**In re: Cesar Chumil**

Western State Hospital (WSH) in Staunton, Virginia secluded Cesar Chumil from the general patient population for over 20 years.[[1]](#footnote-1) It was our position this use of seclusion violated Mr. Chumil' s rights and did not comply with the requirements of state and federal law. We argued the seclusion was neither the least restrictive treatment option available, nor an effective treatment option. In addition, failing to provide Mr. Chumil treatment in Spanish and exacerbating communication issues by insisting he communicate in English - a language WSH admits he has difficulties with, particularly when agitated - violated his state and federal rights and failed to meet WSH's treatment responsibilities under Virginia and federal regulations of mental health care.

Mr. Chumil was born on August 28, 1950. He was born in Guatemala City, Guatemala.[[2]](#footnote-2) In 1978, at the age of 28, Mr. Chumil was first placed in a mental health institution.[[3]](#footnote-3) In 1980, Mr. Chumil moved to the United States and began to reside in Northern Virginia with his family.[[4]](#footnote-4) He was next hospitalized in November 1981.[[5]](#footnote-5) He was released, but hospitalized again in December of 1981, after which he was transferred to WSH, having been diagnosed with passive aggressive personality disorder.[[6]](#footnote-6) On December 31, 1981, while still at WSH, doctors performed an electroencephalogram (BEG), a test to detect abnormalities in the electrical activity of the brain, which showed a disturbance in the frontal temporal area, resulting in altered diagnoses of organic delusional syndrome (axis I) and partial complex seizures (axis III). He was discharged on March 19, 1982, after improvement in his behavior.[[7]](#footnote-7)

On March 31, 1983, he was admitted to WSH again with the diagnosis of chronic paranoid schizophrenia. He briefly responded to medications and received a two-week pass home. In August 1983, WSH changed his diagnoses to organic affective syndrome, antisocial personality disorder, and partial complex seizures.

Mr. Chumil's treatment at WSH continued until he was transferred to Eastern State Hospital in October 1984 in order to work with a Spanish-speaking psychiatrist, Dr. Sanzo. This was in response to a concern that Mr. Chumil' s mental health issues were aggravated by language difficulties and cultural isolation. His treatment team felt that he would progress better if he was being treated by a Spanish-speaking psychiatrist. His behavior did in fact improve while he was working with Dr. Sanzo. After Dr. Sanzo left Eastern State Hospital, Mr. Chumil was transferred back to WSH in March 1985. There his mental health deteriorated. In August 1985, he was transferred to the Forensic Unit at Central State Hospital. After he was severely beaten by the staff at Central State Hospital, he was transferred back to WSH in February 1986.

In 1988, WSH began using contingent seclusion as part of Mr. Chumil's behavioral treatment plan. In 1993, WSH began to seclude Mr. Chumil on a permanent rather than a contingent basis. He was placed in a seclusion pod where he remained until he was moved to the seclusion cell, presumably in reaction to a 1999 United States Department of Justice report,[[8]](#footnote-8) which referenced Mr. Chumil's seclusion as an example of WSH's inappropriate, excessive, and unprofessional use of seclusion and restraint.[[9]](#footnote-9) The report ordered an immediate end to the use of seclusion for the convenience of staff or as an alternative to treatment.

Many medications were administered to Mr. Chumil, with no consistent treatment success, but this variation and experimentation with medication was not matched with behavioral or residential adjustments. Mr. Chumil was confined to a cell[[10]](#footnote-10) in violation of state and federal law for over seven years, preceded by another unlawful confinement for eleven years. His toilet was in plain view of anyone who happened to peer through a window, and Mr. Chumil had no control over whether his windows' view is closed or open - the mechanism for operating the windows was only accessible to staff, who kept it open. Mr. Chumil was caged, to be observed by anyone who happened by his cell, which consisted of a bedroom, bathroom, and a cement 'porch,' which abutted an outdoor common space for patients and was enclosed by tall chain-link fence and a roof. WSH placed semi-opaque screens of tightly woven mesh across the chain-link fence enclosing Mr. Chumil's ‘porch,’ severely limiting his view of the outside. Mr. Chumil's sister and Legally Authorized Representative, was told by a nurse that these screens were put up to protect Mr. Chumil, because other patients outside in the common yard were throwing objects at him through the fence around his 'porch.' WSH also removed the stationary bicycle from Mr. Chumil's 'porch' despite the fact that it provided his only opportunity for physical exercise.

Mr. Chumil's behavioral therapy is not provided in his primary language, His ability to communicate was further diminished after his teeth were removed on March 29, 2005. He remains without dentures to this date.

While WSH maintained that Mr. Chumil was too dangerous to interact with other patients or staff, he was allowed to come out of his seclusion cell for visits to external health care providers and visits with his family, including overnight visits and day visits involving excursions into public areas, such as restaurants and retail stores. Mr. Chumil remained in the seclusion in which he had spent the last eighteen years of his life, with no regular contact with anyone who spoke his language.

In 2004, an unidentified source informed the Legal Aid Justice Center in Charlottesville of Mr. Chumil and his situation.  The Mental Health Law Clinic at UVA Law School began to investigate.

We met with Mr. Chumil many times.  Alex Gulotta and Nathan Veldhuis filed a Formal Human Rights Complaint against Western State Hospital.  Ultimately a multi-day fact finding hearing was held in front of the Local Human Rights Committee.  Despite WSH’s efforts to keep the proceedings from being public, we succeeded in having the proceedings ruled to be open. In short, we prevailed in all but one of our areas of complaint (that he be provided dentures).  WSH appealed to the State Human Rights Committee, where another series of hearings took place.  The State Human Rights Committee ultimately upheld the findings and recommendations of the Local Human Rights Committee.  WSH then appealed to the Commissioner of the then Department of Mental Health, Mental Retardation and Substance Abuse Services.  After meeting with the Commissioner and others it was decided to move him to Northern Virginia Mental Health Institute in an effort to provide a less restrictive environment and to transition him into the patient population.  He was moved and died two weeks later of undiagnosed colon cancer.  He was able to spend the last two weeks of his life with his mother being able to see him every day - she died not long after.

After Mr. Chumil’s death, a lawsuit was filed alleging 14th amendment violations through 42 U.S.C. §1983, medical malpractice and wrongful death.  The family has since elected to nonsuit the case for family reasons. Many thanks to Mic McConnell for all of his invaluable help and advice in that lawsuit.

1. "In 1988 a seclusion program was begun which was intended to replace the restraint program." (Ex. 9, p. 5). [↑](#footnote-ref-1)
2. The biographical information and treatment history outlined in this section was found in Exhibit 9 [↑](#footnote-ref-2)
3. He was hospitalized at Carlos Mora Hospital for 8 months after trying to hit his sister and behaving aggressively. The hospital prescribed medications which seemed to work, his condition reportedly improved, and he was subsequently released. [↑](#footnote-ref-3)
4. He was still taking psychoactive medications at this time. He discontinued the medications, and some time afterwards his mother took him to the hospital because he was suffering convulsions. [↑](#footnote-ref-4)
5. His behavior became increasingly aggressive. He was screaming in his sleep, exhibiting hostile, angry, and combative behaviors, particularly toward his father, and said he was hearing voices. After an altercation with his father, he was taken to the Woodburn Emergency Center in Fairfax County, Virginia, treated briefly, and discharged. On November 13, 1981, he threatened to set his parents' house on fire, was detained by the police, and then hospitalized briefly at Northern Virginia Mental Health Institute in Falls Church, Virginia. [↑](#footnote-ref-5)
6. WSH records indicate that he was agitated, psychotic, physically aggressive, and disruptive, and staff believed that he was a danger to himself and others. He complained of hearing voices telling him to hit others, and believed people were talking and laughing about him. [↑](#footnote-ref-6)
7. During the following year, Mr. Chumil received intermittent treatment at NVMHI for aggressive behavior. [↑](#footnote-ref-7)
8. This report's findings are reflected in a 1999 letter from Bill Lao Lee, Acting Assistant Attorney General to Virginia Governor James S. Gilmore. (Ex. 11). [↑](#footnote-ref-8)
9. The 1999 letter to Governor Gilmore found the use of "seclusion and physical restraints at [WSH were] used excessively, for the convenience of staff; in lieu of treatment, and in circumstances that represent substantial departures from accepted professional judgment." (Ex. 11). The report also noted that "[s]taff lack of understanding of less restrictive measures that could be utilized where appropriate." (Ex. 11). [↑](#footnote-ref-9)
10. Mr. Chumil's bedroom is 234 square feet in area. His bathroom is 110 square feet in area. His 'porch' is 134 square feet in area. (Ex. 16). [↑](#footnote-ref-10)