No. 07-5439

IN THE

Supreme Court of the United States

RALPH BAZE, ET AL.,
Petitioners,
v.

JOHN D. REES, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE SUPREME COURT OF KENTUCKY

BRIEF FOR *AMICI CURIAE* MICHAEL MORALES, MICHAEL TAYLOR, VERNON EVANS, JR., AND JOHN GARY HARDWICK, JR., IN SUPPORT OF PETITIONERS

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November 13, 2007

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INTEREST OF *AMICI CURIAE*[1]

Amici Michael Morales, Michael Taylor, Vernon Evans, Jr., and John Gary Hardwick, Jr., are inmates sentenced to death by the States of California, Missouri, Maryland, and Florida, respectively. *Amicus* Taylor has a petition for certiorari pending before this Court that raises the question of the proper Eighth Amendment legal standard for lethal injection challenges.

Together, *amici* comprise a representative group of death row inmates who have filed civil rights actions challenging the means and manner by which they are likely to be executed. Through discovery, *amici* have uncovered evidence of serious flaws in the lethal injection procedures in their respective jurisdictions. Because prison officials have traditionally shrouded the details of the administration of their execution procedures in secrecy, much of this information has not previously been available to the public. In addition, because many jurisdictions employ similar lethal injection protocols, *amici* have looked to jurisdictions around the country for information relevant to their respective challenges, and are aware of the evidence discovered in those jurisdic-

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than counsel for *amici* made a monetary contribution to its preparation or submission. This brief was written with the assistance of Joy Haviland and Vanessa Ho, students in the Death Penalty Clinic at the University of California, Berkeley School of Law. The parties have consented to the filing of this brief.

tions. By virtue of their litigation, *amici* and their counsel can provide a needed perspective, one that would not otherwise be known to the Court, regarding lethal injection protocols and the various means by which departments of correction implement those protocols.

SUMMARY OF ARGUMENT

Execution by lethal injection can be performed constitutionally. The three-drug formula employed in almost all jurisdictions can result in humane executions, but only if administered properly, with the precision and care the use of such drugs requires. Because the drugs used are so volatile, and will inflict excruciating pain and suffering on inadequately anesthetized inmates, the question is whether jurisdictions that employ lethal injection have put in place reasonable procedures to effectuate a humane execution and to deal with the foreseeable problems with this method of execution. This brief argues that many of them have not done so. Instead, they have turned a blind eye to these foreseeable problems, allowing ignorance and neglect – rather than science and deliberation – to guide the formation and implementation of lethal injection protocols. The result has been botched executions that are entirely predictable and preventable.

To fully appreciate the reality of how lethal injection has been administered, one must look at the entire landscape of lethal injection challenges and, in particular, the information revealed in discovery following the Court's rulings in *Nelson v. Campbell*, 541 U.S. 637 (2004) and *Hill v. McDonough*, 126 S. Ct.

2096 (2006). Unfortunately, compelling examples of incompetent administration are currently under protective order. Nevertheless, information that *is* public reveals a "pervasive lack of professionalism," *Morales v. Tilton*, 465 F. Supp. 2d 972, 980 (N.D. Cal. 2006), in the development and administration of lethal injection protocols in this country. This lack of professionalism makes it inevitable that some inmates will suffer torturous deaths.

As this Court contemplates the appropriate Eighth Amendment standard to adjudicate lethal injection challenges, it should be aware of the flawed practices documented in the records of litigation across the country. The legal standard this Court sets should take account of the multitude of problems these records reveal, and it should allow lower courts to continue what they have already been doing: adjudicating the facts of each case to determine whether the risks that the inmate will experience pain or conscious suffering are sufficient to violate the Eighth Amendment. The vast majority of these courts have applied the "unnecessary risk" standard the Petitioners urge in this case. That framework has enabled courts to evaluate the often appalling evidence revealed in discovery and to differentiate between risks that are the foreseeable result of deficient procedures, and risks that are unavoidable even in carefully constructed procedures, or too remote to be constitutionally significant.

The secrecy surrounding executions, the failure to record relevant data, and the protective orders in place in many jurisdictions make it impossible to exhaustively or reliably catalogue the problems that

have occurred during lethal injections. Additionally, because each jurisdiction has chosen to paralyze inmates before injecting them with potassium chloride, the risk – and reality – of conscious pain or suffering is often not readily apparent. Yet publicly available evidence does demonstrate that executions are often conducted in a haphazard manner by unfit personnel, and that numerous failures have led to substantial uncertainty regarding whether the drugs in many executions were properly administered. Each step of the procedure can go awry, with disastrous (but often unseen) consequences, when prison officials disregard or ignore the inherent risks of the three-drug formula. In short, this brief describes what is known to have gone awry, and why. [2]

ARGUMENT

I. JURISDICTIONS THAT EMPLOY LETHAL INJECTION HAVE CHOSEN A METHOD WITH VERY LITTLE TOLERANCE FOR ERROR.

As the Court is aware, people are executed in this country by the intravenous injection of a three-drug formula involving the serial administration of thiopental,[3] pancuronium bromide, and potassium

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[2] All documents cited in this brief are available from counsel for *amici* upon request from this Court. Virtually all of these documents are also available on the website www.lethalinjection.org, where an annotated, linked version of this brief is posted.

[3] Thiopental is also known as Sodium Pentothal, Sodium Thiopental, or Thiopentone. It will be referred to throughout this brief as thiopental.

chloride. Death in an execution by lethal injection is, in almost all cases, caused by the administration of the potassium chloride. In other words, the inmate is alive throughout the process of execution until the last drug is administered.

"It is undisputed that, without proper anesthesia, the administration of pancuronium bromide and potassium chloride, either separately or in combination, would result in a terrifying, excruciating death." *Harbison v. Little*, No. 3:06-1206, 2007 WL 2821230, at *11 (M.D. Tenn. Sept. 19, 2007). Thus, it is incumbent upon jurisdictions that have chosen to use this method of execution to ensure that sufficient anesthetic depth is achieved and maintained throughout the execution.

Achieving sufficient anesthetic depth – so that the inmate does not experience the pain of a torturous death – is no simple matter.[4] To begin with, thiopental is packaged in kits, not as a pre-mixed solution. The execution team must mix the powdered drug with water immediately prior to injection. Additionally, correctional staff usually must combine several thiopental kits into syringes, in amounts and concentrations with which few if any execution team members have training or expertise. Indeed, preparation of controlled substances, particularly for intravenous use, is a technical task requiring significant training. In order to successfully administer the anesthetic, execution team members must correctly

[4] *See generally Morales v. Tilton*, 465 F. Supp. 2d 972 (N.D. Cal. Nov. 27, 2006); Elizabeth Weil, *The Needle and the Damage Done*, N.Y. Times Magazine, Feb. 11, 2007, at 46.

insert an intravenous catheter into the inmate's veins and then connect and disconnect numerous syringes to the IV port in the correct sequence. If a catheter is improperly placed in an inmate's peripheral vein, or the vein is compromised by repeated punctures from inexperienced or sloppy IV placement, the drugs will enter the surrounding tissue, but will not be delivered to the central nervous system. If team members are unable to maintain access in the peripheral veins, a delicate and complicated procedure may be needed by which an intravenous catheter is placed into a central vein. This procedure "typically requires a greater level of expertise . . . than somebody from the IV team would generally have," and usually must be performed by a physician.[5] These tasks are complicated by the fact that they are divided among multiple people and are not part of the execution team members' day-to-day job responsibilities, so execution personnel can bring little training or expertise to bear.

These complex procedures, employing the dangerous three-drug formula, require the participation of adequately trained and qualified personnel for effective administration. It would not impede executions to recognize the need for qualified personnel to administer the three-drug formula, and to require states to use them where appropriate. It is important to note that there is no shortage of doctors, including anesthesiologists, and other medical professionals who express a willingness to participate in

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[5] Trial Tr. at 139, *Evans v. Saar*, No. 06-149 (D. Md. Oct. 11, 2006) (testimony of Dr. Mark Dershwitz).

lethal injection executions.[6] Nevertheless, as discussed below, lethal injection jurisdictions have continued to rely upon prison employees who are neither trained nor capable of performing the complicated tasks the three-drug formula requires.

The risk here is not of an accident or chance occurrence. Unforeseeable accidents will occur with any execution protocol, and that fact does not render all execution methods unconstitutional. The botched lethal injections that have occurred in this country, and which Petitioner's brief discusses,[7] can be traced directly to poorly-drafted protocols, insistence on remote administration with a highly complex sedative, deficient (or nonexistent) training of execution team members, incompetent oversight, and inadequate facilities. Unless states and the Federal Government are compelled to establish reasonable protections

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[6] *See, e.g.,* David Waisel, *Physician Participation in Capital Punishment,* 82 Mayo Clinic Proceedings 1073, 1078 (2007) (discussing risks inherent in the three-drug formula and arguing, from the perspective of a physician, that doctors should participate in executions); Atul Gawande, *When Law and Ethics Collide – Why Physicians Participate in Executions*, 354 New Eng. J. of Med. 1221, 1229 (2006) (reporting reasons why doctors participate in executions and describing interviews with four doctors and one nurse who have participated in at least 45 executions); Neil Farber et al., *Physicians' Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, 135 Annals of Internal Med. 884, 884-890 (2001) (reporting that 41% of doctors surveyed would participate in executions and concluding that "[d]espite medical society policies, many physicians would be willing to be involved in the execution of adults").

[7] Pet'r's Brief at 20-24, *Baze v. Rees*, No. 07-5439 (U.S. Nov. 5, 2007).

against the foreseeable dangers posed by the three-drug formula, executions that result in the conscious pain or suffering of the inmate will continue to occur.

II. A REVIEW OF PUBLIC, UNDISPUTED FACTS FROM MULTIPLE JURISDICTIONS REVEALS A "PERVASIVE LACK OF PROFESSIONALISM" IN THE DEVELOPMENT OF PROTOCOLS AND THE SELECTION, TRAINING, AND OVERSIGHT OF EXECUTION TEAM MEMBERS.

Despite the complexity and high risk nature of the three-drug formula that jurisdictions have chosen, it is possible to administer the formula in a manner that all but guarantees the adequate anesthetization of the inmate. Unfortunately, the selection, training and oversight of execution team members in many jurisdictions has fallen woefully short of the standard necessary to ensure that the inherent risks in the three-drug protocol remain theoretical. The federal judge presiding over *amicus* Morales' challenge to the administration of California's protocol referred to the development and oversight of the lethal injection process in that state as the product of a "pervasive lack of professionalism." *Morales*, 465 F. Supp. 2d at 980. The extensive lack of professionalism is evident in many jurisdictions, and raises serious doubts as to whether the three-drug formula is working as it should.

A. Untrained and Unqualified Executioners

Even the most detailed, professional protocol for administering the three-drug formula is worthless if it is not read by the prison officials who conduct the executions. Yet records from several jurisdictions reveal that execution team members are routinely ignorant of the procedures that purport to govern the execution process. For example, in Tennessee, prison officials do not require team members to read the newly developed protocol unless they joined the team after the new protocol had been created. *Harbison*, 2007 WL 2821230, at *15. Several members of the federal execution team have not read any versions of the Bureau of Prison's execution protocol.[8] In California, testimony in the *Morales* litigation revealed that most execution team members had never read the protocol. When one was asked in a deposition whether she had done so, she responded, "I don't know what you're talking about."[9] In Maryland, neither the execution team leader, nor the team mem-

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[8] *See, e.g.*, Dep. Tr. of Protected Person 5 at 52, *Roane v. Gonzales*, No. 05-2337 (D.D.C. July 25, 2007); Dep. Tr. of Protected Person 6 at 127-28, *Roane v. Gonzales*, No. 05-2337 (D.D.C. July 24, 2007); Dep. Tr. of Protected Person 8 at 27, *Roane v. Gonzales*, No. 05-2337 (D.D.C. July 25, 2007).

[9] Am. Joint Pre-Hr'g Conf. Statement at 55, *Morales v. Tilton*, No. C06-0219, C06-926 (N.D. Cal. Nov. 27, 2006) [hereinafter "*Morales* Undisputed Facts"]. A Licensed Vocational Nurse who has set catheters in seven of the last nine California executions testified that he had never read the protocol. *Id.* at 19. Witness # 9, a team leader, also never read the protocol. *Id*. at 44.

ber responsible for establishing IV access, had ever seen a copy of the execution operations manual.[10]

1. Lack of training

In theory, rigorous training could compensate for ignorance of the written protocols. Perhaps not surprisingly, however, many of the jurisdictions in which team members are unfamiliar with the protocols also have little to no record of training with respect to implementation of the three-drug formula. Two states with recent histories of problematic, or botched executions – California and Florida – are illustrative of the consequences of inadequate training.

In California, a member of the execution team, who had participated in eight executions and was responsible for mixing and preparing the thiopental for executions, testified that "[w]e don't have training, really."[11] The team did not practice mixing the anesthetic, nor did they practice responses to foreseeable contingencies that could easily arise during executions.[12] There are no procedures in place to address the likely event that an IV will malfunction, because, as one witness testified, "those are the what-ifs that can go a thousand long."[13] One witness testified that

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[10] Trial Tr. at 113-14, *Evans v. Saar*, No. 06-149 (D. Md. Oct. 10, 2006) (testimony of Contractual Team B); Trial Tr. at 119, *Evans v. Saar*, No. 06-149 (D. Md. Sept. 20, 2006) (testimony of Contractual Team A).

[11] *Morales* Undisputed Facts at 13.

[12] *Id.* at 12-14.

[13] *Id.* at 67.

they draw the syringes with "[j]ust whatever volume we pretend to play with."[14] Another witness testified that "[t]here isn't really much training" regarding the administration of lethal drugs and it is "more a self-taught event."[15]

Following the botched execution of Angel Diaz in Florida last year, then-Governor Jeb Bush declared a moratorium on executions and appointed an executive commission to review Florida's lethal injection protocols. The Governor's Commission on Lethal Injection found a "failure of the training of the execution team members."[16] For example, the primary executioner during the Diaz execution, who had also served as the primary executioner for previous executions and had no medical training or qualifications,[17] testified that he does not participate in practice sessions or trainings prior to executions.[18] It is unsurprising, therefore, that team members were slow to realize that they had improperly inserted both of Diaz's IV catheters, and they did not know how to respond properly once they recognized the

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[14] *Id.* at 53.

[15] *Id.* at 41.

[16] Governor's Commission on Administration of Lethal Injection, Final Report with Findings and Recommendations, at 8 (Mar. 1, 2007).

[17] Hr'g Tr. vol. IV at 78, Governor's Commission on Administration of Lethal Injection (Feb. 9, 2007) (testimony of Primary Executioner).

[18] *Id.* at 80.

problem.[19] In fact, they reacted in the worst possible manner, injecting more pancuronium and potassium even though it was evident that Diaz may not have received a sufficient dose of thiopental to adequately anesthetize him.[20]

Without any training or qualifications of their own, and without comprehensive protocols to guide them, execution team members are left to fend for themselves, improvising as they go, and exponentially increasing the likelihood that the inmate will experience excruciating pain or suffering. This is particularly troubling since the execution team members "almost uniformly have no knowledge of the nature or properties of the drugs that are used or the risks or potential problems associated with the procedure." *Morales*, 465 F. Supp. 2d at 979. The executioners are "largely ignorant" and "completely unprepared" for the "known risks" of the three-drug formula. *Harbison,* 2007 WL 2821230, at *17-18. [21]

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[19] Governor's Commission on Administration of Lethal Injection, Final Report with Findings and Recommendations, at 8 (Mar. 1, 2007).

[20] *See*, *e.g.*, Hr'g Tr. vol. IV at 46-47, Governor's Commission on Administration of Lethal Injection (Feb. 19, 2007) (testimony of George B. Sapp).

[21] During federal court testimony in Maryland, the execution team member responsible for injecting the drugs could not identify any of the three drugs used in the protocol. Trial Tr. at 120-121, *Evans v. Saar*, No. 06-149 (D. Md. Sept. 20, 2006) (testimony of Contractual Team A). He also had no understanding of the purpose of each drug. *Id*. at 121. He was not aware that the second drug paralyzes the inmate; instead, he testified that it was his understanding that the second drug functions to "numb the body." *Id*.

2. Lack of screening

The pervasive lack of training is compounded by the fact that many jurisdictions place individuals on the execution team without screening them for any necessary qualifications, such as whether they have the requisite skills and expertise, are reliable, and can be trusted to handle dangerous, and addictive, controlled substances. As a result, many current and former execution team members are particularly ill-suited to carry out the complicated three-drug procedure.

The most well-known example of a jurisdiction entrusting its execution administration to an incompetent individual is the infamous "Dr. Doe" in Missouri. Dr. Doe is a surgeon to whom the Missouri Department of Corrections delegated the overhaul of their entire lethal injection procedures.[22] Dr. Doe was responsible not only for designing Missouri's execution procedures, but also for mixing the drugs and overseeing the executions themselves.[23] Litigation in *amicus* Taylor's case, however, revealed that Dr. Doe never created a written protocol for executions.[24] In fact, he varied the amount of thiopental

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[22] Tr. of Test. of John Doe No.1 at 19-20, 22, *Taylor v. Crawford*, No. 05-4173 (W.D. Mo. June 5, 2006); Jeremy Kohler, *Behind the Mask of the Execution Doctor*, St. Louis Post-Dispatch, July 30, 2006, at A1.

[23] Tr. of Test. of John Doe No.1 at 19-20, 22, *Taylor v. Crawford*, No. 05-4173 (W.D. Mo. June 5, 2006).

[24] During his deposition, Dr. Doe was asked the following: "Q: [T]here's no guide that you follow as you're doing it? A: Ab-

he gave inmates on a whim, without informing anyone.[25] He testified that he had recently begun giving inmates, at most, half the amount of thiopental than he had previously given, because a change in the drug packaging forced him to "improvise."[26] He could not say how much thiopental he had administered in any particular execution, and his poor recordkeeping renders it impossible to reconstruct the dose after the fact.[27] Dr. Doe also suffers from dyslexia, and admitted that "[i]t is not unusual for me to make mistakes," such as transposing numbers.[28] By his own estimate, he had been sued for malpractice more than 20 times, and reprimanded by the State Board of Healing Arts for concealing the malpractice suits from the hospitals where he was a treating physician.[29]

Dr. Doe supervised 54 executions in Missouri.[30] However, during *amicus* Taylor's litigation challenging Missouri's lethal injection procedures, Dr. Doe testified that he was "still improvising" the execution procedures.[31] Despite the fact that the paralytic ef-

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solutely not. Q. So you just rely on your memory? A. Yes." *Id.* at 70.

[25] *Id.* at 13-19.

[26] *Id.* at 9-12, 24.

[27] *Id.* at 14-18.

[28] *Id.* at 25.

[29] Jeremy Kohler, *Behind the Mask of the Execution Doctor*, St. Louis Post-Dispatch, July 30, 2006, at A1.

[30] *Id.*

[31] Tr. of Test. of John Doe No.1 at 10, *Taylor v. Crawford*, No. 05-4173 (W.D. Mo. June 5, 2006).

fect of the pancuronium ensures that executions will look the same regardless of whether adequate anesthesia is given, Dr. Doe believed that he could vary the way he carried out executions as long as his changes did not make any "visible difference" in the appearance or length of the execution.[32]

The State of Missouri was well aware of Dr. Doe's professional disrepute. The Office of the Attorney General both defended the *Taylor* litigation and signed off on the discipline of Dr. Doe.[33] Yet the state fought to keep Dr. Doe's identity a secret and said that it would not hesitate to allow him to continue to carry out executions.[34] The U.S. District Court for the Western District of Missouri, however, ordered that Dr. Doe "shall not participate in any manner, at any level, in the State of Missouri's lethal injection process."[35]

Dr. Doe's manifest incompetence is not an aberration. In fact, public filings in the federal lethal injection litigation reveal that the Federal Government

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[32] *Id.* at 23.

[33] Jeremy Kohler, *Behind the Mask of the Execution Doctor*, St. Louis Post-Dispatch, July 30, 2006, at A1.

[34] Trial Tr. at 387-392, *Taylor v. Crawford*, No. 05-4173 (W.D. Mo. June 13, 2006) (testimony of Larry Crawford, Director, Mo. Dept. of Corrections).

[35] *Taylor v. Crawford*, No. 2:05-CV-04173-FJG, at 2, (W.D. Mo. Sept. 12, 2006) (Order). The State appealed that order. Several months after appellate argument, the Attorney General represented to the court that Dr. Doe would no longer participate in executions in Missouri. *See* Letter from Michael Pritchett, Assistant Attorney General of Missouri, to Michael Gans, Clerk, U.S. Court of Appeals, 8th Cir. (Apr. 17, 2007).

uses the very same Dr. Doe to develop execution procedures, place and monitor intravenous lines, and monitor levels of consciousness.[36] In other words, the Federal Government chose to rely upon the only person in the country who has been explicitly barred by a federal court from participating in lethal injection executions.

Other jurisdictions fare no better when it comes to the selection and screening of the individuals who are responsible for developing and carrying out the execution procedures. In California, former San Quentin Prison Warden Steven Ornoski – who presided over the executions of Stanley Williams, Clarence Ray Allen, and the scheduled execution of *amicus* Morales[37] – testified that there are no rules or regulations that require him to evaluate the "bona fides" of the team members.[38] No warden or supervisor ever reviewed any of the team members' qualifications, experience, training, or personnel files.[39] The *Morales* litigation record reveals that the execution team leader was disciplined for smuggling illegal drugs into San Quentin Prison, yet was subse-

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[36] Pls.' and Intervenor Pls.' Opp'n to Def.'s Mot. and Corrected Mot. for J. on the Pleadings and Mot. to Lift the Stay of the Pls.' Executions at 38-40, *Roane v. Gonzales*, No. 05-2337 (D.D.C. Oct. 10, 2007) (redacted version, publicly filed).

[37] Williams was executed on December 13, 2005 and Allen was executed on January 17, 2006. *Morales v. Hickman*, 415 F. Supp. 2d 1037, 1045 (N.D. Cal. 2006).

[38] *Morales* Undisputed Facts at 3.

[39] *Id.* at 3-4.

quently appointed to the execution team.[40] The *Morales* litigation also uncovered the fact that "substantial" quantities of thiopental purportedly checked out for execution purposes had gone missing, and the federal judge suggested that a criminal investigation may be necessary to investigate the possible theft of thiopental by members of the execution team.[41]

B. Deficient and Incomprehensible Execution Procedures

Even if jurisdictions employed competent, qualified, and well-trained personnel to execute inmates, they would not be able to successfully implement lethal injection protocols that are incomprehensible, internally inconsistent, or fail to provide for foreseeable contingencies. Yet prison officials in many jurisdictions have put little stock in the development of professional, comprehensive procedures. They have routinely entrusted this complex responsibility to personnel with no medical training or prior experience with lethal injection. Often, they have merely

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[40] *Id.* at 3. The federal judge in the *Harbison* litigation lamented the fact that the Tennessee Department of Corrections did not screen potential execution team members for substance abuse or psychological disorders or test team members for drug use prior to the execution. "This is a particular issue because one of the paramedics – IV Team Member B – has a history of drug and alcohol addiction and psychological disorders." *Harbison v. Little*, No. 3:06-1206, 2007 WL 2821230, at *15 (M.D. Tenn. Sept. 19, 2007).

[41] *Morales v. Tilton*, 465 F. Supp. 2d 972, 979 n.9 (N.D. Cal. 2006).

copied the deficient procedures from other jurisdictions.

1. Nonsensical protocols

In some cases, the protocols reflect a complete lack of attention to what should be a rigorous and scientifically-vetted process. In Tennessee, the carelessness with which the protocol was drafted bordered on the absurd. In that state, the written lethal injection protocol included substantial elements of the old protocol for execution by electrocution.[42] Purportedly used by Tennessee officials in two executions (including one in June of 2006), the protocol instructed prison officials to shave the inmate's head and legs[43] and to have a fire extinguisher nearby prior to the lethal injection.[44] If the prison officials were to follow the protocol's further instructions to the letter, they would first "check the electrodes to insure that they are properly attached," then "proceed to electrical control panel and activate for execution," and the executioner would then "engage the automatic rheostat," which turns on the electric voltage. After the "cycle runs its course" the facility manager would "disconnect electrical cables in rear of chair." Finally, "following the completion of the

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[42] Tennessee Governor Phil Bredesen called the written directives a "cut and paste job." Sheila Burke, *Tennessee Will Lift Ban on Executions*, Tennessean, May 1, 2007, at 1A.

[43] State of Tennessee, Manual of Execution: Lethal Injection, at 34 (Oct. 1, 2006) (rescinded by Executive Order Feb. 1, 2007).

[44] *Id.* at 6.

lethal injection process," the physician will enter and conduct an examination.[45]

Tennessee is not alone. Protocols in other states also have inexplicable provisions that reflect at best, a misunderstanding of the drugs and equipment used in the three-drug formula, and at worst, a callous disregard for the danger inherent in that procedure. For example, at least two jurisdictions, including North Carolina and Oklahoma, have called for administration of the anesthetic drug after the inmate has already been executed. [46] The revised federal protocol, in a procedure that needlessly exalts anonymity over safety, calls for the use of a "blank" IV line that is not connected to the inmate, but rather connects to an empty container.[47] This procedure ostensibly protects the execution team members from knowing which member is administering the chemicals to the inmate and which is simply injecting chemicals into an empty container.[48] However, not only does this procedure add unnecessary complications to the execution process by requiring the

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[45] *Id.* at 35-36.

[46] Aff. of Marvin L. Polk at 2, *Page v. Beck*, No. 5:04-CT-04-BO (E.D.N.C. Jan. 6, 2004); Decl. of Dr. Mark J.S. Heath at 17, *Patton v. Jones*, No. 06-591 (W.D. Okla. July 27, 2006).

[47] Ex. 4R, *Addendum to Bureau of Prisons Execution Protocol Federal Death Sentence Implementation Procedures* (effective July 1, 2007) at 3, Decl. of Dr. Mark J.S. Heath, *Roane v. Gonzales*, No. 05-2337 (D.D.C. Sept. 7, 2007) (redacted version, publicly filed).

[48] Decl. of Dr. Mark J.S. Heath at 24, *Roane v. Gonzales*, No. 05-2337 (D.D.C. Sept. 7, 2007) (redacted version, publicly filed).

preparation of as many as 20 extra drug syringes,[49] it would only accomplish its apparent purpose if the executioners had been so poorly trained that they could not tell the difference between injecting a syringe into an empty container and injecting a syringe intravenously into a human being.[50]

2. Dangerously inappropriate priorities

There is ample reason to question whether officials in some jurisdictions grasp the seriousness of their constitutional responsibilities. In California, for example, former Warden Ornoski testified that "he believes that a 'successful execution' is simply one where 'the inmate ends up dead at the end of the process.' When asked whether he considered a successful execution to mean anything else, he responded, 'I'm thinking not.'" *Morales*, 465 F. Supp. 2d at 983 n.14.

To the extent that states do carefully consider aspects of their lethal injection protocols, inappropriate concerns are often paramount. Certainly one example is the use of pancuronium bromide, which protects the witnesses from watching an unpleasant death but also masks the ability of anyone except well-trained and experienced professionals to know whether the inmate is experiencing searing pain or conscious suffocation.[51] But there are other exam-

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[49] *Id.*

[50] *Id.*

[51] Dr. Mark Dershwitz, an expert for the state in many jurisdictions, including Kentucky, recently testified in a deposition that the principal benefit of using pancuronium is its effect

ples of inappropriate priorities. In Missouri, Dr. Doe testified that the Director of the Department of Corrections relies on him to "keep [the Director] looking good . . . so [the Director] does not have to go out and explain why we made a mistake or we may have a problem or why it didn't go smoothly."[52] In Tennessee an executive commission recommended that the state use a one-drug method similar to that used in animal euthanasia, in order to reduce the risk of conscious suffering during lethal injections. *Harbison*, 2007 WL 2821230, at *3-5. They made this advisement after consulting with medical experts, including the State of Kentucky's expert, Dr. Dershwitz, who recommended a one-drug protocol to the commission. *Id.* at *3. Nonetheless, the Commissioner of the Department of Corrections, who had no medical training, rejected all of the committee's suggestions. He eventually admitted that he had done so because he did not want "Tennessee to be at the forefront of making the change from the three-drug protocol to the one-drug protocol" and that he thought adoption of a one-drug protocol could lead to "political ramifications." *Id.* at *7.

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on execution witnesses: "Q. Is there anything beneficial that pancuronium does for the inmate? A. Not the inmate directly. Q. And indirectly? A. It may decrease the misperception of these involuntary movements as consistent with suffering on the part of the witnesses, including the inmate's family. Q. But for the inmate himself? A. I said no." Dep. Tr. vol. I at 119-120, *Jackson v. Danberg*, No. 06-CV-300 (D. Del. Sept. 10, 2007) (testimony of Dr. Mark Dershwitz).

[52] Tr. of Test. of John Doe No.1 at 62, *Taylor v. Crawford*, No. 05-4173 (W.D. Mo. June 5, 2006).

3. Remote administration and inadequate assessment of anesthetic depth

In many lethal injection jurisdictions, the execution team members administer the lethal drugs and monitor the inmate from a remote location. Remote administration prevents the execution team members from properly assessing whether the inmate is receiving the anesthesia and whether the anesthesia achieves the desired effect. Remote administration increases the risk of error, from improper pushing of the drugs, to unnecessarily lengthy lines of tubing that can malfunction. Dr. Dershwitz has acknowledged that, during the induction of even routine anesthesia in a medical setting, the anesthesiologist stands in the same room as the patient, immediately adjacent to the inmate's IV site. He or she injects anesthetic drugs, carefully attuned to the needs of the patient, from this bedside location. Dr. Dershwitz has further acknowledged that "Standard I" in the American Society of Anesthesiologists' Minimal Monitoring Standards requires continuous bedside monitoring.[53]

Despite the undisputed importance of closely monitoring the IV line, many states provide only for remote monitoring. Because states insist on executioner anonymity, they have used separate rooms for infusion of the chemicals. This requires remote administration, often through lengthy tubing. For example, in California, the federal judge found that

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[53] Trial Tr. at 113-14, *Evans v. Saar*, No. 06-149 (D. Md. Oct. 11, 2006) (testimony of Dr. Mark Dershwitz).

"[t]he lighting is too dim, and the execution team members are too far away, to permit effective observation of any unusual or unexpected movements by the condemned inmate, much less to determine whether the inmate is conscious." *Morales*, 465 F. Supp. 2d at 980. Similarly, a federal judge found that the Tennessee lethal injection system, where the executioners administer the lethal chemicals and monitor the IV lines from a tiny, poorly lit room outside of the execution chamber, was inadequate and increased the inmate's risk of experiencing unnecessary pain. *Harbison*, 2007 WL 2821230, at *9, *19.

Remote administration creates a foreseeable risk of inadequate administration of anesthesia. So too do protocols that call for token checks for consciousness but no real assessment of anesthetic depth.

Potassium chloride is excruciatingly painful, similar to a "surgical stimulus." J.A. 604. Inmates therefore must be placed in a surgical plane of anesthesia to ensure that they do not wake up upon injection of the potassium – after they are already paralyzed. Verifying a surgical plane of anesthesia, particularly in paralyzed individuals, is a complex task that requires synthesizing many subtle indicia of responsiveness. It can only be performed reliably by persons with advanced training in anesthesia.[54]

A number of jurisdictions have begun to tweak their lethal injection protocols in a way that purports

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[54] Post-Trial Decl. of Dr. Mark J.S. Heath at 15, *Morales v. Tilton*, No. C06-0219, C06-926 (N.D. Cal. Nov. 9, 2006).

to measure anesthetic depth. The impetus to assess anesthetic depth comes, presumably, from a realization on the part of prison officials that there is indeed a risk of excruciating pain if the first drug is not properly administered.[55] Despite this implicit acknowledgement, many jurisdictions do not adequately monitor the delivery of anesthesia to the inmate, nor do they properly assess anesthetic depth prior to administering the second and third drugs. For example, the Federal Bureau of Prisons provides that the execution team should wait to administer the paralytic until the inmate looks "sleepy."[56] There is no explanation of how to make this determination, to what level of anesthetic depth "sleepy" is supposed to correspond, or what steps to take if the inmate does not seem "sleepy."[57]

In North Carolina, an earlier incarnation of the state's protocol called for the Warden to determine whether "an inmate was unconscious upon hearing the inmate's 'snoring.'"[58] After several legal challenges, prison officials persuaded a federal court to permit an execution to proceed, in part, by represent-

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[55] In contrast, the lethal injection protocol in some jurisdictions, including Kentucky, provides for no assessment of either consciousness *or* anesthetic depth. The federal judge in Tennessee referred to this failure as "the most glaring omission in the new protocol." *Harbison*, 2007 WL 2821230, at *12.

[56] Ex. 4S, *Protocol Lead Script*, Decl. of Dr. Mark J.S. Heath, *Roane v. Gonzales*, No. 05-2337 (D.D.C. Sept. 7, 2007) (redacted version, publicly filed).

[57] *Id*.

[58] *Conner v. N.C. Council of State,* No. 07-GOV-0238, 07-GOV-0264, at 12 (N.C. O.A.H. Aug. 9, 2007).

ing to the court that a physician would monitor the inmate's consciousness throughout the execution. *Brown v. Beck*, No. 5:06-CT-3018-H, 2006 WL 3914717, at 4-5, (E.D.N.C. Apr. 17, 2006) (final order denying preliminary injunction). However, the physician present at the execution was never told of this requirement, and in fact later testified that he had not monitored the inmate's consciousness during the execution process.[59]

Several other jurisdictions have added steps to their protocols that call for shaking the inmate, poking him, or calling his name. These steps, however, do not permit an assessment of anesthetic depth and betray a fundamental misunderstanding of the nature of the inherent risks in the three-drug formula.[60]

The "consciousness check" some jurisdictions are now instituting does not come close to verifying sufficient anesthetic depth. These jurisdictions propose to have personnel with little or no medical training shake or touch the inmate and look for a physical re-

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[59] Hr'g Tr. at 245-50, *Conner v. N.C. Council of State*, No. 07-GOV-0238, 07-GOV-0264 (N.C. O.A.H. May 21, 2007) (testimony of Dr. Obi Umesi).

[60] Dr. Doe, Missouri's former executioner and one of the Federal Government's lethal injection consultants, demonstrated this fundamental misunderstanding when he testified that "the only thing that can be monitored [during the execution] is facial expression and you can judge when the effect of the drug is accomplished, and that can be seen from across a room through a window." *Taylor v. Crawford*, No. 05-4173-CV-C-FJG, 2006 WL 1779035, at *6 (W.D. Mo. June 26, 2006).

sponse. [61] For example, in Indiana, after the thiopental has been injected into the IV, the Warden examines the IV site and looks for "signs of consciousness."[62] Warden Ed Buss testified, "I walk around the offender. I look for any signs of consciousness. I say his name. I touch him. . . . Maybe a gentle shake to see if we can detect any consciousness."[63] In Alabama, a recent addition to the state's lethal injection protocol calls for a prison guard to check that the inmate is unconscious by calling the inmate by name, brushing his eyelashes with a finger, and pinching his arm. A spokesman for the Alabama Department of Corrections stated that the new procedure is "simply a consciousness check."[64]

These procedures may indicate that an individual is lightly unconscious, or sleeping, but cannot indicate any more than that, and may be unreliable even on that point. One could poke, or speak to, a sleeping person without eliciting a response, but one would never assume from that reaction that the sleeping person could therefore be injected with a drug that causes searing pain upon administration. Moreover, given that many jurisdictions offer inmates strong sedatives prior to their executions, inmates may be aware, but unable to provide a discernible response to the "consciousness check." And,

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[61] *See* Decl. of Dr. Mark J.S. Heath at 4, *Taylor v. Crawford*, No. 05-4173 (W.D. Mo. July 24, 2006).

[62] Trial Tr. at 199, *Timberlake v. Buss*, No. 06-1859 (S.D. Ind. Apr. 26, 2007) (testimony of Warden Ed Buss)

[63] *Id*.

[64] Stan Diel, *State's New Execution Procedure Detailed*, Birmingham News, Oct. 26, 2007, at 1A.

of course, once the inmate is paralyzed, this check will be completely ineffectual, because no amount of poking, prodding, or shouting is capable of eliciting a response. Those gestures serve only to provide witnesses, and perhaps the execution team members themselves, with the false assurance that the appropriate level of anesthetic depth has been achieved.

4. Inadequate facilities

Finally, the lack of concern for anything other than a quick execution that "looks" painless is evident in the physical conditions under which lethal injections are conducted. The execution chambers in many jurisdictions were not designed for lethal injection executions and suffer from a number of critical deficiencies.[65] In most jurisdictions, prison officials administer lethal drugs from a small anteroom separated from the execution chamber. Often this anteroom is poorly lit, purposefully, so that witnesses cannot see into the chamber. For example, in California, after the team members set the IVs and leave the execution chamber, the lights are turned down.[66] During the execution of Clarence Ray Allen, the doctor filling out the execution record needed the aid of

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[65] California has recently spent approximately $800,000 rebuilding its execution chamber in an effort to correct some of the deficiencies in the facilities, Mark Martin, *Lawmakers Rip Governor Over Death Chamber*, S. F. Chron., May 9, 2007, at B1, but not before the state executed eleven people in a converted gas chamber that the court found increased the risk of improperly placed IVs and undetected problems. *Morales v. Tilton*, 465 F. Supp. 2d 972, 980 (N.D. Cal. 2006).

[66] *Morales* Undisputed Facts at 21.

a small flashlight to see what he was doing.[67] In Missouri, the personnel who administer the injections are in the dark and also use a small flashlight to identify the syringes. *Taylor v. Crawford*, No. 05-4173-CV-C-FJG, 2006 WL 1779035, at *5 (W.D. Mo. June 26, 2006). It is difficult enough for non-medical personnel to inject numerous syringes in a high-stress situation, without forcing them to manipulate the IV-syringe connections in a small, dark space, while juggling a flashlight, and attempting to inject the syringes in the correct order.

In California, the anteroom is not only poorly lit, but is often crowded with state officials on hand to witness the execution. *Morales*, 465 F. Supp. 2d at 980. As a result, execution team members have testified that "simple movement has been difficult." *Id*. Former warden Ornoski testified that during executions it was so crowded that he could do little more than "shuffle from side to side a foot or two."[68] He also testified that, during Clarence Ray Allen's execution, it was so crowded that he couldn't "move from my spot much, if any."[69] One execution team member, who was in charge of passing the drug syringes to the executioner, testified that the anteroom was so crowded that she would "have to kind of reach around people" when handing syringes to the executioner.[70]

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[67] *Id*.

[68] *Morales* Undisputed Facts at 16.

[69] *Id.*

[70] *Id.* at 48.

III. THE INCOMPETENT ADMINISTRATION OF LETHAL INJECTION PROCEDURES HAS RESULTED IN FORESEEABLE AND PREVENTABLE PROBLEMS IN NUMEROUS EXECUTIONS.

When unqualified personnel working in inadequate facilities perform a complicated and dangerous procedure with little margin for error, it should not be surprising when things go wrong. In the lethal injection context, when things go wrong, inmates suffer excruciating deaths. The so-called botched executions that have garnered widespread attention in the popular media are stark examples.[71] Because of the use of pancuronium and the paucity of execution data, it is unknown how many other botched executions have gone unnoticed. What is significant about the executions that have gone awry is that they can be traced back directly to the "pervasive lack of professionalism" in the development and oversight of the lethal injection process in many jurisdictions. What gives the botched executions constitutional significance is that they were foreseeable and preventable.[72]

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[71] *See*, *e.g.*, John Mangels, *Condemned Killer Complains Lethal Injection "Isn't Working,"* Cleveland Plain Dealer, May 3, 2006, at A1; Sonja Clinesmith, *Moans Pierced Silence During Wait,* Arkansas Democrat Gazette, Jan. 26, 1992, at 1B; Adam Liptak, *After Problem Execution, Governor Bush Suspends the Death Penalty in Florida*, N.Y. Times, Dec. 16, 2006, at A11.

[72] "[I]mplementation of lethal injection is broken, but it can be fixed." *Morales v. Tilton*, 465 F. Supp. 2d 972, 974 (N.D. Cal. Nov. 27, 2006).

Perhaps the best example of the subtlety with which insufficient anesthesia can manifest itself is provided by California execution records. In at least six out of the past eleven executions by lethal injection in California, execution logs indicated that inmates continued to breathe for far longer than the state's expert asserted would be expected in inmates who had received the full dose of thiopental. *Morales*, 465 F. Supp. 2d at 975 n.3. These inmates were likely not deeply anesthetized, and therefore may have been conscious when the execution team injected them with pancuronium bromide and potassium chloride. *Morales*, 465 F. Supp. 2d at 975 (citing *Morales v. Hickman*, 415 F. Supp. 2d 1037, 1045 (N.D. Cal. 2006)). Indeed, the state's own expert, Dr. Robert Singler, later acknowledged that based on the continued breathing and "the heart rates reflected in the execution log, [Robert Lee Massie, executed in March of 2001] well may have been awake when he was injected with potassium chloride." *Id.* at 980.[73]

What is particularly disturbing about the California evidence is that execution personnel recorded the vital signs, but were insufficiently trained in anesthesia to recognize the significance of their observations, and never thought to investigate further. *See generally Morales*, 415 F. Supp. 2d at 1044-1045. As a result, several inmates were executed while exhibiting signs of inadequate anesthesia. Of course, the use of pancuronium renders it impossible to de-

[73] The only reason Dr. Singler could not be more definitive was "principally because of the poor quality of the log itself." *Id.*

termine with certainty whether these executions were humane.

Sometimes lethal injection executions go wrong in obvious and gruesome ways. Usually that is the case when prison officials – untrained, unqualified, and poorly supervised – have difficulties establishing and maintaining venous access. These difficulties introduce the very real risk that the inmate will not properly receive the anesthetic and will be injected with pancuronium bromide and potassium chloride while conscious but paralyzed. Infiltration, for example, occurs when a catheter is placed improperly and the thiopental enters the tissue surrounding the vein instead of the vein itself.[74] It prevents the full dose of thiopental from reaching the central nervous system and thus may result in inadequate anesthesia.[75] Similarly, sometimes veins perforate, leak, or rupture while an execution team member is inserting the catheter or injecting the thiopental, which causes some or all of the drug to leave the vein and enter the surrounding tissue.[76] In other cases, the IV tubes themselves leak, preventing some or all of the drugs from reaching the inmate's veins.[77]

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[74] Decl. of Dr. Mark J.S. Heath at 11-12, *Morales v. Hickman*, No. C06-0219, C06-926 (N.D. Cal. Jan. 12, 2006).

[75] *Id.*

[76] *Id.*

[77] *Id.* In Maryland, state officials admitted that, during the execution of Tyrone Gilliam on November 16, 1998, the IV was administered incorrectly and that the "IV line leaked and a small puddle of liquid formed on the floor." Def.'s Answer to Compl. at 6-7, *Evans v. Saar*, No. 06-149 (D. Md. Mar. 13, 2006). *See also Oken v. Sizer*, 321 F. Supp. 2d 658, 667 n.7 (D.

Recent executions in several states demonstrate the foreseeable problem of infiltration and its consequences to the entire execution process. When the State of Florida executed Angel Diaz on December 13, 2006, "it is undisputed that . . . the intravenous lines were not functioning properly because the catheters passed through [Diaz's] veins in both arms and this delivered the lethal chemical into soft tissue, rather than into his veins." *Lightbourne v. McCollum*, No. SC06-2391, 2007 WL 3196533, at * 15 (Fla. Nov. 1, 2007). Eyewitness reports and an autopsy investigation by the Medical Examiner for the Eighth District of Florida lead to the conclusion that Diaz was likely not properly anesthetized during the execution.[78] For over twenty minutes, Diaz was blinking, moving around, gasping for air, grimacing, struggling to breathe, trying to speak, and clenching his jaw.[79] Despite signs that the anesthetic was not working, the execution team injected the second and third drugs, and then administered the entire three drug sequence a second time.[80] An autopsy revealed that Diaz had fluid-filled, one-foot long blisters on

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Md. 2004) (noting that the State conceded that the IV "was maladministered and dripped" during Gilliam's execution in 1998).

[78] Hr'g Tr. vol. IV at 171-74, Governor's Commission on Administration of Lethal Injection (Feb. 12, 2007) (testimony of Dr. William Frank Hamilton).

[79] *See* Chris Tisch, *Governor Bush Halts Executions*, St. Petersburg Times, Dec. 16, 2006, at 1A.

[80] *See*, *e.g.*, Hr'g Tr. vol IV at 46-47, Governor's Commission on Administration of Lethal Injection (Feb. 19, 2007) (testimony of George B. Sapp).

both of his arms, indicating that the IV sites had malfunctioned and did not properly deliver the drugs into his veins.[81] The Florida Supreme Court recently acknowledged that "the execution of Diaz raised legitimate concerns about the adequacy of Florida's lethal injection procedures and the ability of the DOC to implement them." *Lightbourne,* 2007 WL 3196533, at * 16. As noted above, then-Governor Jeb Bush's commission on lethal injections concluded that the prison employees assigned to the Diaz execution, the ones who had so much trouble injecting the drugs into Diaz' veins, were not properly trained to do their jobs.[82]

The Ohio execution of Joseph Clark on May 2, 2006 was initially delayed for approximately twenty-two minutes while a group of technicians searched for a vein in which to insert an intravenous line.[83] Four minutes after the execution team began administering the lethal chemicals, Clark lifted his head up and said, "[i]t's not working."[84] Prison officials then determined that Clark's vein collapsed.[85] The paramedics spent more than half an hour attempting to

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[81] Hr'g Tr. vol. IV at 164-66, Governor's Commission on Administration of Lethal Injection (Feb. 12, 2007) (testimony of Dr. William Frank Hamilton).

[82] Governor's Commission on Administration of Lethal Injection, Final Report with Findings and Recommendations, at 8 (Mar. 1, 2007).

[83] *See*, *e.g.*, Adam Liptak, *Trouble Finding Inmate's Vein Slows Lethal Injection in Ohio*, N.Y. Times, May 3, 2006, at A16.

[84] *Id.*

[85] *Id.*

insert another IV.[86] The execution continued and officials pronounced Clark dead nearly ninety minutes after the execution commenced.[87] An independent autopsy examination later indicated a total of nineteen needle puncture wounds.[88]

After the thiopental injections began in the Oklahoma execution of Lloyd LaFevers on January 30, 2001, several witnesses observed him raise his head off the bed, breathe deeply, as if he were gasping for air.[89] An autopsy performed the next day by the State Medical Examiner found it likely that one of LaFevers' IVs had infiltrated during the execution.[90] A federal judge in Oklahoma heard testimony regarding LaFevers' and noted that "something did go awry and most regrettably so."[91]

The State of California executed Stanley Williams on December 13, 2005. *Morales*, 415 F. Supp. 2d at 1045. A Registered Nurse on the execution team, who was responsible for setting one of the catheters in Williams' arms, made two unsuccessful

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[86] *Id.*

[87] *Id.*

[88] Autopsy Report for Joseph Clark, Dr. L.J. Dragovic, Office of the Medical Examiner, Oakland County, Michigan (Aug. 15, 2006), at 2.

[89] *See*, *e.g.*, Aff. of Catherine Burton at 1, *Patton v. Jones*, No. 06-591 (W.D. Okla. Feb. 19, 2004); Decl. of Patrick J. Ehlers at 2, *Patton v. Jones*, No. 06-591 (W.D. Okla. Mar. 1, 2004).

[90] Autopsy Report for Lloyd LaFevers, Dr. Larry Balding, Office of the Chief Medical Examiner, Oklahoma City, Oklahoma (Jan. 31, 2001).

[91] Prelim. Inj. Tr. at 235, *Patton v. Jones*, No. 06-591 (W.D. Okla. Aug. 8, 2006).

attempts to set the catheter in the left arm, the backup line.[92] On the third attempt, it is likely that Williams' vein ruptured. The two medical personnel thought the line was working when they left the chamber, only to be told later that the IV line was still not flowing, and had failed.[93] Despite this failure, the Warden told the team to "proceed" and the team did so, "without the IV line in the left arm properly set or operating."[94] The difficulty setting the IV created a risk that both IVs would be compromised and the drugs would not be successfully delivered. It also demonstrates that the individuals selected for establishing IV access could not discern whether the IV was properly placed. Indeed, logs of Williams' execution indicated physical signs inconsistent with deep anesthesia.[95] The execution team apparently failed to fully appreciate this risk: the nurse who was unable to properly set the catheter in Williams' arm later testified that other execution team members' only response to the problem was "sh-t does happen."[96]

These are but a few examples of the ways in which the "pervasive lack of professionalism" has led to botched executions that are the direct, foreseeable result of the inadequate attention paid to the inherent risks of the three-drug protocol. The states, and the Federal Government, have *chosen* a three-drug

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[92] *Morales* Undisputed Facts at 18.

[93] *Id.*

[94] *Id.*

[95] *Morales*, 415 F. Supp. 2d at 1045 n.13.

[96] *Morales* Undisputed Facts at 54.

lethal injection formula that is fraught with risk. If they do nothing to ameliorate the risk, executions will go awry. If they ignore the foreseeable – and preventable – problems with the formula they have chosen, they do so at their constitutional peril.

CONCLUSION

For the foregoing reasons, the judgment of the Kentucky Supreme Court should be reversed.

Respectfully submitted,

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NOVEMBER 13, 2007