

THE GOVERNOR'S COMMISSION
ON ADMINISTRATION OF LETHAL INJECTION

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HARRY SINGLETARY

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HONORABLE STAN MORRIS

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RODNEY DOSS

REPRESENTATIVE DENNIS ROSS

P R O C E E D I N G S

THE CHAIR: At this time, I'll call the Governor's Commission on Administration of Lethal Injection to order. Noted for the record, it's the second meeting.

Once again, thanks to all the members for being here. I appreciate you being here. And I don't think -- while we went through and identified everybody last time. I think that so everybody knows, in person we have with us Rodney Doss. And thank you.

MR. DOSS: Mr. Chairman, thank you. I'm sorry I wasn't with you last week.

THE CHAIR: That's quite all right. No problem.

MR. DOSS: In spirit.

THE CHAIR: I understand. And would you tell, just so the other members of the Commission know, a little bit about your background.

MR. DOSS: Certainly. I come from, basically, a law enforcement background, having served with two sheriff's administrations and assisting the executive director of the Florida Sheriff's Association. I have been with the Attorney General's Office now for 20 years, having first served as executive director of statewide prosecution and other administrative and management responsibilities since then. I am currently the director of the Division of Victim Services and

Criminal Justice programs for the Attorney General.

THE CHAIR: Thank you. Scheduling matters. I need to let everybody know, about 20 minutes ago I heard from Max Changus, who, if you recall from the last session, was DOC. And the witnesses will be available, but not until just after one o'clock, the witnesses that he was going to bring. In addition to that, since he's flying in at 12:40, there will be a slight change because he was bringing the video with him. And so, we'll take a lunch hour and, at that time, I'll set up the video equipment that we have. And, hopefully, with some luck, it will work properly since I haven't tested his DVD device on this system.

One of the things I wanted to bring up to the members is that this Friday's meeting, it's my intention, unless I hear some strenuous objection from the members, to open the session from 1:00 o'clock to three o'clock open to the public for public comment. And we'll see that that gets out. And, hopefully, the members of the press will help disseminate that so that we get that covered.

So, anybody that's interested from the public in testifying in front of this Commission can do so. Again, a word to the members of the public, please put out that the purpose and the focus of the testimony

needs to deal with the procedures and protocols of the administration of lethal injection as opposed to anybody's personal views on the death penalty.

At this particular time, one of the witnesses that we're going to hear from is Dr. Clark. Is Dr. Clark --

MR. CANNON: She's in the other room.

THE CHAIR: Could you get her for me?

MR. CANNON: Yes.

THE CHAIR: Thanks.

MS. SNURKOWSKI: Are you going to do roll call?

THE CHAIR: Oh, that would be a great idea. Let's do roll call for the record. Just identify yourselves as you go around. Bill Jennings, Chairman.

SENATOR CRIST: Victor Crist, state senator.

DR. VARLOTTA: Dr. David Varlotta.

MR. LAPPIN: Harley Lappin, Director of Bureau of Prisons.

MR. SINGLETARY: Harry Singletary.

DR. MORRIS: Dr. Steve Morris.

MS. SNURKOWSKI: Carolyn Snurkowski, Attorney General's Office.

JUDGE MORRIS: Stanley Morris.

DR. SPRINGER: Dr. Peter Springer.

MR. DOSS: Rodney Doss, Attorney General's Office.

REPRESENTATIVE ROSS: Dennis Ross, state

representative.

THE CHAIR: Thank you. And while we're waiting for her, the majority of the witnesses testifying after the lunch break will be testifying by telephone, will be calling in.

EXAMINATION OF DR. DENISE CLARK

BY MR. JENNINGS:

Q Dr. Clark, welcome. Would you state your full name for the record, please.

A Denise Stewart Clark.

Q And how are you employed?

A I'm employed as a full-time family practice physician in private practice.

Q And do you have any specialty?

A One of the specialties I have is I have been especially trained in vein therapy for spider veins, varicose veins, using ultrasound-guided techniques. And I had a practice doing, pretty much, exclusively that for about three-and-a-half years.

Q And can you give us a little bit of background on your medical as in where you graduated from, that sort of thing, for the record.

A I graduated -- I'm an osteopathic physician. I graduated from Kirksville College of Osteopathic Medicine in 1989. I did a rotating internship at Dallas Fort Worth

Medical Center. I then worked full time in an emergency room for a year-and-a-half, and then I proceeded to complete two residencies, one at the University of Florida, Gainesville, in pathology and one at Florida Hospital, east Orlando, in family practice.

Q And with regards to your subspecialty, I guess, in veins, can you give the members a little bit of feel for exactly, in a little bit greater detail, what that entails?

A Are you talking about starting an IV or drawing blood or just getting venous access?

Q Just, in general, your -- maybe, perhaps, your specialization in that area, how you obtained that specialization.

A I obtained the specialization from a specialist in Jacksonville who's been doing vein therapy for about 20 years and has trained people from all over the world.

Q And I assume part of this specialty includes the insertion of IVs?

A It didn't require it, but I could do that if necessary. It wasn't part of the procedure, actually.

Q And you had indicated something -- I think you said ultrasound and things. Could you explain a little bit about that, please.

A For people that have leg veins that are varicose that are deeper under the skin, you can't see the veins with

the naked eye. So, ultrasound-guided imaging was used to advance the vein into -- the needle into the appropriate vein for that treatment.

Q And just so everybody's clear, how does that actually work?

A Well, you have the patient laying on the table, usually with the leg out to one side. You put some gel on the leg and use an ultrasound probe to locate the deep saphenous vein, which is the most common one that I was dealing with. That, typically, can't be seen from the surface. It's a deeper vein.

Q And just so that I'm clear, is this ultrasound similar to what an expectant mother goes through when they are ultrasounding for the child, showing images?

A It's very similar. It's a different type of probe, but it's a very similar procedure.

Q And does this particular procedure allow you to actually locate the vein, the particular vein, you're after? It has that type of quality image, I guess?

A Correct.

Q And other than on legs, have you used this particular techniques on any other veins?

A I have not.

Q You have not. Okay. Have you had a chance to review Dr. Hamilton's preliminary findings?

A Preliminary findings, yes.

Q And after reviewing that, could you share with the Commission your thoughts?

A There are ten items listed under the preliminary autopsy findings, and the first three are relevant to the execution process, and 4-10 is, basically, other findings unrelated to the process. Line 1, "Intravascular lines attached to vena puncture wounds in right/left elbow region" means that there was an IV line in both areas here. Line 2 states, "The perforation of the veins and penetration of the cannula into the underlying soft tissues of both right and left antecubital fossae." These are the antecubita fossae.

Q I'm sorry. Just so the record, you're pointing to?

A I'm sorry. The area in front of the elbow which bends when you bend your arm, the crease. And a cannula is like a little tube that goes into the vein for an IV. And that is the cannula. And number 2 is saying that the veins were perforated and penetrated into the underlying soft tissues of both sides, which could indicate that either the cannula had become dislodged from the vein and ended up in the soft tissue, or it could have perforated completely through the vein and end up in the soft tissue.

Q Just so I'm clear, I'm sorry, what -- when you said, again -

A Cannula?

Q Yes.

A That's the flexible tube. When you start an IV, you have a needle that has a flexible tube over the catheter, over covering it. You insert the needle into the vein, and once you're sure you're in the vein, you withdraw the needle and advance to the flexible tube into the vein. And that's where the fluids go through. That's the cannula.

Q And are there varying sizes of these tubes as far as length?

A Yes, there are.

Q And just for -- what is the approximate range for the lengths, if you know?

A Well, depending on the type of catheter, they can range from an inch-and-a-half long up to, you know, probably 35 or 40 centimeters long, depending on where it's going.

Q Okay. If you would continue, please.

MS. SNURKOWSKI: Can I ask a question while we're on number 2?

THE CHAIR: Sure.

MS. SNURKOWSKI: So, the technical terminology here does not reflect what might have transpired. It just reflects the end result. Is that what you're saying? You don't know how it got to this end?

DR. CLARK: It's difficult to say from what he's

saying here. Obviously, when you start an IV, you put a needle in, you're going to perforate a vein. But penetration into the underlying soft tissues implies that the catheter either came out of the vein and ended up in the soft tissue or went completely through the vein and ended up in the soft tissue.

MS. SNURKOWSKI: All right. So, there's nothing in here that articulates --

DR. CLARK: Exactly what happened.

MS. SNURKOWSKI: All right. Thank you.

DR. MORRIS: Let me also clarify that. Dr. Morris. Could it also mean that the needle penetrated soft tissue as it was going into the vein? From the terminology that's written here.

DR. CLARK: It could mean that, but it's hard --

DR. MORRIS: It could mean that, though.

DR. CLARK: It could mean that. Yes, it could. It's difficult to say because they only mention a cannula.

Number 3, "Mechanically disrupted fluid-filled bulla on flexor aspects of right and left arms and forearms." Again, we're talking about the inside surface of the arm around the elbow. That's the flexor aspect of the arm. And mechanically disrupted fluid-filled bulla. Bulla are large blisters. And

mechanically disruptive would imply that the blister had been opened by some means. But it was also -- it didn't say how extensive, but was involving the arms and also the forearms, which extends down to the wrist area.

THE CHAIR: Members, do you have any questions?

DR. MORRIS: I have a couple of questions.

THE CHAIR: Yes.

DR. MORRIS: Dr. Morris again. You described what you do. Is, primarily, your procedures mostly cosmetic or therapeutic or a combination of both?

DR. CLARK: A combination of both.

DR. MORRIS: Okay. In your specialty -- I know you say, at this point with your professional career, you actually don't start as many IVs as, I'm sure, as when you were in the emergency room. Is that fair to say?

DR. CLARK: That's fair.

DR. MORRIS: But you still would cannulate vessels, veins.

DR. CLARK: I draw blood in my office all the time.

DR. MORRIS: All the time. And even with a fine needle -- which I know the technique is a little different, but you still have to cannulate those blood

vessels.

DR. CLARK: With the needle you do, yes.

DR. MORRIS: Okay. And also in what you do, you also inject -- I'm assuming you inject sclerant or substances that scar veins down? Do you do that as part of your practice?

DR. CLARK: That was part of the practice that I had done before.

DR. MORRIS: Okay. Would you be able to enlighten us on some of the complications that could occur when you inject toxic medicines into veins?

DR. CLARK: Sure. When you inject anything into a vein, a number of things can happen. One thing is a person could be allergic, have an allergic reaction, to anything injected into the vein. A lot of solutions are very caustic or very irritating to veins and can cause a lot of inflammation and vasospasm, which means the vein kind of goes into a spasm and shrinks down.

Then, also, the problems with just the catheter itself staying in the vein, being the correct size for the vein it's in for the purpose that it's to be used for, including the vein can rupture.

The catheter or the needle could go through the vein and cause what is called extravasation of the fluid into the soft tissue around the vein. Those are

-- and other complications can occur, depending on which vein you're trying to locate as well.

DR. MORRIS: Going back to what type of substance you inject into the vein. So, if you injected a substance that was caustic, a hypertonic, very concentrated solution, is it possible that you could have a problem with the vein?

DR. CLARK: Absolutely.

DR. MORRIS: And, again, in your opinion, what types of complications, specifically, with injecting caustic substances can occur to the vein?

DR. CLARK: Well, the vein becomes irritated and goes into a spasm, and when it does that it kind of -- it's not as dilated as it was prior. It shrinks down a little, which makes things more difficult to get into it. And what develops is a localized phlebitis, which is an inflammation of the vein. If you're talking about a short-term solution, for example, in the hospital, in the antibiotic, something may be injected in the vein, and it's flushed. But usually, that's not so much a problem.

But the purpose of sclerotherapy, which is to shrink down the veins that are cosmetic and also cause varicose veins, is to irritate that lining so that it, basically, scars the vein down and the vein is no

longer useable.

DR. MORRIS: But that sclerant is a big hypertonic, very irritating. By design, it's an irritating type of solution.

DR. CLARK: That's the way it works. Right.

DR. MORRIS: And that, within itself, you would say it's fair to say, that that would cause a rupture of those blood vessels? Could it, potentially, cause that?

DR. CLARK: Potentially.

DR. MORRIS: You also said the purpose of the ultrasound. You talked about using the ultrasound before to help identify the vein. You use that primarily in leg veins, correct? Am I correct?

DR. CLARK: I used it exclusively in leg veins.

DR. MORRIS: Okay. So, you don't have any knowledge, or extensive knowledge, in using it in upper extremities.

DR. CLARK: I have some knowledge, but not any experience in using it myself.

DR. MORRIS: Is that a technique, do you feel, that's required to use, say, to cannulate an upper extremity vein? Is that a procedure that's required? I'm asking, can you start an IV without that?

DR. CLARK: You can start an IV without it.

DR. MORRIS: Would you say you can be proficient at starting an IV without using ultrasound?

DR. CLARK: You could if you take proper experience and proper anatomy.

DR. MORRIS: Okay. That's it. Thank you.

DR. VARLOTTA: What would you say the failure rate for cannulating veins is? Has that been described?

DR. CLARK: The failure rate is -- it's been described in internal jugular vein and subclavian vein cannulations, but I'm not aware of peripheral vein. For example, in this type of case where the arm veins were used. I'm not as aware of any studies on that. The studies I'm aware of are involving, excuse me, the subclavian and internal jugular veins.

DR. VARLOTTA: The other question I had is, is there a certain failure rate even when you're cannulating using an ultrasound?

DR. CLARK: There is a failure rate, and it's been approximated to be about 15 percent.

DR. VARLOTTA: So, in up to 15 percent of cases, 15 out of 100, even using the ultrasound you may fail to cannulate properly the vein that you have targeted.

DR. CLARK: That's correct. That's the failure rate, and the complication rate has been even predicted to be higher than that.

MR. LAPPIN: Harley Lappin. Good morning, Dr. Clark. What type of expertise or what type of people are able to use this ultrasound? Does it require a doctor? Nurse? Medical technician?

DR. CLARK: Mostly it's medical people -- physicians, nurses with certain specialties.

MR. LAPPIN: Mid-level practitioners.

DR. CLARK: Mid-level practitioners. Right. And, typically, they're only trained if they have a need to be trained. Those cases, they're very specific. It's not a general part of the training. For example, it just depends on what kind of a practice the person is doing and whether they're going to need that procedure.

MR. LAPPIN: Given your expertise on vein therapy and your working in an emergency room, are there other ways to gain access to a vein other than in the arms and using a needle?

DR. CLARK: Other than using a needle, I'm not aware of any other way to access the vein. But the arms are usually -- the arms or hands are usually the first place that's attempted. But there are veins in the groin, in the neck, for example, in the upper arms, that can also be used. But I'm not aware of a way to penetrate a vein without using a needle.

MS. SNURKOWSKI: Carolyn Snurkowski. And I may

not be as articulate as the medical viewers. Forgive me. But you were talking about a failure rate with regard to using the ultrasound and the end results of that. What kind of examples would that be in your practice? For example, you're trying to find veins and either destroy them or cosmetically modify them. What kind of examples would you see in your practice? This would be in legs, right?

DR. CLARK: Well, in the legs, yes. We're talking the legs. The studies were not done on the legs that I know of. Well, one thing is -- one of the major reasons, besides just viewing the vein, you know, just getting a good picture of the vein where you can actually see where the needle is going is you want to avoid hitting an artery. That's really important. If you inject a sclerant, which is an irritating solution, into an artery, that will lead to pretty serious complications. So, it's very important --

MS. SNURKOWSKI: For example, what could happen?

DR. CLARK: The area of tissue, whenever the limb or whatever area that the artery supplies blood to, the blood supply will be, basically, cut off and the tissue dies.

MS. SNURKOWSKI: So, it's catastrophic.

DR. CLARK: Absolutely.

MS. SNURKOWSKI: Second of all, with regard to the ultrasound -- and you use ultrasound in your practice?

DR. CLARK: I did.

MS. SNURKOWSKI: You don't use it currently?

DR. CLARK: Currently I'm in family practice.

MS. SNURKOWSKI: Oh, I see. Just in the vein, when you were doing the veins.

DR. CLARK: Right.

MS. SNURKOWSKI: And is that a standard procedure for doing that kind of medical technique?

DR. CLARK: Only for that particular procedure. It's called ultrasound-guided sclerotherapy, as opposed to sclerotherapy just means you're injecting a sclerant into the vein. Most of the time, it's cosmetic, and those are usually surface veins. The ultrasound-guided is more for the deeper veins. Excuse me. The purpose of using the ultrasound, obviously the deeper veins are not cosmetic veins. Those are medical vein problems. People can get leg ulcers from problems with those veins. The ultrasound is used to isolate that vein so that you're sure you're in the proper vein.

MS. SNURKOWSKI: And I think you just said, and I may not word it right. You're saying the ultrasound is used in the specific procedure that you were involved in. Is that universally used in other types of

procedures? Is there --

DR. CLARK: Oh, the ultrasound?

MS. SNURKOWSKI: Yes.

DR. CLARK: Oh, sure. It's used in a lot of different medical procedures.

MS. SNURKOWSKI: No, just for veins.

DR. CLARK: It's not a routine.

MS. SNURKOWSKI: And would that normally be done in a hospital setting where somebody is setting up an IV? Would you normally see an ultrasound being used?

DR. CLARK: Most of the time, yes.

MS. SNURKOWSKI: You would see an ultrasound being used?

DR. CLARK: Well, let's put it this way. That's a procedure that would really only be attempted if attempts at peripheral access were not successful. That's more of a last resort type of thing. It's not an initial thing a person would do.

MS. SNURKOWSKI: So, it's not -- but it's not a procedure that is normally done on a daily basis in a hospital, is it?

DR. CLARK: It wouldn't be used for the arm veins. It, really, would be mostly used for -- if you're talking about scarring the vein, an IV or getting into access, it would be mostly for internal jugular of

subclavian, possibly in the groin.

MS. SNURKOWSKI: So, it's something for a deeper vein.

DR. CLARK: Right. Absolutely.

MS. SNURKOWSKI: Not a surface vein.

DR. CLARK: You wouldn't need it for a surface vein.

THE CHAIR: I'm sorry. Dr. Springer. We're going down the line.

DR. SPRINGER: Okay. Just one question. As far as the 15 percent complication rate, is that for the central veins that you talked about or --

DR. CLARK: That's actually for internal jugular and for subclavian vein.

DR. SPRINGER: And did they discuss the complications? You said there were more -- there's indication that there may be more percentage, a higher percentage of complications?

DR. CLARK: Well, the 15 percent is actually the failure rate of actually getting into the vein or establishing you might be in the vein. The complication rate is higher. And the complication rate describes other -- for example, you know, the failure rate is just you're not getting into the vein. That's just the failure rate. The complication rate is that

when you're doing a procedure what can happen, what kind of things can come up as a result of doing the procedure. Does that make sense?

DR. SPRINGER: Yes. I guess the question I have is for the 15 percent, is that 15 percent of attempts that fail or is that 15 percent of all cases? So, if you're attempting a central line, one penetration through the skin, is that the 15 percent failure or is that procedures?

DR. CLARK: Well, the studies were done with attempts, attempted. There were a certain number -- the studies were with certain numbers of patients and how many attempts were, you know -- how many attempts were tried before a vein was actually successfully --

DR. SPRINGER: And the study, is this one study or is this -- it's not just many studies?

DR. CLARK: Well, I had two studies that I'm aware of that address that issue.

DR. SPRINGER: And are they both, pretty much, the same percentages?

DR. CLARK: Uh-huh. They are.

DR. SPRINGER: And then, the next question I had, since we do have ultrasound-guided therapies here or procedures that can be done through ultrasound guidance, would you feel it's prudent, in a high

profile case, a case such as this, to obtain venous access, whether it be central or peripheral, through ultrasound-guided?

Would you say there's a better chance of success if you used the ultrasound machine? Can you make that statement?

DR. CLARK: Actually, the studies using ultrasound guided for the subclavian and interjugular veins, there was really no difference using the ultrasound versus not using the ultrasound. So, there was no clear advantage to using the ultrasound for that purpose.

DR. SPRINGER: So, they're saying that the equivocal 15 percent complication rate is for both, non-ultrasound guided versus ultrasound guided, either one?

DR. CLARK: Right. With or without. Actually, there was one study where there was a particular type of ultrasound used, and, actually, the failure rate was higher with the ultrasound than it was without the ultrasound. So, that was just one study I saw.

DR. VARLOTTA: Can these devices, ultrasound devices, be used in the state of Florida without a physician supervising?

DR. CLARK: I don't believe they can. Obviously, nurses and mid-level providers can be trained, but they

are always working under the supervision of a physician.

DR. VARLOTTA: And the last question I have is how do you think the manufacture of these devices would react if they knew they were to be applied for this purpose?

DR. CLARK: The manufacturers of the ultrasound? I would think they -- this is strictly my opinion. I would think they wouldn't be anxious for people to know it was being used for that purpose.

DR. VARLOTTA: Thank you.

DR. MORRIS: A couple other points of clarification. The use of the ultrasound -- and I think there was a little confusion. The use of the ultrasound can be used in a number of diagnostic procedures other than for just locating veins.

DR. CLARK: Absolutely. Yes.

DR. MORRIS: And so, when you say the use of ultrasound is very common in the hospital, that was what you were referring to.

DR. CLARK: Exactly.

DR. MORRIS: The use of ultrasound in starting a peripheral IV, hand, arm, is that a common procedure, or if you're starting an IV, say, in the emergency room setting, are the nurses, doctors, technicians, are they

running for an ultrasound machine or do they usually start IVs without that?

DR. CLARK: No, they normally start the IVs without it, typically, for arms or hands.

DR. MORRIS: So, if you can see it, that's the best way to start the IV --

DR. CLARK: Absolutely.

DR. MORRIS: -- versus trying to do an ultrasound, right?

DR. CLARK: Absolutely.

DR. MORRIS: And the other thing we talked specifically about complication rates. A complication associated with a peripheral IV versus a complication associated with a central access, like you referred to jugular veins, femoral veins, the complication, compare both of those, peripheral IV complication versus a central IV complication.

DR. MORRIS: With the peripheral veins, the complications, besides the vein, you know, rupturing, extravasation of the fluid into the surrounding tissues like we discussed before --

DR. MORRIS: Let's start with just starting the IV. Just starting the IV. So, if you had a complication with starting the IV and you penetrate the vein through and through, how would you control that

with a peripheral IV?

DR. CLARK: Control it?

DR. MORRIS: How would you manage that?

DR. CLARK: Well, you would pull back on the vein and try to get the cannula to go inside.

DR. MORRIS: If that didn't work?

DR. CLARK: If it didn't work, then you would have to -- you would try, maybe, readjusting, changing the position of the cannula. If that didn't work, then that procedure really should be aborted.

DR. MORRIS: And to abort it means to do what?

DR. CLARK: Means to stop at that location.

DR. MORRIS: And how do you manage that site locally? What do you do?

DR. CLARK: What you do is you pull out the needle and/or the cannula, whatever is in there, and put pressure on the area.

DR. MORRIS: For a minute? Two minutes?

DR. CLARK: If you're talking about a vein?

DR. MORRIS: Peripheral vein.

DR. CLARK: Peripheral vein is just, maybe, you know, 30 seconds or so. In people who are anticoagulated, in other words, if they're taking medications to thin their blood, it's going to take longer.

DR. MORRIS: For a central access, let's say same complication, you perforated, you mentioned striking an artery. Because that's why you use the ultrasound for is central.

DR. CLARK: Right, right.

DR. MORRIS: So, you have a complication and you perforated the vein, or you perforated the artery. How do you manage that complication?

DR. CLARK: Well, that's a lot more difficult because when you perforate an artery, that's a lot more serious. A person can bleed to death from that. You have to put pressure on an artery for much longer than you a vein because it's a much more high pressure vessel. Additionally, in the neck, which is a complication you wouldn't have in a peripheral vein in the arm, if you're using the internal jugular or the subclavian, you have additional complications. For example, a pneumothorax, which is a collapsing of the lung. A hemothorax, which means blood has gotten into the lung cavity and collapsed the lung. And that's a true emergency. People die from that if it's not treated properly.

DR. MORRIS: Thank you.

THE CHAIR: Dr. Springer.

DR. SPRINGER: Two more questions here. The

studies that you cited, the percentages, are those recent studies or are they --

DR. CLARK: They're recent.

DR. SPRINGER: How recent? And if we could get a copy of that --

DR. CLARK: Sure.

DR. SPRINGER: -- if you wouldn't mind.

DR. CLARK: This one is from -- well, this one is from 1998. It also mentions that it's very highly operator dependent. Another one here -- well, this one's 1997. Those are two that address the issue of the internal jugular and the subclavian.

DR. SPRINGER: And then, I guess the follow-up question would be are you aware that there's a growing trend in using ultrasound for central venous access? Are you aware that there is increasingly more recommendations being made that all central lines should be done under ultrasound guidance?

DR. CLARK: Right. And that's in the hospital. Yes, those are things would be done in the hospital, not on an out-patient basis.

THE CHAIR: Moving down the line.

MR. DOSS: Thank you, Mr. Chairman. Dr. Clark, Rodney Doss. Are there other devices readily available other than the ultrasound probe to validate that venous

penetration has taken place? Is there any other devices out there that are being used routine to do that? Then I have a follow-up question.

DR. CLARK: I'm not aware of any device other than ultrasound.

MR. DOSS: Help me understand a little bit. What does medical standard -- I know we have medical experts here on the Commission. In general use -- emergency room, ER entities -- what is it -- I heard testimony last week from the physician's assistant referring to a flash.

What is the standard that says I have successfully made peripheral venous access? How do I know, as a practitioner, that something went wrong, that it's not successful penetration? What are the tests?

DR. CLARK: Well, when you insert a needle with a catheter over it into the vein, and the hub of the vein -- excuse me. On the hub of the catheter there's a chamber where you'll see blood flash back into it, and you know you're inside the vein. If you don't see blood coming back in the hub, then you're not in the vein.

MR. DOSS: So, if you're in soft tissue, you don't get the flash?

DR. CLARK: Right.

THE CHAIR: Oh, I'm sorry. Yes, representative.

REPRESENTATIVE ROSS: Thank you. Dr. Clark, Dennis Ross. I'm following up on his question. In the event of a cannulation that fails, what happens -- and you perforated a vein. What happens to the fluids that are being injected? Do they just -- do they continue to flow or do they stop?

DR. CLARK: Typically, what happens with a person who starts an IV and the cannula is supposedly in the vein, the IV is turned on and the fluid is allowed to flow -- it should flow freely into the vein if it's in proper position. If it isn't, it's not going to go in unless it's forced in.

REPRESENTATIVE ROSS: Manually.

DR. CLARK: Correct.

REPRESENTATIVE ROSS: And in this particular case, did you review any other records other than the autopsy report findings that we have before us, such as medical records of Mr. Diaz?

DR. CLARK: No, I didn't.

REPRESENTATIVE ROSS: Okay. Would you have an opinion, based on your venous specialty, as to whether the cannulations performed in this case was appropriate or inappropriate?

DR. CLARK: Actually, I just got -- I was just

handed this, so I didn't have a chance to completely read the whole thing. You're talking about just starting the IV?

REPRESENTATIVE ROSS: Yes, ma'am. Based on the finding, specifically number 2. Can you render an opinion as to whether that cannulations was -

DR. CLARK: Are you talking about the preliminary report?

REPRESENTATIVE ROSS: Yes, ma'am. That's my understanding that's all you reviewed.

DR. CLARK: Oh. Well, I have part -- I have also some other -- well, it's not actually the full autopsy report. It's some other findings that were observed during the execution. So --

REPRESENTATIVE ROSS: Would you have an opinion, based on your specialty, vein assessment specialist, as to whether the cannulations done in this case on the findings of the autopsy report were done appropriately? Or can you tell?

DR. CLARK: It's very difficult to say from just number 2 because the cannulations could have pulled out of the vein and into the soft tissue during patient movement or whatever. But if you look at number 3, that suggests that there was definitely a problem with the cannulations of the vein, that it's most likely it

was done improperly.

REPRESENTATIVE ROSS: And the evidence of that is the blisters that you talked about?

DR. CLARK: Right.

REPRESENTATIVE ROSS: That would have been the cause or the effect of an inappropriate cannulations?

DR. CLARK: Yes. That could be caused from a couple of things. It could be the fluid being pushed into the soft tissue directly or -- I guess it just depends on what the blister is filled with. I mean, if it's filled with the IV fluid or the fluid that's going in it. But it could also be a severe reaction to the irritation from the cannula.

REPRESENTATIVE ROSS: Okay. And we don't have any findings as to what that fluid was in the --

DR. CLARK: No.

REPRESENTATIVE ROSS: -- blister. Thank you.

THE CHAIR: I have a follow-up. One second. You were shown earlier that report that you referred to, just to be clear for the record.

Was that the preliminary report from the Department of Corrections?

DR. CLARK: Summary of the findings of Department of Corrections Task Force.

THE CHAIR: Correct. And did you have a chance to

review the part that dealt with the administration of lethal chemicals?

DR. CLARK: I haven't had a chance to read the entire thing. It was just -- it was handed to me just before, but I --

THE CHAIR: Okay. On page 7, members. Page 7. Did you have a chance to read that? I think it says "Administration of Lethal Drugs." If not, you take a moment to just read that paragraph.

DR. CLARK: If I could have a moment, please.

THE CHAIR: Sure. Okay. Have you read that part?

DR. CLARK: Yes, I've read it.

THE CHAIR: What amounts to one, two, three paragraphs there.

DR. CLARK: Yes, I have.

THE CHAIR: Does that have any impact in helping you to be more specific when you review the autopsy report to number 2 and 3? Preliminary autopsy report, excuse me. Does that help you in your opinion as to what likely caused 2 and 3 in the preliminary autopsy report?

DR. CLARK: Well, it says, to me, that the first line that was attempted was not successful and what is in 2 and 3 here could be a result of that IV not being inserted properly. The other thing is that they did

not establish the IV access in the primary site. They went to the second site -- sorry, I lost my train of thought.

Oh, there was mention in this report about having some -- having to really push the IV fluids. There was a lot of resistance. And that goes along with these. That correlates with what's happened in 2 and 3 on the preliminary report. Because when an IV is in a proper location it should be effortless to push a fluid into it, and if there's any resistance, that's a sign that there's a problem there. It's not going in right and it has to be forced to -- it would have to be forced to make this kind of a problem.

THE CHAIR: All right. You talked a little bit about the flash. As the IV is being initially inserted into the vein, can you get the flash at that point, but yet the IV can either continue through and puncture the other side of the vein and you'll still get the flash?

DR. CLARK: What can happen is when you insert the needle and the catheter into the vein together and you get that flash, the technique is to pull the needle out and then to feed the catheter in the rest of the way. But what can happen is, depending on the type of catheter, the angulation of the catheter, it could actually go through and perforate the wall without the

needle.

THE CHAIR: Thank you. Are there some other questions? Dr. Morris.

DR. MORRIS: Doctor, a question for you. What does the term "you are IV infiltrated"? What does that refer to?

DR. CLARK: What that means is that the IV fluid that's intended to go into the vein has gotten out of vein into the surrounding tissue. It's the same thing as extravasation.

DR. MORRIS: And what period of time could that occur? One minute? Twenty-four hours?

DR. CLARK: It can occur, pretty much, at anytime. It can occur initially if the vein isn't properly cannulated. It can occur later if the cannula gets dislodged from the vein.

DR. MORRIS: Can it occur even if the cannula is in proper position? Can you still get an infiltrated IV?

DR. CLARK: You can if the vein has ruptured.

DR. MORRIS: Okay. And what will cause a vein to rupture?

DR. CLARK: Excess force in pushing fluid --

DR. MORRIS: The type of solution? Is that possible?

DR. CLARK: It's possible.

DR. MORRIS: Thank you.

DR. VARLOTTA: I was going to ask to go back to bringing up the central lines, and you said there was certain serious complications. Would you recommend that they be done in a setting where those complications could not be treated --

DR. CLARK: Absolutely not.

DR. VARLOTTA: -- or addressed?

DR. CLARK: Those procedures are done only -- or are properly done only in a hospital setting where if a complication like that arises it can be dealt with immediately because it's critical.

DR. VARLOTTA: So, where the personnel and the expertise is available to treat those complications.

DR. CLARK: Right.

MR. LAPPIN: Harley Lappin. Just a point of clarification. When you say "those procedures," can you explain what you mean by "those procedures" in a central line?

DR. CLARK: When you're inserting a central line as opposed to a peripheral line.

MR. LAPPIN: Can you explain that?

DR. CLARK: A central line is a line that goes into the subclavian vein or into the vena cava. It's a

deeper line that goes more directly into the large vein.

MR. LAPPIN: So, you're not using a needle in that case.

DR. CLARK: Oh, yes, yes.

MR. LAPPIN: To gain access. And then you slide the line in. Is that how it works?

DR. CLARK: That's right. That's right.

MR. LAPPIN: So, either subclavian or femoral, you don't recommend that -- or that's not done in places other than in a hospital? So, like, other than emergency rooms, ambulances, EMTs, those folks?

DR. CLARK: It can be done. It can be done. But, you know, the complications can't be dealt with adequately. Most of the time, a peripheral vein, even the external jugular, which is much easier to cannulate than the internal jugular, and that's a peripheral vein, those are usually the ones that are attempted first.

The deeper ones really should be done where if a complication -- the biggest complication you have to worry about besides all the others, the infections and so on, thrombosis, is perforating the lung. And that's got to be recognized immediately and it's got to be treated immediately. And it has to be done by people

who are properly trained to do it in a setting where it can be done.

MR. LAPPIN: So, have you done this yourself or you've seen other people do it?

DR. CLARK: Well, when I was in training, and in the emergency room I have done it.

MR. LAPPIN: Let's say for the artery in the leg.

DR. CLARK: Well, the artery or the vein?

MR. LAPPIN: The vein. I'm sorry.

DR. CLARK: That one, I'm not aware of anybody really using ultrasound to --

MR. LAPPIN: I don't mean ultrasound. Just accessing that vein with a catheter tube.

DR. CLARK: It can be accessed.

MR. LAPPIN: Is it, basically, the same concerns in the leg as it does in the neck or --

DR. CLARK: Well, no. You're not near the lung. So, that's the major complication when you're doing a subclavian or internal jugular is the lung collapse or blood filling up in the lung or injuring arteries.

MR. LAPPIN: So, a venous catheter access -- I think that's the term -- in a vein in a leg doesn't have the same complications as, maybe, the one in the neck.

DR. CLARK: It doesn't have all of the same

complications.

MR. LAPPIN: All the same complications.

DR. CLARK: The other complications are in any vein. For example, getting a blood clot or, you know, going through the vein, infection. Those type of things are universal to no matter which vein we're talking about. But unique to the veins in the upper -- in the neck and upper chest are the potential of collapsing a lung.

MS. SNURKOWSKI: Carolyn Snurkowski again. You had -- we've had testimony the last time around that they received a flash bulla in both arms and the procedure was commenced, and after the second vial, then they saw resistance. How would you -- what would you perceive was the problem there?

DR. CLARK: Well, if one vial went in effortlessly, then something had to have happened between the first and the second vial. For example, the catheter could have been dislodged in some way, either by personnel or the patient.

MS. SNURKOWSKI: Is that normally what would happen, there was something that was disturbed?

DR. CLARK: Yes. I mean, something has got to go wrong --

MS. SNURKOWSKI: It's not like something that is

free flowing often gets clogged. Is it apparatus?
Could the apparatus somehow --

DR. CLARK: There could be a kink in the line. There could be a kink in the IV line or the catheter itself. The catheter tech, I guess -- it's beveled, so it could be up against the vein wall. But that's usually not a problem when you're inserting fluid because that fluid going through there would open that back up. The IV could infiltrate, which that happens.

Those are the most common -- if you've got an IV that's already established and it's going fine, then something had to have happened between that and the next time when it's not successful injecting anything. It could be any of those things.

THE CHAIR: Judge.

JUDGE MORRIS: If you'll turn to the pages prior to that, page 5, in the other document. It should be a paragraph on page 5 styled "Administration of Lethal Chemicals." In the middle of that paragraph, there is reference to the executioner advising the assistant member of the team he could no longer push the syringe.

That was on Line A. If you go five or six lines down, it says that during the administration and guidance from the assisting execution team member, the secondary executioners started with a saline flush from Stand B

into Line A. At some point, they go back to Line A.

So, my question is how is that possible if they couldn't push to Line A and they switched over to B? Is there some -- does it clear itself up? What happens that would allow them to go back to Line A?

DR. CLARK: Well, you know, my question here is it doesn't say that they had to use excess force to get the saline flush in Line A the second time.

JUDGE MORRIS: That's my question to you.

DR. CLARK: I would question whether that was the case. Because unless they did something to try to fix the problem, they couldn't get in the vein if there was a problem. You have to figure out what the problem is and correct it before you can actually get the solution to go in effortlessly the way it should. My question would be, you know, what kind of force had they used if they didn't make any other correction to the line.

THE CHAIR: Do you have a question?

SENATOR CRIST: Yes, I do. I wanted to follow up on the earlier question. You mentioned that if the catheter was inserted properly and he had flow, then it would be consistent to believe that the flow would be consistent. But you also mentioned earlier that the body could react to the chemicals. Could the veins have contracted and the body begin to reject the

chemical and restrict the flow?

DR. CLARK: That is a possibility, depending on the size of the vein, the size of the catheter. You know, the veins, when they do get irritated, they do kind of shrink up a little bit, you know. And so, it is possible for it to happen where, you know, the flow just wouldn't be adequate after that. But you would know that right away. You would see that there's a problem.

SENATOR CRIST: And what about the differences between two individuals and their cardiovascular system, one having, maybe, a cleaner flow -- I'm not a doctor. So, one having, let's say, more scarring, more blockage within their vascular system than someone else being able to administer the drug.

DR. CLARK: Well, when you're talking about, for example, like atherosclerosis, that's on the arterial side. That's not the vein side. Those are in the arteries. And we're doing vein access here. But to answer your other question, there are situations where people, their veins are not adequate because, for example, if they've abused IV drugs, given blood numerous or plasma numerous times, or a particular vein has been punctured over and over and over, and then it's just scarred, then that can render the vein

useless.

SENATOR CRIST: Thank you.

THE CHAIR: I want to go back to the question. In critical practice, how do you know that an IV is working properly?

DR. CLARK: The solution that's going into the vein flows freely. It flows without anybody having to do anything. You've got an IV bag hanging there and a line going into the catheter, and you can see that the flow is --

DR. VARLOTTA: In spaces the like antecubital or the femoral, could the fluid flow freely even though it's not going into the vascular system?

DR. CLARK: I would think no. That has to be something that -- it just wouldn't do that. There's not enough pressure there. It has to be forced in to get into -- to cause infiltration. It has to be forced in.

DR. VARLOTTA: Are there spaces where -- or potential spaces where the fluid could accumulate even though it's not going under pressure?

DR. CLARK: Well, I suppose if the vein -- if the catheter was right under the skin, I mean, right underneath the skin, you know, that's a little more flexible, I guess, you would say, I guess it's a

possibility. Again, I would think that you would have to use some sort of force to get it to go into those spaces.

DR. VARLOTTA: Okay. I have a question about in the preliminary autopsy findings about number 7. Do you think number 7 can give us clues as to whether the chemicals were properly or improperly administered?

DR. CLARK: Well, pulmonary congestion and edema, that can occur. That usually occurs with fluid overload of some kind, and it can also occur when there's damage to the heart. For example, an arrhythmia or some sort of damage to the heart that could, I guess, be a consequence.

DR. VARLOTTA: Could it occur if someone tried to expand their lungs against a closed glottis?

DR. CLARK: It could.

DR. VARLOTTA: Do you think the improper administration of these chemicals could have resulted in that?

DR. CLARK: It could have. And the reason I say that is because in number 6 the jugular venous distention is usually something you also see against pressure of some kind. For example, when people cough or bear down, that's -- so, that would suggest to me that that is certainly a possibility.

DR. VARLOTTA: Thank you.

THE CHAIR: I have one follow-up question. In your clinical setting, what would you do if you're attempting to have -- putting pressure, as in putting a solution into an IV, and you're meeting resistance. What would you do when that happens?

DR. CLARK: When that happens, you have to assess the site and see what the problem is. You look and see, does it look like the vein is infiltrated? In other words, you can see swelling around to see if that's occurred. Try repositioning the catheter, maybe pulling it out a little bit to see if it was just up against the vein wall. Repositioning, you know, maybe just a little movement here and there, can sometimes, you know, free it up.

Sometimes, also, catheters get inserted up against a valve in the vein. The veins have valves that keep the flow properly going in the proper direction, and arteries don't have veins -- or valves, excuse me. But the veins do. And if you have a catheter that gets up against the valve, that could, you know -- and you're forcing fluid against that, that could cause a problem with a rupture.

Once you do maneuver it to try to see if the problem has been corrected and you try again to push

fluid in, it just shouldn't be difficult. If it's in the proper place, it should not require a lot of force.

THE CHAIR: When you say you go to the site, you're referring to the place where the IV is attached to the patient?

DR. CLARK: Correct.

THE CHAIR: Anybody have any other questions? Thanks. Appreciate you coming. Thank you very much.

MR. CANNON: We're going to get copies of those two articles?

DR. CLARK: Yes.

THE CHAIR: Okay. Thank you again.

DR. CLARK: Thank you. For purposes of bookkeeping here -- we're probably going to take a break in just a moment. But some of the witnesses that we thought we were going to have available today decided they would either call in or they would be present on Friday. So, I need to let you all know that Friday is probably going to be a fairly busy day, especially if we are going to have testimony in the morning. So, my question to those that had difficult -- obviously don't live in Tampa, had to come in and didn't fly in and stay in a hotel. You drove in from various locations -- Dr. Springer, in particular. How was the traffic today?

DR. SPRINGER: Good.

THE CHAIR: Did anybody else, those folks from Tallahassee, anybody drive down?

JUDGE MORRIS: I drove down.

THE CHAIR: That's right. Gainesville. How did that work out?

JUDGE MORRIS: It worked fine if you're starting at 10. If you're starting at 9 it's going to be a lot more difficult because of the Tampa traffic coming north.

THE CHAIR: I was going to try to split the baby. What do you think about 9:30? Does that make --

JUDGE MORRIS: We'll try anything if that's what you want.

MS. SNURKOWSKI: I already have my hotel near here. 9:15.

THE CHAIR: And you're here at 9:30. You're flying at 9:30. Okay. Well, that takes care of that. Maybe a shortened lunch. We'll do that. So, just to alert everybody. The other --

MR. LAPPIN: So, what time are we going to start?

THE CHAIR: We're going to start at 10. We're starting at 10. We'll try and to, maybe, longer into what would be our lunch before we go to the public session.

MR. LAPPIN: Any idea what time you think it will end for those of us leaving?

THE CHAIR: Well, we're going to try and start the public testimony right after lunch, so that would probably be 1, 1:30. It's scheduled for 3 is what went out. Probably. Depends on how many folks. I think, if necessary, we probably ought to go to 4. I think for those driving, if you get out of here by 4, the roads will be all right for you, except maybe the Judge. You need to clear a certain area there that we'll will clog down. Having left my office heading to Tallahassee at 4 becomes problematic sometimes.

The other question I have is I need to sort of let you know that one witness, who was an eyewitness to the execution of Mr. Diaz, doesn't want to testify without a subpoena. We're exploring alternative routes since I don't see anything within the Governor's Executive Board that gives this committee any basis for doing a subpoena. So, we're attempting to do other ways of handling that. I'm not sure why, but they just feel that way. So, I'm alerting the committee to that one little problem of one of the other eyewitnesses.

As a point of getting a feel for what the committee members have read, has everybody had a chance to read the -- some, at least, some of the articles

that were in the paper that came out after the execution? And I don't mean just as to what eyewitnesses said or what those particular reporters saw, what they personally said that they witnessed as opposed to them saying, "John Jones told me this," their giving their firsthand account? Has anybody had a chance to look at any of those articles? Well, we'll see if we can make some of those available that we have. And I would also ask Carolyn if you have any if you would get those to me.

MS. SNURKOWSKI: Are you talking about what's in the packet?

THE CHAIR: Yes. I was going to see if they've had a chance to read any of those.

MS. SNURKOWSKI: No. We just got them this morning.

THE CHAIR: Okay. Well, I figured some folks may have done this on their own.

MS. SNURKOWSKI: I may have. Right. I may have some other articles, but I think they're, pretty much, like these.

THE CHAIR: Yes, Senator.

SENATOR CRIST: In all honesty, I mean, in previous experiences dealing with information through news reported articles, I remember back in the Medina

case when the electric chair, the apparatus caught fire. You read the articles and they varied, but the one thing that most of them had in common is they were not accurate. They said the flame -- some of them said the flame was a foot long, lasted three minutes. That was not the case.

So, I think if we're going to read information and use it as part of our discussion and/or development of positions in here, it should be factual information based on witnesses either under oath or in a more formal setting than a news reporter simply reporting on what they may or may not have seen accurately.

THE CHAIR: Yes.

MS. SNURKOWSKI: I was wondering, are we going to have a period of time -- and how do you envision whether the whole group can just have general discussion? Because I think there's a lot of talent, medical talent, on this Commission that might provide us with some information or give us an overview, too. It doesn't necessarily have to be testimony, but their life experiences. And I think that would be helpful in giving us some insight as to what transpired. And I just wondered if we're going to have occasion -- do you think that will be after we do our interim report or do you have any feel of that?

THE CHAIR: Clearly, I think the Commission, as a group, needs to discuss the testimony they've heard, the direction. We'll get a feel for how everybody thinks. I think, probably, just go down -- maybe I can put something together where we break it into different segments so the discussion is a little organized and we don't just jump around.

Maybe we'll go down and the first matter will be how do you view the Diaz execution, whether protocols were followed, whether -- you know, things of that nature. And then go from there with any suggestions on if you even think there needs to be changes, any changes. Maybe do something like that. I'm certainly open to suggestions in that area from other members of the Commission on how they would like that particular segment to go.

But that's my general thought is to sort of compartmentalize the discussion so that we stay on point as opposed to digressing into too many subject matters in one area. And if anybody has an area that they would like to have brought up, please, you can e-mail me, call me, whatever, and I'll be happy to see that. Same as if you have a witness that you think would be beneficial. Ms. Snurkowski has e-mailed me several witnesses, attempting to get those, including

the anesthesiologist that, we're hopeful, will be available by phone on Friday.

That's why I'm saying if those folks are available, including some of the additional folks from DOC, it will be a long -- and, probably, I've been sort of very open about all the questions and stuff. I think if we have a really busy Friday and everybody comes on board, we're going to have to move that fairly quickly. Yes, Judge?

JUDGE MORRIS: Is there a way to get -- there's a way to get it. Can we get at least see four of the prior autopsies and toxicologies? At least the doctors could review them to see if there is something that could be gleaned out of those in comparison with what we ultimately received that may be indicative of some problem. I don't know if it would be or not. But it's the same medical examiner whose done at least the prior -- I'm going to take the prior four.

THE CHAIR: Okay.

JUDGE MORRIS: Because if we have those reports, we might be able to make a comparison on, at least an educated one.

MS. SNURKOWSKI: Maybe we ought to ask him to bring them. Well, if he comes.

THE CHAIR: It's our intention to have him come.

MR. SNURKOWSKI: Ask him to bring them if he has them in his records.

THE CHAIR: I'll see if I can, maybe, get those even before he comes so we can distribute them. Which, I guess, brings us to this point. On the offhand, or maybe now probable chance, given the number of witnesses that chose Friday over Monday, and the fact that we're going to have public testimony the last part of that, given the shortness of that, probably we're going to need another meeting on expert testimony in the area, if you want to call it that. Testimony in the area. We're going to need an additional meeting on that.

So, that brings to our Monday/Friday scheduling. And the reason I'm bringing it up this early is because if you want it the Monday after that Friday, those folks really need to be contacted early this week to make sure they can be here. So, what's the pleasure of the --

JUDGE MORRIS: You're talking about the 12th?

THE CHAIR: Either the 12th -- well, the 12th is probably out if anybody is going up to the prison. Probably, let's try that Friday. That, probably, would be the best.

MS. SNURKOWSKI: That's after our interim report

is due.

THE CHAIR: Well, let's look at it this way. How many folks can make it on Monday the 12th? Why don't do it that way? Better yet, how many cannot? Okay. How about Friday, the following Friday?

MR. CANNON: The 16th.

THE CHAIR: Sixteenth. Thank you.

DR. VARLOTTA: I'm going to be out of town, but I suppose I could fly in and fly back out. I'm going to be on vacation, but I could come in Friday and leave.

THE CHAIR: Okay.

DR. VARLOTTA: I could act like an out-of-towner.

THE CHAIR: Anybody else cannot make it on the 16th?

JUDGE MORRIS: I can try to make arrangements.

THE CHAIR: You think you can make arrangements on that date, too?

DR. MORRIS: I don't think so. I'd be better off on the Monday. But those two days, unfortunately, with the scheduling.

THE CHAIR: So, Friday the 12th -- I mean, Friday the 16th will hurt you. You can't even call in, correct?

DR. MORRIS: Correct.

THE CHAIR: Again, I'm sorry, the folks that could not make it on the 12th, is there a possibility that you could call in?

DR. MORRIS: For a portion, but --

THE CHAIR: But not the whole time.

DR. MORRIS: Not the whole time.

THE CHAIR:

JUDGE MORRIS: Are we locked into Mondays and Fridays?

THE CHAIR: Well, I think when we deviate from a Monday and Friday, we're going to lose two folks.

JUDGE MORRIS: Well, that's why I'm asking. I would assume -- we have committee meetings every, pretty much, Tuesday, Wednesday and Thursday. So, I'm sure --

SENATOR CRIST: Next week we're here, though.

JUDGE MORRIS: You are here.

SENATOR: CRIST: Yes. They canceled the appropriations week.

REPRESENTATIVE ROSS: We still have about -- I'm sure that I can get an excused absence because of my appointment on this task force.

THE CHAIR: How about -- let's, actually, back up, Friday, because that gives me more time.

JUDGE MORRIS: What about Wednesday following the

Monday as well, Monday and Tuesday?

THE CHAIR: Okay. How many folks -- I'm going to back up. How many can't make it on a Thursday the 15th? You're still not. Okay. How about Tuesday the 13th? You're still -

(All talking at once therefore inaudible.)

THE CHAIR: Why don't we try for Tuesday the 13th.

Senator Christ: In addition to Monday or instead of Monday?

THE CHAIR: No, instead of a Monday. Instead of Monday. And you can't get out of Monday, right?

MR. LAPPIN: I can push everything off one day and make it Monday, but I can't make it on Tuesday. That's my dilemma. I can do Monday but I can't do Tuesday.

THE CHAIR: Okay. Other folks that couldn't make Monday the 12th, other than yourself? Which I believe was Mr. Singletary. Anybody else on Monday? And you said you could call in for part of it. Which part? So I can get a feel.

MR. SINGLETARY: How long are we talking about?

THE CHAIR: I will schedule it for longer than I hope it will go only so that it's scheduled for that. What I'm going to try and do is, hopefully, we can wrap it up that morning. You know, maybe if we go to one o'clock, from 10 to 1, that would be my hope to be done

by. And I would think that we should be able to do that.

MR. SINGLETARY: Well, I probably could -- I probably could call in and -- I'll see whether I can work some magic and do Monday, but I could call in for a significant portion of that.

THE CHAIR: Let's make it Monday the 12th then.

DR. MORRIS: That would be a problem for me, but I can -

THE CHAIR: We'll need to get -- because, probably, there will be at least one witness calling in. So, we'll need to call the state and set up a conference call. That's the only way that's going to work now. The apparatus here will take only one incoming line, so we'll have to do a conference call. So, it's Monday the 13th.

MR. CANNON: Twelfth.

SENATOR CRIST: Monday the 12th.

THE CHAIR: Monday the 12th.

MR. LAPPIN: Are you planning a time and place?

THE CHAIR: Let's make it here at this point. The time will be the same, ten o'clock, since that seems to work best. And we'll check. If there is a difference, I will alert not only the members of the Commission, but also the members. The press, through the

Governor's press office, will send out a notice like they have for all the other meetings.

MR. LAPPIN: You're figuring till one o'clock?

THE CHAIR: Till one o'clock.

MR. LAPPIN: I have to be in California by Tuesday morning.

THE CHAIR: We'll have you out. With that, why don't we -- since the -- I'm sorry, go ahead. Yes, Mr. Doss.

MR. DOSS: May I digress just one second --

THE CHAIR: Sure.

MR. DOSS: -- and ask this question of you, Mr. Chairman. Based on the testimony I heard this morning, I would ask of you is there anticipated testimony from those that are scheduled that can testify to the qualifications of the individual that actually forcing the fluids they were handling, Line A, Line B??

THE CHAIR: I believe that one of the individuals calling in today will be able to testify as to their qualifications.

MR. DOSS: The burning question in my mind is, from the doctor's testimony this morning, if this is a -- it seemed to be a pretty clearly diagnosable problem, and forcing fluids would be counterproductive without making some kind of change. And I would just

be really interested in hearing from some source that was there why that didn't happen.

THE CHAIR: Dr. Varlotta.

DR. VARLOTTA: I would just comment that Mr. Matthews, the P.A., he testified that -- I believe he testified that all the people doing their functions were qualified to do so.

MR. DOSS: I remember his testimony to that effect, but I still have a question why, if they were highly qualified individuals, was there not an identifiable problem that said, "Hey, it's not working.

Why are we having to force this fluid?" And I'm sure there will be other testimony that may help bear that out.

MR. LAPPIN: I can't answer that, but I think that's where it goes back to did they follow the protocol. Because the protocol indicated they should stop, and then check the IV insertions to ensure that they were operating properly. They opted to go to Line B. So, it could just be a procedural issue that they didn't do what protocol told them to do, and that was stop and go check and then start again.

THE CHAIR: Why don't we take lunch a little bit early, and then, hopefully, we'll be able to have, via telephone, some of those witnesses starting. Why don't

we say till 12:45.

(There was a break for lunch)

(The video is being shown)

THE CHAIR: The death chamber of Florida State Prison. And I'm going to try to enlarge this so it's full screen. Is this the witness' observation area or is this from the -- why don't we go through the whole thing first and then we'll go back and ask some questions.

MR. CHANGUS: You're looking what you would see from where the witnesses are.

THE CHAIR: And for the record, would you identify your full name, please?

MR. CHANGUS: I'm Max Changus. I work for the Florida Department of Corrections, the Office of General Counsel.

THE CHAIR: So, this is the view that the witnesses would have, correct?

MR. CHANGUS: Correct.

THE CHAIR: And that window over there on the right is where the chemical staff view. And below the clock, that's not a mirror. Is that another viewing area?

MR. CHANGUS: It's another viewing area. I provided schematic there that may provide some

reference point for you. Under the clock, yes, that's another, you know, kind of similar one-way mirror device that actually has -- from that point is where the FDLE -- using the pointer here, okay. So, that should be where the FDLE person is. And then, this right here, behind that area, is where the executioners and the other staff assisting. And then, the gurney that you see, I believe that's how it's set up. So, the head is under that clock.

And as you see on the diagram up there, there's an officer at his head, holding down the head strap that was discussed. Met last Monday. Mr. Polk, who testified last time, the assistant warden, is kind of off in this area here. So, when he was describing what he could see, it's from that vantage point.

MS. SNURKOWSKI: Where are the phones in relationship?

MR. CHANGUS: The phones are right over here. I think the warden would have been standing right about here, and another assistant warden standing about there, okay. And then, as you see on your diagram, I think there's someone right there and a person there, a person there. Okay. So, that's what the view from the executioner's view would be through that window there.

DR. MORRIS: This little door here, I didn't see

that on the other side. Did I miss that?

THE CHAIR: It was off.

DR. MORRIS: It was off to the side.

THE CHAIR: It looked real small.

MR. CHANGUS: Yes, that's the pass-through.

MR. LAPPIN: Why is that window so small?

DR. MORRIS: How big is it?

MR. CHANGUS: I do not. I could get those for you if you like.

MR. LAPPIN: Why not have that whole wall just mirrored glass so you have completely nonrestricted view?

MR. CHANGUS: Well, I would submit that the area that's behind -- it's not like there's a huge room behind it. That's only one little -- the window/mirror is, basically --

MR. LAPPIN: You could put an aluminum frame divider wall there filled with glass with a two-way mirror reflected on it.

MR. CHANGUS: Again, I would submit that either that the room that the executioner and folks are operating in is not all that large.

MR. DOSS: What's behind that curtain?

MR. CHANGUS: I mean, I guess there's a little bit of wall there, but there's not -

MS. SNURKOWSKI: Where is the door that they go into that they lock? Where is the door?

MR. CHANGUS: There's a door right here that's locked.

MS. SNURKOWSKI: Okay.

MR. CHANGUS: And that kind of seals the chamber there. And then there's, in this area here, there's a little -- there's another door to that where the chemicals are locked prior to administration. But during that time it's open, because it's not that large of a space.

DR. MORRIS: Is this the pass-through?

MR. CHANGUS: Yes, sir.

DR. MORRIS: So, that's just an open area, then, behind the curtain.

MR. CHANGUS: Pretty much, yes. There's a little hallway.

THE CHAIR: Can you orient us a little bit?

MR. CHANGUS: Pardon?

THE CHAIR: Can you orient us?

MR. CHANGUS: Sure. Well, basically, the phones would be on that wall. Here, again, is the one-way mirror that the executioner is looking through. Again, gurney would be in about that place here. So, it's only about seven-, eight-foot across this way.

MS. SNURKOWSKI: All right. From the window to the gurney edge, how far is that?

MR. CHANGUS: I would say -- I would say it's about four feet.

MS. SNURKOWSKI: Four feet?

THE CHAIR: And this is where the head would be?

MR. CHANGUS: Yes. And here, what you're looking through there is the door from the execution chamber into the witness room. And that's closed during this time.

MS. SNURKOWSKI: So, this is the witness' vantage point. Almost anybody sitting in this area -- is that what this is from?

MR. CHANGUS: Correct.

MS. SNURKOWSKI: Can see the whole area?

MR. CHANGUS: Yes. Because the witness room goes back -- there are about three rows of chairs or so.

DR. SPRINGER: The strap that they were touching there, can you orient me where that sits on the prisoner's arm? Is it high up on the arm? Lower on the arm? The arm straps there. Where would that fall?

MR. CHANGUS: Well, you see this metal plate right there? Okay. And I think they talked about the hands basically being strapped down there. Do you see what I'm saying? There's a wrap-around to secure the hand.

So, moving up from there.

DR. SPRINGER: So, that would be down towards the the hand.

MR. CHANGUS: Yes.

DR. SPRINGER: But not here in this?

MR. CHANGUS: That's my -- I mean, that's my observation.

DR. SPRINGER: But not here?

MR. CHANGUS: No. It wouldn't be in the crook of the elbow, if that's what you're asking.

MS. SNURKOWSKI: And then, the straps, the way the head would be would be all the way to the left, right?

MR. CHANGUS: Right.

MS. SNURKOWSKI: That's the head. And then, those two straps go around the chest?

MR. CHANGUS: Yes.

THE CHAIR: And this strap is the one for the upper arms or --

MR. CHANGUS: Well, I think that's what the doctor was just asking. My recollection --

DR. MORRIS: And is that adjustable?

MR. CHANGUS: Yes, I think there is some adjustment.

MS. SNURKOWSKI: Well, do those just wing out or are they fixed?

MR. SINGLETARY: The boards, do they fan out or do they come closer?

MR. CHANGUS: My thought is that they fanned out, but I wouldn't -- I'm not going to swear to that. Does anybody need to see it again?

THE CHAIR: That was sufficient/

(No response)

(There was a short break off the record)

THE CHAIR: Back on the record. Also, for the members who got to see it that way, we're having a meeting on the 12th, which is when DOC has setup if you want to personally see the room. Does anyone here wish to see the room? Not on that date. It would have to be a different date. So, if anybody wants to personally go up there, just raise your hand and I'll see that it's set up.

(No response)

Okay. I think Mr. Crist had a question.

SENATOR CRIST: I've got a question. One of the members of our panel is with the federal corrections system. And you execute, I understand, at the federal level; is that correct?

MR. LAPPIN: Correct.

SENATOR CRIST: And the method of execution?

MR. LAPPIN: Lethal injection.

SENATOR CRIST: How are your rooms set up? And are they different from the way our room is set up in Florida?

MR. LAPPIN: It is set up different than this room. Again, this room was not set up to be a lethal injection facility. This was, I assume, set up to be an electrocution. In advance of us building an execution facility, we went and looked at all the other facilities to figure out what would be the best scenario for a lethal injection execution. And based on that, we built a lethal injection room. And it's a little better lit.

We have -- the window is not that much larger, I think, than this window, although it's positioned differently. But we have a camera in there. Not to record anything. We cannot record -- the law doesn't allow us to record those executions either. But it does give the folks in the chemical room great visibility of the inmate, both through the window, through this closed-circuit television, and audible so they can hear, they can see, and they can have just a better set-up than what many other locations I've seen around. I can even bring a tape if you'd like to see the set-up, a videotape that you can show if that was of interest to you.

THE CHAIR: I think I'd be interested.

SENATOR CRIST: I think it would be very interesting.

THE CHAIR: Very helpful. Just so I know technically what I need, is it on a DVD like we just saw or is it, like, on a VHS?

MR. LAPPIN: It's a VHS. Is that easier if you just have a T.V. with a VHS? Or I might be able to get it on DVD. I can check.

THE CHAIR: I think I can run VHS through the same equipment.

MR. LAPPIN: I'll see if I can get it in either and I'll let you know.

THE CHAIR: Okay. Great.

MR. LAPPIN: But, again, our folks -- who operating the chemical room where our expertise is, they want more visibility. They want to be able to see the offender's face so they can assess what's occurring, as well as being able to hear. Because oftentimes the inmate -- they want to make sure the inmate is asleep before the second drug is injected.

SENATOR CRIST: Thank you.

THE CHAIR: Great. Thanks.

MR. DOSS: Can I follow up on that, please?

THE CHAIR: Certainly.

MR. DOSS: Is there just one facility or are there multiple facilities?

THE CHAIR: In the federal system?

MR. DOSS: Yes.

MR. LAPPIN: One facility.

MR. DOSS: Just one?

MR. LAPPIN: For the entire federal system in Terre Haute, Indiana.

THE CHAIR: We're waiting for the folks that are going to testify next call in to Mr. Changus. So, there will be a brief thing. And while we're doing that, I'm going to make sure the telephone system is working correctly. So, if you all would like to a very brief, let's say, ten minutes.

(There was a short break off the record)

THE CHAIR: Are you still there?

MR. CHANGUS: We're on the speaker phone right now. Can you hear?

THE CHAIR: Turn it up.

WARDEN BRYANT:: Can you hear me now?

MR. CHANGUS: No. It's still pretty low. Hold on one second. It's still very low. One second. Is there anything more you can do with this?

DR. VARLOTTA: Hold the button down.

THE CHAIR: Other than the court reporter, all

other recordings cease while the folks that were in the actual death chamber behind the scene are giving testimony today. I'm throwing that out to the Commission. To protect their anonymity, they don't want any recordings other than by the court reporter. Anybody have a feeling on that?

REPRESENTATIVE ROSS: Do we have a choice? I mean, are they going to testify if it is recorded?

MR. CHANGUS: We're just looking to -- you know, this is just a step, and I think you're just not looking to have a recording where people are going to modify or -- you know, we're trying to keep the identify secret. And that's the most important thing that we're here on.

WARDEN BRYANT: Are you talking about for the commission members for (inaudible) or are you talking about -

MR. CHANGUS: No. I'm just talking about what we're doing right now.

COURT REPORTER: I'm not going to be able to hear him if it's not any louder than that.

SENATOR CRIST: I can't hear him either.

MR. CHANGUS: Well, and that's another issue as well.

THE CHAIR: We don't want the recordings so that

those recordings don't end up on the Internet or used in other manners to identify participants in this process. So, I'd defer to the DOC to honor that request.

WARDEN BRYANT: Testing, testing.

MR. CHANGUS: A little better. Yes, I think you can hear well enough. We'd ask folks to please speak up.

WARDEN BRYANT: Okay. We'll remind them to speak up. If they get to talking as usual, it might not be loud, then you might have to remind them by saying speak up. And I'm sure everybody would be glad to talk louder. I'm here to verify that the individual that's sitting in front of me is the person in question medically qualified execution team member.

MR. DOSS: We could not hear anything he said down here.

MR. CHANGUS: Warden, you're on the speaker again, right?

WARDEN BRYANT: No, no, no, I'm not on the speaker phone. I tried my phone to call several other phones to make sure that what we are doing is not prohibiting this telephone here. And I've tested it several times this morning and the volume is good on it. It must be some equipment on your end.

MR. CHANGUS: Okay. Do we want to go forward?

THE CHAIR: Why don't you ask him to call back in, like, five minutes and let's test it and I'll try the other phone. Although, we didn't have any luck before.

MR. CHANGUS: Warden, we're going to see if we can address if there are problems on this end, and if you'd call back in five minutes.

WARDEN BRYANT: You've got it.

MR. CHANGUS: Thank you.

WARDEN BRYANT: I'm here to confirm that the individual in front of me is medically qualified Florida execution team.

MR. CHANGUS: Okay. Hold on a second, Warden Bryant. One thing.

THE CHAIR: I've had a chance to talk to Pat Glisten, Attorney General's Office, is an expert in public records, and she's advised that the tape recordings should be allowed.

MR. CHANGUS: Okay. That's fine. It was just a request. And, you know, this is interesting ground here. So, that's fine. Warden, are you ready?

WARDEN BRYANT: Yes.

THE CHAIR: And who do we have, in the sense of, do we have one of the individuals involved with the IV or one of the individuals involved in the delivery of

the drugs?

WARDEN BRYANT: This would be the individual that is medically qualified with the IV.

MS. SNURKOWSKI: You need to have him identify himself on the record.

THE CHAIR: The warden?

MS. SNURKOWSKI: The warden.

MR. CHANGUS: Warden Bryant, can you please identify yourself on the record?

WARDEN BRYANT: Okay. This is Warden Randall Bryant.

THE CHAIR: Could you have the witness tell us, please, where they were physically located or approximately -- strike that. What were they doing or what were their responsibilities --

WARDEN BRYANT: Excuse me just a second. I don't mean to interrupt. But what I'm planning on doing is turning the phone over to him so he can hear the question that you're asking and he'll be able to respond. Now, we will have a mechanism on the phone that I'm going to turn on now, that this is what it's going to sound like.

MR. CHANGUS: Now, can you go ahead and try again?

COURT REPORTER: We can't hear you.

WARDEN BRYANT: Okay. Then I guess I'll just

relay the answers back to you then.

DR. MORRIS: That's not satisfactory. Because, you know, this is medical personnel and he's not going to be able to relay technical medical information, especially for the purposes of asking questions. That's going to be difficult.

WARDEN BRYANT: Max, is it causing that much that everyone can't hear?

MR. CHANGUS: Yes. It, pretty much -- it, pretty much, eliminates any ability to hear.

WARDEN BRYANT: Really?

MR. CHANGUS: Yes.

WARDEN BRYANT: Well, I guess that's the difference when it's, I guess, on that speaker than talking on a single phone. Because we have tested it on phones and it didn't change the volume. Just changed the tone of the voice and it being a little garbled.

MR. CHANGUS: Okay. Can you try it again? Are you talking? Warden Bryant?

WARDEN BRYANT: Yes?

MR. CHANGUS: That will not work.

WARDEN BRYANT: Okay.

MR. DOSS: Mr. Chairman?

THE CHAIR: Yes.

MR. DOSS: Did I miss something? Is there some reason why we cannot hear directly from the individual that's going to be giving testimony, even protecting their anonymity? Was is it necessary that information be relayed?

THE CHAIR: It wasn't going to be relayed. What they were trying was a mechanism that would disguise their voice.

MR. DOSS: This person is not in -- he's not available?

MR. CHANGUS: No, he's there. The idea is that we have a device to alter the voice. Because, again, these folks are concerned about their identities.

MR. DOSS: Just tell them to protect in an octave higher or something. I don't think the technology -- the technology, I think, is interfering with our ability to hear accurate and direct information.

DR. MORRIS: There is technology out there available that we can do this. It's just we don't have it right now. I mean, I'm trying to err on the side of judgment for both sides. It's just if the person is concerned about their anonymity, I think we have to respect that and I think we've got to set up a system that we can get the information that we need from them and we can also protect their anonymity.

There's a system that's out there. It's just this is not doing it. I guess, maybe, someone else can give an opinion as well. But I don't think we ought to force them to use equipment that's not going to protect their anonymity. But I think we also, on our side, need to be able to get the information we need. The relaying of information from the warden to that person, from that person back to the warden, I don't think that's going to be effective for our purposes. But on the same turn, I don't think the way this system is set up is, necessarily, going to respect the anonymity of the people that are going to be giving us that information.

MR. CHANGUS: I agree.

JUDGE MORRIS: I agree.

THE CHAIR: Anybody disagree with that?

MR. CHANGUS: What's the practical effect of that, is my question?

THE CHAIR: Well, the practical effect is, I guess, we're going to try and see if we can find a different system. If that doesn't work, it would seem, to me, that we're going to be at a point which we could do this in an electronic sense by having them text, a text messaging system where they -- not e-mail, but a more where you're on direct line communication.

DR. VARLOTTA: Instant massaging?

THE CHAIR: Instant massaging. Thank you.

JUDGE MORRIS: May I make a suggestion on that line?

THE CHAIR: Yes, sir.

JUDGE MORRIS: Can you use real time court reporting at both ends? In other words, what happens is you verbally ask your questions. The real time court reporter immediately types them out, just like she would in the transcript, and it comes up on a screen somewhere else, and they immediately give their answers, type them back and it comes back on the screen to us.

Now, it's a pain in the neck. But I don't know, unless you've got the devices that you're talking about, and I don't know who would have those. I don't know anybody in the state government that has what I think you're talking about, which is like a media type thing that runs on national networks to mask voices. And I don't think we have that. And I don't think the DOC has anything like that. And I don't know of any other agency that does. One of the media outlets may have it. I doubt if they would be looking to lend it to us. But the bottom line of it is that there's got to be some device to do this.

But I am not satisfied to have the questions asked to the warden and the warden ask this person and repeat back. The process would take too long and I think things would be lost in the translation. It's too important for that. So, we need to figure out a way to do this before we take this testimony if we're going to do it in that fashion.

THE CHAIR: And, Max, I assume the person does not want to, as was suggested, a handkerchief or something over their mouth, that they would rather have something, another step.

MR. CHANGUS: Yes. I mean, they're looking to have their voice altered. I don't know that the handkerchief is going to do it. And, again, I understand you all have been waiting a long time today.

I appreciate your understanding to the extent. But, you know, this is an important issue for us and it is in statute as well. So, we're just trying -- and I'm open to suggestions.

MS. SNURKOWSKI: Well, did you not say that or the warden not say that when it was on the speaker phone it didn't seem to change them? Did he try it with speaker phone, with him being on a speaker phone?

MR. CHANGUS: Warden -- is he on a speaker phone you mean?

MS. SNURKOWSKI: No. I thought he said earlier that on a speaker phone they were able to do that. They could have the machinery put on that.

WARDEN BRYANT: No, no, no.

MR. CHANGUS: Just a regular phone.

WARDEN BRYANT: No. I was saying I've used this equipment with other telephones, to include cell phones, and it worked quite well. I don't know the configuration of what it's doing to your speaker phone type equipment.

JUDGE MORRIS: Mr. Chairman?

THE CHAIR: Yes.

JUDGE MORRIS: For the sake of expedience --

WARDEN BRYANT: Hey, Max.

MR. CHANGUS: Yes, sir.

WARDEN BRYANT: Do you have a regular phone in there that the individual could hook your line up to instead of the speaker phone? I'm just asking have you tried a regular phone, like the person that wants to ask the question, he's using a phone to ask the question, then he can hear the response?

MR. CHANGUS: No. I don't think -- the Commission members aren't interested in that. I think they're looking for the free flow of questions and allowing everyone to hear, and, of course, the folks in the

gallery as well.

WARDEN BRYANT: All right.

MR. CHANGUS: Hold on one second, Chairman.

(There was a short break off the record)

MR. CHANGUS: I'm going to try to give him a call back. Try the device again, please. Are you trying? All right. That's not working.

WARDEN BRYANT: It's only set up to be used like it was phone on phone type thing.

THE CHAIR: Max, is the warden back on line?

MR. CHANGUS: Yes. Warden, are you back on the line?

WARDEN BRYANT: Oh, yeah.

THE CHAIR: Warden?

WARDEN BRYANT: Yes, sir.

THE CHAIR: I'd like to thank you for your efforts in this area. If you could, with Max, if you could arrange for the witnesses to be available again on Friday. We'll have one or two different ways to do this. One will be perhaps the federal government will be nice enough to loan us one of their voice devices that will disguise a voice. And as a backup, I'll have real time court reporters ready to go also.

WARDEN BRYANT: Yes, sir.

THE CHAIR: Okay. We'll see if we can't make this

work Friday.

WARDEN BRYANT: Yes, sir. I appreciate it. Sorry for the inconvenience.

THE CHAIR: No problem. On Friday, because we're doing public testimony from one o'clock to three o'clock, you'll need to be done nearer to 10 a.m. The witnesses call in at - Let's make it, say, 11:15. 11:15, Warden?

WARDEN BRYANT: Yes, sir, I hear you.

THE CHAIR: Okay. That's great. Thank you very much. Sorry it didn't work.

WARDEN BRYANT: No, sir, I'm sorry. Thank you.

MR. CHANGUS: Thank you, Warden.

THE CHAIR: Just so the Committee members know, in addition to those witnesses --

JUDGE MORRIS: How many of them are there? Sorry.

THE CHAIR: Three, I believe.

JUDGE MORRIS: Three?

THE CHAIR: Three. FDLE agent, Tim Westveer, will be available Friday. Also, Dr. Gravinstein. And he's scheduled for 10:15; is that correct?

MS. SNURKOWSKI: Yes.

THE CHAIR: Dr. Gravenstein is the toxicologist.

MS. SNURKOWSKI: No. Dr. Gravenstein is the head of the anesthesiologist department at U of F.

THE CHAIR: Excuse me. Anesthesiologist. Also, we're going to endeavor -- I don't know that we're going to get all that done. We'll see what Dr. Hamilton's schedule is. Hopefully, Monday will work for him. And also, excuse me, Dr. Goldberg, the toxicologist. Did you have a time for him?

MS. SNURKOWSKI: No, I don't. And Monday may be better for him.

THE CHAIR: It's beginning to look like Monday is going to be better. I think with these three, having Tim Westveer, and then Dr. Gravenstein, it's probably going to get us close. And we'll see about Dr. Hamilton.

MS. SNURKOWSKI: Right. We have another eye witness.

THE CHAIR: That's true. Another eye witness.

REPRESENTATIVE ROSS: Chairman, I have no objection, if the others wouldn't, to have a working lunch when we do these so we could make the best use of our time.

THE CHAIR: That would be great.

REPRESENTATIVE ROSS: And I would have no problem doing whatever is necessary to have the lunch brought in and we can work right through it.

THE CHAIR: So, you're suggesting that you all are

going to brown bag it?

MS. SNURKOWSKI: Yes.

THE CHAIR: Okay. We'll make arrangements in that area. We'll do it that way. I have some sort of -- when we get to the point of catering in the sense of availability, I'll see if I can't send something out to everybody or call you personally to see what your preferences are, assuming we have choices. Anything further? It's 2:35. Anything else from Committee members?

I did want to let everybody know that the preliminary report, which I need to thank Carolyn Snurkowski for doing the line and share of that. I made some minor alterations, but she certainly did the work on that. Thank you very much. I appreciate that.

That's included in your packet, so if you want to take a look at that and want to make comments, we'll discuss that on Friday. Be prepared to do that. Anybody have any new business?

MR. DOSS: Mr. Chairman, I'd like to have one point of clarification in identifying Ms. Glisten. As you correctly identified Ms. Glisten as formerly the general counsel for the Florida Attorney General's Office. She is now one of the Cabinet aids and policy coordinators for our Sunshine in Florida government

with Governor Crist staff. So, she is Florida's expert on public records and Sunshine provisions in Florida government and median. So, she is an appropriate authority and I just want to make sure she was properly recognized.

THE CHAIR: Thank you. I appreciate that, Mr. Doss. Nothing further?

MS. SNURKOWSKI: Maybe we ought to talk about, a little bit, what you plan -- we do have some other plans as far as where we're going with this. And we talked a little bit about having some discussions among the panel or the Commission members with regard to when the testimony has been taken. And what we've heard so far and we anticipate, now that we have a sense about what we're anticipating the testimony from whom we will have the testimony, perhaps we need to think about is there anybody else -- you know, before we get too far down the road, is there anybody that you might want to hear from. I think maybe we ought to think about that.

And then, also, although we have a time table, the 15th is for the interim report, what we think we're going to do in the interim report. What do we anticipate we'll -- because that's coming very close on the heels of having all these meetings. And I thought, at one point, on our first agenda, there was some tasks

force or there were tasks that you were going to assign people. Have we -- do we know anymore about that?

THE CHAIR: I have thought about that, I just haven't -- the group -- I want to make sure before we do that, that everybody has enough to do. I don't want to do it and waste folks' time. I just don't want to do that. I want to make sure that those individual committees -- there's no doubt that the doctor group will have plenty to do in their particular area.

But I don't think that, with the exception of that group, I need to make sure that everybody will have enough to do. I don't want to waste time of the others. I just don't think that that would be fair to your time. Because everybody is giving up a lot of time to be here for these meetings and that would be an additional time outside of these meetings. And I'll have a final answer for you on Friday. We'll make that the -- I think the next report we're going to try to have on the 15th.

So, we're going to need to have, hopefully -- after we get through with these witnesses, we'll have a little bit better feel, at that point, of where we want to go if anything further. I think we're going to try and hear, hopefully, from an EMT, or paramedic. Excuse me. Paramedic. We'll try to hear from a paramedic

also.

MS. SNURKOWSKI: So, you still have witnesses that you cannot really identify yet, haven't identified yet.

THE CHAIR: Right. And there's still some hopes from, perhaps, one of the nurse practitioners. We may be able to get one of those. But we'll see how that plays out. Yes, Mr. Singletary.

MR. SINGLETARY: Yes. At a minimum I would like to see what Director Lappin has with the layout and the thinking they had around setting up their unit, if we're going to recommend modifications. Because that was originally for the electric chair. I'd like to just know what his thinking and their thinking about why they set it up, why they put the different equipment and have some kind of design of that. Because one of the recommendations is redesign the chamber to do that.

I'd at least like to know their -- see their schematic and what the thinking was and why they did it the way they did it in some form, written or otherwise.

Because that way we have a makeshift. And if we want to think it over again, then we need to at least have a start. And if the federal bureau did all of that, we might as well start where they started, you know, and not have to rethink the wheel.

THE CHAIR: That sounds reasonable. Do you know whether that's in a report form or whether live testimony is available?

MR. LAPPIN: I can bring a video. I can bring a schematic. Whether or not there is documentation of why we designed it the way we did, I'll have to check because I wasn't involved at that point.

THE CHAIR: Okay.

MR. LAPPIN: But, certainly, I think it explained why we did certain things that we did do given what we've learned elsewhere. So, the video, the schematic and at least firsthand knowledge of why we did what we did in constructing a facility to carry out lethal injection. And I'll check and see if there's some historical data on why they came to the conclusions they did.

THE CHAIR: Anybody else? Anything additional?

MR. LAPPIN: Excuse me. There will be some more DOC staff who will be testifying. I guess we could even get the warden, correct? If we have a couple follow-up questions.

THE CHAIR: Questions for the warden? Sure. At least by phone?

MR. CHANGUS: Yes, at least by phone. I'm sure he'd be willing to do so.

THE CHAIR: If it doesn't come out in the testimony from the folks who inserted the IVs, my guess is the best person to go to would be the warden. And since he testified, it shouldn't be that difficult. And he would work on the speaker phone.

DR. MORRIS: Well, there's a positive.

THE CHAIR:: I've been looking for one.

DR. SPRINGER: Can you review our schedule.

THE CHAIR: This Friday at ten o'clock we'll begin again. It's going to be a very long session, I anticipate. We're going to try and start promptly at 10. We have a number of witnesses from Dr. Gravenstein, agent with FDLE, one of the witnesses that was physically present. I should say lay witness physically present. Potential for the toxicologist who did the toxicology on Mr. Diaz. And also, potentially, Dr. Hamilton, who did the autopsy.

MR. SINGLETARY: And I want to work the director to death. A second thing we talked about is two-way communication. He talked about the camera. There needs to be some kind of two-way communication between the people, executioner and the warden, or whoever, that they know something is gone or something is not or something is.

And I think they have a system where there is some

two-way communication. And I think it's something maybe we ought to recommend it. I'd like to recommend it. That's going to be one of the things we talk about recommending. And I think they have done some work on that and you don't need to reinvent the wheel once again.

MR. LAPPIN: And I think part of the issue is the decision-maker and what role they play. Given that most decision-makers in these cases are not medical folks, but they certainly play a primary role in the protocol, the adherence to the protocol, and when, in fact, you should make changes. And given that, you need communication between those folks. So, I can walk through what we did to ensure that that communication exists regarding a problem in the chemical room, but also with other aspects.

THE CHAIR: All right. That would certainly be helpful to us.

DR. MORRIS: So, Friday at ten to three?

THE CHAIR: Yes. And at 1:00 o'clock we're going to -- and I can't tell you how long that will last. It depends on how many members of the public want to make comments. But, at that time, we'll be taking --

DR. VARLOTTA: Okay. And then Monday the 12th?

THE CHAIR: Monday the 12th we're going to reserve

for -- because I feel pretty confident that not all these doctors are going to be -- Dr. Gravenstein is, certainly, going to be on Friday. But Dr. Hamilton, probably, will be Monday. We'll do him, and then any other folks, like the paramedic as well as any of the other witnesses, I think, at that time. Mr. Lappin, probably, can go through and play the video and have your presentation.

DR. VARLOTTA: And then, we're leaving the 16th up in the air or out or in?

THE CHAIR: I think we haven't set the 16th at this point.

SENATOR CRIST: Rap up on Monday?

THE CHAIR: You can, certainly, aim for that. I think we're going to need one more meeting after the interim report to finalize the report and everybody get together in a working format is what that that report should look like.

And there's, probably, a chance that -- there's a chance that that last meeting will probably be in Tallahassee. There's, probably, a chance of that. I think there's a large group of folks from Tallahassee.

It's the same distance for the Judge, I think, to go to Tallahassee as it is here. I'm not sure about Dr. Springer. It may be slightly closer for you to

Tallahassee. Probably not.

DR. SPRINGER: I think it's a little longer. Maybe there's a better chance that I could get an airline.

DR. VARLOTTA: I have another question. Is it appropriate for entities to deliver statements, written statements?

THE CHAIR: Certainly.

DR. VARLOTTA: So, if a concerned organization wants to weigh in, is the Commission accepting those?

THE CHAIR: Yes. That's public comment and we would accept that and disseminate that to every member.

In fact, I've gotten -- today I was presented with some information from the public members that was just delivered. I'll have that copied and Fed Exod. out to all the Commission members. There's a packet of it. It came from various sources up in Tallahassee and sent up to them as opposed to my office.

Anything else? At this point, we stand adjourned.

(The meeting was adjourned at 2:45 p.m.)

CERTIFICATE OF NOTARY

STATE OF FLORIDA

COUNTY OF HILLSBOROUGH

I, Patricia K. Gough, a Notary Public in and for the State of Florida at Large, do hereby certify that the foregoing proceedings were taken before me in the cause, at the time and place, and in the presence of counsel as set out in the caption hereto, at Page 1 hereof; and that the foregoing typewritten transcript consisting of pages contained herein, inclusive, is a true record of the proceedings had at said session.

I FURTHER CERTIFY that I am neither an attorney or counsel of any of the parties in this cause, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in the event of said cause.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal this 8th day of February 2007

NOTARY PUBLIC, STATE OF FLORIDA AT LARGE

My commission expires May 21, 2007

