeatedly requested copies of certain reviews conducted by CVTC in conjunction with Resident A's death. CVTC acknowledged VOPA's requests, but failed to provide the reviews. J.A. 14.

Resident B. "Resident B," an individual with mental retardation, was assaulted at CVTC by another resident, and was observed by CVTC staff running from Resident B's room covered in blood. A CVTC staff member found multiple pieces of human ear tissue and a large amount of blood on the floor in Resident B's room. J.A. 14-15.

VOPA initiated an investigation to determine whether Resident B's injuries resulted from abuse or neglect. VOPA repeatedly requested copies of certain reviews conducted by CVTC concerning Resident B's injuries, but CVTC refused to provide them. J.A. 15.

Resident C. The second death was that of an individual with mental illness, "Resident C," who was a patient at Central State Hospital (CSH), which respondent Montgomery runs under the supervision of respondent Stewart. J.A. 15.

Resident C complained of being unable to breathe when CSH staff attempted to place him in restraints. During this restraint incident, efforts to revive Resident C became necessary, but failed. Resident C was transported to a community hospital where he was pronounced dead. J.A. 16.

VOPA initiated an investigation to determine whether the death was the result of abuse or neglect. VOPA repeatedly requested copies of certain reviews conducted by CSH relating to the death of Resident C, but its requests were rebuffed on grounds of peer review privilege. J.A. 16.

C. Proceedings Below

1. VOPA filed this action against respondent state officials in the United States District Court for