CRIES OF ANGUISH

The Nation's Voice on Mental Illness
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A Summary of Reports of Restraints & Seclusion Abuse Received Since the October 1998 Investigation by The Hartford Courant

Compiled by the National Alliance for the Mentally Ill (NAMI) *Through March 2000*

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Since *The Hartford Courant* published its "Deadly Restraint" investigative series in October 1998, NAMI has received a steady stream of reports of both recent and past abuse of restraints and seclusion, including more deaths.

There have been 58 incidents from 24 states and the District of Columbia that have been reported, approximately half of which have occurred since publication of the *Courant* series. Only five are over five years old.

This chart summarizes accounts received through March 2000. Unless previously identified in news accounts, the names of individuals and facilities involved in each incident (and the person who made the report) are omitted in the interest of privacy and in some cases to avoid possible retaliation.

Unless otherwise indicated, the source of each report is the person actually involved in the incident. NAMI has not independently investigated each incident, but will provide assistance to government authorities or news reporters who wish additional details about specific incidents or to talk with sources directly.

The focus of this report is on licensed treatment facilities. NAMI also has received reports of deaths and serious injuries in schools, juvenile justice facilities, and correctional facilities, but

they are not included in this chart because they fall outside the scope of currently pending legislation.

State/Location	Facility	Incident Details	Date/Source
ARIZONA Phoenix	State Hospital	2 young women in restraints in separate seclusion rooms • 1.5 hours (15 minute checks) at time of observation • *"shortage of staff"* cited by officials as a reason for use of restraints	**February 1999/ eyewitness**
Tucson	Desert Hills Center for Youth & Families	State investigators found medical neglect after a girl filed 15 requests for medical attention in January 1998, before staff discovered her back was fractured. The girl alleged that a staff member injured her back while restraining her a month before	**December 1997/reported 4/2/98** ***Arizona Republic***
Tucson	Desert Hills Center for Youth & Families	**Edith Campos, 15 died of "oxygen deprivation caused by a harmful restraint"** 2 days after being held in a prone position by 2 staff members, apparently after an altercation with another patient	**February 4, 1998/reported 3/13/98** ***Arizona Republic***
Tucson	Desert Hills Center for Youth & Families	A staff member used his body to pin a misbehaving 8 year old boy's knees to the boy's chest while telling him to stop struggling. The boy began to gasp and to complain that his leg hurt and was released after 20 seconds • a nurse resigned after accusing the supervisor involved in the incident *"There's absolutely no reason to get rough with children. There were plenty of us there and displays of anger toward a child are not appropriate."*	**March 18, 1998/reported 4/2/98** ***Arizona Republic***
CALIFORNIA Berkeley	Hospital	Man asked for something to help him sleep • placed in seclusion • no bathroom; left to defecate in his clothing	**1993/reported by parents 2/99**

State/Location	Facility	**Incident Details**	**Date/Source**
[California] Chula Vista	New Alternatives (private residential care facility)	**Kristal Mayon-Ceniceros, 16-year-old, died of respiratory arrest** • face put down on floor • arms and legs restrained by 4 staff members	**February 5, 1999/AP Wire**
Greenbraie (resident)	County Hospital	Man (6'7") admitted to psych ward involuntarily through ER after calling 911 for help. Given antipsychotic drugs despite lack of consent; denied sleep medication even thought it was prescribed. Became agitated and hit an exit sign. • Staff told him that if he would go into seclusion room he would not be restrained. He cooperated • Put into restraints in seclusion for 12-14 hours; during which time his charts showed he was calm and cooperative • *"Yet they did not let him up…He started thrashing around. Then they shot him full of drugs…He was treated inhumane, denied all dignity, had to urinate on himself."*	**Late March 1999/reported to NAMI by mother 3/29/99**
Los Altos (resident)	Unknown (described by consumer as "a very reputable, well-run" hospital)	29-year-old woman • hands and feet restrained to bed • isolated in room for 18 hours (est.) • nurses entered room only twice • water left out of reach • throughout hospitalization never informed of the nature of her illness	**1995/reported to NAMI 2/99**
Oakland	Hospital	Newly widowed mother of 3 • restrained for 4 hours after refusing medication because she still hoped to nurse her youngest child • considered it a punishment • *"Restraints are used to break your sprit, and the humiliation puts one into a major depression…I don't think I've ever recovered the confidence and self-esteem I used to have."*	**1989/reported to NAMI 2/99**

State/Location	Facility	Incident Details	**Date/Source**
[California] San Francisco	Inpatient mental health center	Son was in a coma , the result of being placed in restraints	**December 1999 reported to NAMI by father**
San Luis Obispo	General Hospital	Woman placed in seclusion all night • defecated in clothes • drank her own urine to quench thirst from lithium • morning staff horrified at length of confinement	**1997/reported to NAMI by parents 2/99**
Stockton	San Joaquin County MHS Psychiatric Health Facility	Rick Griffin, 36 (6'3", 340 lbs) • **death from cardio-respiratory failure and extreme agitation** • wrestled to floor by 8 staff • bound in leather restraints	**November 1998/Sister and *Stockton Record***
COLORADO Colorado Springs	Residential treatment facility	12 year old boy on 3 medications; remains mostly quiet, distant, unresponsive; "his hands shake as though he's recuperating from a 3 day drunk." • *"{He} has told me about the restraint room… and it reminds me of something that they would do to people in mental institutions in the 50's…not the 90's."* • *"This does not seem to be what a 12 year old boy should be going through…I don't feel they are doing anything but controlling him with heavy duty drugs instead of finding the one drug or combination that will help him live a normal life."*	**Reported to NAMI by grandmother March 1999**
CONNECTICUT Norwalk	Hospital	22-year-old retarded man with disability (inward knee caps) shackled at ankles	**November 20, 1998/ eyewitness**

State/Location	Facility	Incident Details	Date/Source
DISTRICT OF COLUMBIA	Military Hospital	• Put into restraints for biting fists, screaming and crying. • Medicated with Haldol; unconscious for a day; brief periods of consciousness during second day; could hear but not open eyes. • "The doctor labeled me with Borderline Personality Disorder…a label that was a fancy way of saying 'lying manipulative bitch' and it worked. No one did believe me except for my friends and family."	**July 1998; reported May 29, 1999**
	Saint Elizabeth's Hospital	• In May, 1999, a 22 year old patient alleged that two staff members put him in restraints, then kicked and punched him in the mouth. • Later, a 16-year-old accused a staff member of punching him in the mouth while being put into restraints. • In 1997 and 1998, the hospital's in-house patient's advocate received about 20 abuse complaints; about six were confirmed. By June 1999, one had been confirmed. • The hospital's court-appointed outside patient's advocate receives about one abuse complaint a month, mostly involving patients put into restraints. Some restraints are put on so tightly that they cause bleeding. • Hospital acknowledges that allegations are difficult to prove because of cover-ups or conflicting statements. Some are not reported, sometimes out of fear of retaliation. Few allegations surface publicly.	**Washington Post/June 7, 1999**
FLORIDA Silver Springs (This entry is included because the child was placed in a privately run camp for juvenile offenders despite recommendations that he be placed in a mental health facility	Camp E-Kel-Etu	**Michael Wiltsie, age 12, died at a wilderness camp when placed face down in a physical restraint.** • Michael Wiltsie (65 lbs.) was held down on his stomach with his arms at his side as a counselor (320 lbs.) sat on top of him. • The Marion County Grand Jury decided not to charge the counselor in the death of Wiltsie, who died of "compressional asphyxiation, because he was following the procedures for which he had been trained."	**February 5, 2000** **Reported by the St. Petersburg Times**

State/Location	Facility	Incident Details	Date/Source
Tampa	Hospital	Hospital's former medical director for psychiatry reports that hospital policy required anyone admitted involuntarily for evaluation to be restrained. Police can initiate "observation and evaluation" of persons under Florida law, can be kept in restraints up to 24 hours in the emergency room, without any requirement that a psychiatrist see them. • *"I have been appalled at the ways that restraints are used in many facilities. States allow their use in very abusive and dangerous ways."* • *"These people would be left unsupervised for varying lengths of time.* • *Good clinical care "should include careful observation by qualified nursing personnel trained in the use of restraint alternatives and, if restraints are required, in their application."*	**Dates unknown; contacted NAMI 4/6/99**
West Palm Beach	45th Street Mental Health Center (adolescent residential facility)	**Laura Hanson, 17-year-old, stopped breathing and died after staff member used "basket hold" to break up fight and restrain her** • involved reaching around patient's body from behind and pulling arms across chest	**November 19, 1998/reported in *Palm Beach Post,* (11/21/98)**
GEORGIA Atlanta	Psychiatric hospital Forensic unit	• Psychiatric nurse witnessed the use of a "locking jumpsuit" on a patient, with sewn crotch and zipper locked in back with a padlock. Patient must ask staff to unlock suit whenever he needs to use the toilet. Meets the state definition of restraint because it is a mechanical device limiting a person's access to his own body. • Device seems "very degrading" and possibly a violation of hospital policy. Patient has a history of sex offenses, but none recently. There is no MD order. When patient refused to wear it, he was placed on "a restrictive observation level" apparently as punishment. • I have been working psych hospital for nearly 20 years and have never seen any devices like this used and fail to see what therapeutic or protective rationale there can be for (it).	**Date undetermined** **Reported 4/27/99**

State/Location	Facility	Incident Details	Date/Source
Atlanta	Hospital	A 9 year old girl was left in a "time-out" room for three hours where she screamed, when the girl did not quiet down she was then placed in a therapeutic hold, and then given four shots of a sedative. • Parents did not find out about the events till they paid $200 for a copy of the medical records	**October 1999** **Reported by parents**
INDIANA Unknown	Hospital	16 year old boy restrained for a week; then two weeks • Second time was because he "head-butted" an attendant while 4-5 people were holding him face down and he could not breathe. Doctors and staff told mother that he was lying' that he could breathe. • Even though admitted voluntarily, the hospital threatened a 72 hour hold and involuntary commitment when his mother sought to discharge him for a second evaluation at a top psychiatric research institution. Mother hired an attorney and got help from the Indiana Protection & Advocacy (P&A) agency. • *"Adolescent programs in psychiatric hospitals are geared mostly to behavior modification…and overlook the bio-medical aspect.:* • *"My son was tied to a bed in 4 way restraints for close to 2 weeks. This I believe was torture. {Then he was} walking around in leg and wrist shackles. He was being punished for reacting to a very real fear that he could not breathe and was going to die. I'm so angry. This MUST stop! Our kids are dying."* • *"I'm angry at systems that will eventually work, if you have parents who care and will fight for you…{a} family that knows your rights and who{m} to contact…{or} the means to hire an attorney. Who's going to be there for the ones who can't fight for themselves? These kids are not just dying physically.. They are dying inside emotionally. You can see it in their eyes."*	**Early 1999/reported to NAMI by mother 4/6/99**

State/Location	Facility	Incident Details	**Date/Source**
LOUISIANA Houma	Hospital	Woman admitted in manic state during night shift with no orientation; attacked nurses after forced medications. Strapped down “forever.” “They only came and checked on me a few times and didn’t do much to help me through it," was told that if she didn’t keep quiet, she’d have a sheet put over head. Thinks the incident could have been avoided with "more patience and understanding.:	**April 20, 1999/reported to NAMI July 1999**
MARYLAND Baltimore	Hospital	Woman was in emergency room for 10.5 hours • locked in steel room by guards • injected in arm without consent • refused access to own psychiatrist • not allowed to leave until she "behaved"	**1997/reported to NAMI 2/99**
Outside Baltimore	Hospital	• Man, 25, has been in physical restraints for three years, day and night. He even sleeps in restraints .	**Since 1996** **Reported by father 5/5/99**
Rockville	Hospital	• 44 year old professional woman sought voluntary treatment for bipolar disorder; placed in 4 point restraints and sent elsewhere because of lack of insurance. • "In 1996, I was caught in a corporate downsizing…I lost the home I had rented for 8 years and within 6 months was hospitalized. For the next 7 months after release from the hospital, I was homeless…My efforts to help myself were impeded by ignorance about mental illness on the part of the very professionals who were supposed to help."	**Date undetermined, reported** **June 2, 1999**
MASSACHUSETTS Hyde Park	Residential treatment facility	**A 16 year old boy died after being restrained by two workers during a struggle.** • Medical Examiner determined cause of death to be trauma to the neck. • Workers forced the patient to the floor to restrain him and pulled his head up and backward, obstructing the patients breathing	**Reported March 2, 2000** **Digest report**

State/Location	Facility	Incident Details	**Date/Source**
MINNESOTA Ramsey County	Hospital	Woman brought to commitment hearing in hospital basement tied to a wheelchair in public elevator • *"This was extremely demeaning to my loved one, who has no history of either self-harm or harm to others when decompensated."*	**Late 1998 or 1999/reported to NAMI 2/99 by family member**
MISSOURI Fulton	Hospital	Mother reported incidents involving her 33 year old son • "Who can survive the torture of 1,851 hours of seclusion" • "My son was in 4 point tie down straps spread eagle on a bed in a closed seclusion room for 34 consecutive days and on other occasions 26, 10, and 9 days." • "My son is slowly dying…Please help me save my son."	**Reported February 29, 2000 by the patients mother**
NEBRASKA Kearney	Hospital	• Man kept in seclusion and sometimes in restraints for 10 days, because staff said first that he "needed to sleep" instead of pacing at night; then, because he was not acting "appropriately." • "He describes it as traumatic stress experience, similar to being a prisoner of war." She believes it contributed to a suicide attempt a few months later. • "My son says that too many times he has (been) treated punitively and with a lack of respect…damaging self-esteem and making recovery more difficult." • "A little talking might have calmed down the situation."	**1991 reported to NAMI by mother**
Resident of Omaha	Unknown	• Man placed in restraints at age 20 • "It was very uncomfortable, and I wasn't going to do harm to anyone or myself."	**1970 reported June 5, 1999**

State/Location	Facility	Incident Details	**Date/Source**
NEVADA Las Vegas resident	Unknown	28-year-old woman voluntarily committed for treatment of conditions related to child abuse • *"Suddenly the guard had a pair of huge leather cuffs with padlocks on them… All I knew was that I was being strapped down to a bed by a strange man with a gun. THIS IS NOT GOOD THERAPY FOR A RAPE VICTIM… All I could do was close my eyes and try to pretend this wasn't happening to me."* • *"I had to hold myself together if I wanted to get out of there…pretending nothing was wrong, just as I had while being molested."* • *"The trauma of my day in Hell has been incorporated into the mental problem I was seeking help for when I went there…(its) flashback happened long after flashbacks to the original abuse experience stopped."*	**1997/reported to NAMI 2/99**
NEW JERSEY Burlington	Hospital	Woman's first experience with restraints was in 1983, while being transferred to another hospital, put into restraints even thought she was non-violent • In 1998, it happened again at the same hospital Staff told her it was "the law," but no other facility has ever restrained her • *"I felt raped and only later when I looked at the dictionary did I discover this was the right word. Its first and original meaning is 'to be overcome by force and carried away'… I suffer deep scars from the experience to this day."*	**1983 and December 1998 reported to NAMI 1/99**

State/Location	Facility	Incident Details	**Date/Source**
NEW YORK Binghamton	Hospital	18-year-old male • tackled to floor by 5 staff members • hit in face, bruised • turned over and used penis as a lever • put into restraints • investigation dropped because of lack of witness • staff cursed at patients: i.e., *"Shut the fuck up!"* to a woman sobbing for her father • *"I think if I were a paranoid person, being strapped down to a bed for two hours would just make it worse."*	**February 1998/reported to NAMI 2/98 by mother**
Nanuet resident	Residential treatment facility for children	• 12 year old boy thrown across room; restrained face down while bleeding from cut. • Treated in ER for contusions, abrasions on face, lacerations requiring stitches, • Staff claims he jumped backwards and injured the back of his head, and that they held him down to put Peroxide on the wound.	**June 15, 1999; reported by parents with photographs**
New York City	Psychiatric hospital	A senior lawyer in one of the nation's largest insurance and financial institutions experienced a psychotic episode in a taxi en route to his psychiatrist's office. • Driver called police, who handcuffed him, took him to precinct station and handcuffed him to a radiator while waiting for an ambulance to arrive. • "That's not the bad part." In Bellevue, he was put in a straightjacket and chained to an antique wooden wheelchair. He started rocking and twisting. Eventually, the chair flipped on its side, and he banged his head on the concrete floor.	**January 1984** **Reported 4/13/99**

State/Location	Facility	Incident Details	**Date/Source**
[New York] Westchester	Hospital	26-year-old woman put in restraints for 12 hours; when released during visit by mother, she began sobbing • mother was told the daughter would be put back into restraints unless she stopped crying • mother considered legal action, but decided not to sue because daughter was still fragile • *"I regret that I didn't and she does too, because so many others have died in New York, New Jersey and Connecticut."*	**1989/reported to NAMI 2/99 by mother**
NORTH CAROLINA Asheville	Hospital	Staff kept adding medications; after 3 days, woman was found "semi-comatose on the floor." They placed her in restraints and stopped all meds. • She woke up 3 days later unable to talk. • She continued in the hospital for 3 weeks "with no counseling, rehabilitation or anything." • "Believe me, 60 Minutes hardly broke the ice." Has mobility, memory and speaking problems today "from what Charter did to me." • Sought legal help but could not find a lawyer willing to take on Charter without bills from Charter.	**October 1994** **Reported 4/21/99**
Banner Elk	Grandfather Home	**Timithy Thomas, age 9, died in a "baskethold" after first being isolated in a "quiet room"**	**March 11, 1999/based on *Charlotte Courier reports***
Caldwell County	Residential treatment facility	Son was restrained by a 400 pound staff person for not wanting to return a "goal sheet" • "My son gave no fight, he requested to have some of the burden off, because he could not breathe, he then spit saliva from his mouth trying to keep his mouth clear to breathe. When he spit, the staff person shoved my sons face into the cement floor and applied more pressure."	**February 2000** **Reported by the family**

State/Location	Facility	Incident Details	Date/Source
[North Carolina] Charlotte	Hospital Adolescent unit	• Girl was a patient at the time 60 Minutes secretly videotaped the unit's conditions, including use of restraints. • Videotaped conditions were not "rare or occasional, but rather the expected, day-to-day modus operandi." • Patients were doubly vulnerable: because they were children and mentally ill • Wants punitive and corrective action	**May 5, 1999** **Parent's letter to NAMI**
Gastonia	My Brothers House Residential group home	**Sabrina Elizabeth Day, age 15, died when a staff member restrained her and she hit her head** • Sabrina had been placed in restraints several times before. • *"I'm mad, upset, hurt…All I wanted was help for her and now she's dead."— mother*	**Feb 2000** **Charlotte Observer Report**
Western	Unknown	Boy hospitalized 4 times since age 8; • boy put in time-out room until he stopped crying • boy kept at lowest level of token system while lying on bed, sobbing uncontrollably for 3 days. When he finally calmed down and asked for a deck of cards to play Solitaire, the request denied because he had not earned the privilege • *"They should have rejoiced that he chose to do something other than sob."*	**Undetermined /reported to NAMI December 1999 by mother**
Western	Unknown	6-year-old boy • no family visits allowed during first 24 hours; then only one 5 minute call per day; visits twice a week; despite acute separation anxiety • staff psychiatrist changed medication to one tried before with side-effects, even though referring psychiatrist and mother believed it inappropriate; family was forced to acquiesce or else face discharge • *"And then where would he go?'*	**December 1999/reported to NAMI by mother's peer counselor**

State/Location	Facility	Incident Details	**Date/Source**
OHIO Homeworth	Hospital	Man restrained in leather straps "many times" during a three-month period. • **died from "neuroleptic malignant syndrome" which parents believe was caused by Haldol and "not being watched carefully enough."** • **died in restraints, running temperature of 108 degrees** • autopsy reported marks on ankles and wrists and big bruise on chest • *"I would like to see these things changed… so these things do not happen to other mental patients."*	**April 25, 1998/reported to NAMI 3/99 by parents**
OREGON Portland	Hospital	Woman placed in isolation room • not allowed to talk with brother • not allowed to use bathroom • "freaked out" after 30 hours; began screaming • was "taken down" on her back; head slammed repeatedly on floor • released shortly before Christmas without shoes, coat or transportation	**December 1998/reported to NAMI 2/99 and 5/99**
PENNSYLVANIA Norristown	Hospital	• *"My mother spent over fifty years at this state hospital and she had told me what they had done to her from her neck to the balls of her feet…There was no accountability or state investigations. May times we would go and visit her on a weekly basis, and for over 50 years, we would see her restrained to the bed with sores on her body."* • *"One time in 1995 I had witnessed children being restrained in a four person prone with staff sitting on a child's back, children being locked up in rooms alone…the children were only aged 6- to 14."*	**Reported March 12, 1999** **In a letter from a family member**

State/Location	Facility	**Incident Details**	**Date/Source**
[Pennsylvania] Orefield (Lehigh County)	KidsPeace (residential treatment facility)	**Mark Draheim, 14-year-old died of oxygen deprivation to brain after being restrained by 3 staff members** • preliminary autopsy found abrasion on body	**December 1998/reported to NAMI by family and *Morning Call***
Painesville	Lake West Hospital	**Gregory Cooper choked to death while being restrained** • He was sedated, strapped face down to a gurney, with a back board tied on top of him and a towel over his mouth to prevent him from spitting. • Lake County coroner ruled that the death was a homicide caused by the restraints. • "You can't go back and take away the horror of the way he died."	**February 19, 2000** **Reported in the Lake County Plain Dealer**
TENNESSEE Blount County	Pennisula Village (residential treatment facility for adolescents)	12-year-old female in Special Treatment Unit placed in straightjacket • *"It's called a burrito…I would be in the middle of the floor where everybody could watch me."* • medication cut in half against advice of regular psychiatrist; discharged in handcuffs in worse condition than when admitted • STU patients can write home, but cannot receive mail from or talk on phone with parents; girl wrote letters that family never received • for "less serious outbursts," staff take patients down to ground and pin them • more serious episodes put patients in a "burrito" or 5 point leather restraints on a bed • doors are locked, windows covered, lights on 24 hours a day	**1994/reported by mother and *Metro Pulse* 1/97**

State/Location	Facility	Incident Details	Date/Source
TEXAS Unknown	Hospital	• Woman has been restrained and abused "too many times to count." • Once in seclusion with no supervision, she knocked herself our and had to recover in the medical unit • "I have horror stories I thought no one would ever believe." • Now a consumer advocate in Austin	**Dates Un-determined** **Reported 4/22/99**
San Antonio	Hospital	**Randy Steele, a 9 year old boy died after two hospital workers pinned him to the floor during a violent struggle** • A staff worker restrained Steele holding his arms and wrestling him to the floor, he struggled to breathe and began vomiting.	**Reported February 24, 2000** **By the Associated Press**
San Antonio	Hospital	**A 16 year old girl died while in restraints** from a heart condition, the hospital was put on probation for violating restraint standards.	**Reported February 9, 2000** **By the Associated Press**
San Antonio	Hospital	**A 14 year old boy died in restraints.**	**March 9, 2000** **Reported by advocate**

State/Location	Facility	Incident Details	Date/Source
VIRGINIA Northern VA	Hospital	After 2 days without phone contact or staff progress report, mother drove 90 minutes to hospital: • found 29-year-old son in isolation room; underwear filled with feces • transferred back to room only after mother yelled at staff • when staff washed son in shower stall, mother saw more than 12 injection sites on buttocks • Son recalled only being put in restraints and in isolation: *"The worst thing was when everyone's away."* • *"This state of living terror continued for 3 days."*	**November 1998/reported to NAMI 12/98 by mother**
Staunton	State Hospital	Cesar Chumil, 50, has been hospitalized since 1982 in three different state public hospitals. Known as "the man in the bubble," has been secluded in a Plexiglas cell for the past decade. Officials consider him violent and untreatable; yet he regularly visits his family on 5-day passes without any restrictions, restraints, or incidents • in one hospital, Cesar spent over a year bound to a chair. His "reward" for good behavior was to have his restraints loosened a notch or two. When united for family visits, he would be so weak that he would fall to the floor, covered with bloody blisters. • another "reward" for good behavior was for Cesar to be put on a mattress in restraints in an activity room and allowed to watch other patients move about. • *"My family blames the hospital for my uncle's aggression. He must feel anger like any other human being who is humiliated and treated like a beast."*	**1982 to present/reported to NAMI by family members**

State/Location	Facility	Incident Details	Date/Source
WISONSIN Madison	Mendota Mental Health Institute	• During first three months of 1999, there were 745 episodes of restraints use for a total of 1608.5 hours • Court order and consent decree in effect from class action suit.	**Reported May 1999 by Diane Greenley, Supervising Attorney Wisconsin Coalition for Advocacy**
Milwaukee	Hospital	• Placed in steel and leather straight jacket "for keeps" • Could not urinate or move bowels	**Date undetermined; reported January 20, 1999**

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