Exhibit B

☐ EXPEDITE
☐ No hearing set
☒ Hearing is set
Date: 11/20/2008
Time: 9:00 a.m.
Judge Wickham

THE HONORABLE CHRIS WICKHAM

SUPERIOR COURT OF THE STATE OF WASHINGTON
FOR THURSTON COUNTY

DAROLD R. J. STENSON,

Plaintiff,

v.

ELDON VAIL, Secretary of Washington Department of Corrections (in his official capacity); *et al.*,

Defendants.

No. 08-2-02080-8

SUPPLEMENTAL DECLARATION OF DR. MICHAEL J. SOUTER

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SUPPLEMENTAL DECLARATION OF DR. MICHAEL J. SOUTER

I, MICHAEL J. SOUTER, hereby declare as follows:

1. I am over the age of 18 and make this declaration on my personal knowledge.

2. I submitted a declaration in this action dated October 14, 2008.

3. I understand that the Department of Corrections ("DOC") amended its execution policy DOC 490.200 effective October 25, 2008 and I have reviewed the revised policy. I have also reviewed the policy that the Supreme Court reviewed in *Baze v.* Rees, 128 S. Ct. 1520 (2008). In my professional opinion, considering the medical aspects of the two policies, they are not the same or substantially similar. The Kentucky policy has requirements that exceed those in the Washington policy. In my professional opinion, under DOC's written policy, there is a serious risk that the inmate may not be adequately sedated after administration of the sodium thiopental. As I stated in my initial declaration submitted in this case, all aspects of the DOC's procedures and practices should be carefully reviewed.

4. The policy would permit the use of the painful cut-down procedure described in my initial declaration. It would also permit DOC to access the inmate's veins anywhere, including in the neck. Insertion in the neck is feasible into a superficial vein – the external jugular – but this is often collapsed, and usually requires a voluntary maneuver on the part of the patient/inmate to make the vein stand out – the bearing down motion of popping one's ears for example. Insertion is also possible into a deeper vein – the internal jugular vein - but this is technically difficult and beyond the skills of most general physicians. There are risks of hitting nerves, arteries and even the lung.

5. I have briefly reviewed the declarations that the Defendants submitted with their opposition to Mr. Stenson's request for a preliminary injunction (Declarations of

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Sinclair, Pacholke, Witten, Dershwitz, and Couper). Given that these were just submitted, I have not had time to perform any in-depth review, nor have I had the benefit of reviewing any cross-examination of these individuals, but I will address a few errors so that the Court will understand that these witnesses need to be cross-examined and that there are material issues with what they say.

6. For example, Mr. Sinclair's observation that Mr. Stenson does not appear to have any collapsed veins at present, is not a predictor of whether the execution team will, in fact, have difficulty placing the intravenous tubing ("cannula") into Mr. Stenson on execution. Just because a vein is not collapsed at one moment does not mean it will not be collapsed the next – any anesthesiologist will have experienced veins which disappear with the onset of fear and anxiety – this is known as vasoconstriction. As I stated in my previous declaration, fear and its physiological consequences are significant factors of difficulty that may obstruct successful placement of the cannula. This has to be taken into consideration in assessing the training of persons siting the cannula as well as in the assumptions made about the likelihood of success for any given person.

7. The 14 1/2 feet length of tubing is almost three times longer than that used in the Kentucky procedure reviewed by the Supreme Court. As the length of the distance for the drugs to travel increases, so too does the risk of maladministration.

8. Assessing consciousness is not simple. Consciousness is a continuum, where people can be unaware of their surroundings but still rousable to consciousness by touch, through to unresponsiveness to voice or touch but responsiveness to pain, through to complete unresponsiveness. Dr. Dershwitz' definition of unconsciousness as unresponsiveness to a verbal command (Decl. at ¶ 7) is narrow, and may even be better termed as awareness (although this again is a simple term applied to a complex

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phenomenon). The practice of anesthesia amply illustrates that an inability to respond to a verbal command is not the same as saying that the person would not feel pain.

9. Mr. Sinclair's description, at ¶ 10 of his declaration, about what happens after the "flash", is incorrect. If a flash is not received indicating that the vein has been entered, and the vein is missed, the needle should not go into "subcutaneous muscle" as he says if it was properly inserted. It will more likely go into the mixture of fat and fibrous fascia that lies beneath the skin. Going into muscle is a sign that the needle was inserted far too deeply or clumsily and causes soreness. Another common scenario is that the needle can go in (eliciting a flash) and then out of the vein and subsequently leak from the vein into surrounding tissues. This may result in a reduced drug dosage actually delivered to the inmate's circulation. Even when the cannula is initially sited correctly, it can subsequently move out of the vein(e.g movement of the arm increasing the distance between skin and the entry point of the cannula into the vein). If this happens, the swelling of tissues upon drug injection may not be significant enough to alert an onlooker that the cannula has slipped into the tissue, again resulting in lesser dosage of drugs delivered to the circulation. Movement of the cannula is also not unknown with bolus injections, where a strong surge of drugs is delivered rather than a gradual flow, and this phenomenon is accentuated by any increased resistance of the vessel (e.g small veins, external compression, arm movement kinking the vein).

10. Dr. Dershwitz's assertion that the protocol would render an inmate unconscious simply assumes the trouble-free insertion of intravenous lines and competence in administration.

11. Dr. Cooper's statement about induction doses (Decl. ¶ 4) is completely wrong. 100 mg of thiopental is NOT a typical induction dose unless we are talking about a

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child. The normal dose range for induction of anesthesia into normal patients in a hospital setting is 3-7 mg/kg. That range is a consequence of adjuvant drugs (e.g. opiates) delivered concurrently which reduces the dose required. For an adult of 70 kg, using 5 mg/kg as a reasonable dose for induction of anesthesia, the dosage would be more in the range of 350 mg.

I declare under penalty of perjury of the laws of the United States and the State of Washington that the foregoing is true and correct.

DATED this 18th day of November, 2008

Michael J. Souter

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