

1 EXPEDITE
2 No Hearing Set
3 Hearing is Set
4 Date: December 12, 2008
5 Time: 9:00 a.m.
6 The Honorable Chris Wickham

7 **STATE OF WASHINGTON**
8 **THURSTON COUNTY SUPERIOR COURT**

9 DAROLD R.J. STENSON,

10 Plaintiff,

11 v.

12 ELDON VAIL; STEPHEN SINCLAIR;
13 MARC STERN; CHERYL STRANGE;
14 WASHINGTON STATE
15 DEPARTMENT OF CORRECTIONS,
and DOES 1-50

16 Defendants.

NO. 08-2-02080-8

DEFENDANTS' MOTION FOR
SUMMARY JUDGMENT AND
MEMORANDUM IN SUPPORT
THEREOF

17 **MOTION**

18 Defendants, by and through their attorneys of record, ROBERT M. MCKENNA,
19 Attorney General, and SARA J. OLSON and JOHN J. SAMSON, Assistant Attorneys
20 General, move for summary judgment in this matter. This motion is based upon the
21 argument set forth below, the attached exhibits, and Civil Rule 56. As this Court is aware,
22 a motion to dismiss, pursuant to CR 12(b)(6) is currently pending and set for argument on
23 November 20, 2008. Defendants present this motion for summary judgment in the event
24 that the Court denies the motion to dismiss. If the motion to dismiss is denied, Defendants
25 may move to have this motion for summary judgment considered in an expedited fashion.
26 Defendants do not concede that a stay is necessary to consider this motion for summary
judgment.

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MEMORANDUM

I. STATEMENT OF THE CASE

In 1994, a Clallam County jury sentenced Darold Stenson to death for the aggravated first degree murders of his wife Denise Stenson, and business partner, Frank Hoerner. See State v. Stenson, 132 Wn.2d 668, 940 P.2d 1239 (1997). The Washington Supreme Court affirmed the convictions and sentence on direct review on July 24, 1997. Id. The United States Supreme Court denied certiorari on March 9, 1998. Stenson v. Washington, 523 U.S. 1008, 118 S. Ct. 1193, 140 L. Ed. 2d 323 (1998).

Following Stenson's unsuccessful direct appeal, he challenged his conviction and sentence by way of multiple personal restraint petitions. The Washington Supreme Court denied Stenson's first personal restraint petition on January 4, 2001. In re Stenson, 142 Wn.2d 710, 16 P.3d 1 (2001). The Court denied Stenson's second personal restraint petition as time barred on September 11, 2003, and denied Stenson's third personal restraint petition as an "abuse of the writ" on November 24, 2004. In re Stenson, 150 Wn.2d 207, 76 P.3d 241 (2003); In re Stenson, 153 Wn.2d 137, 102 P.3d 151 (2004).

Stenson filed a habeas corpus petition in 2001, challenging his convictions and sentence in federal court. Stenson v. Lambert, US District Court Cause No. C01-252P. The district court denied the petition on July 26, 2005, the Ninth Circuit affirmed dismissal of the petition on September 24, 2007, and the Ninth Circuit denied rehearing *en banc* on March 19, 2008. Stenson v. Lambert, 504 F.3d 873 (9th Cir. 2007). Stenson's petition for a writ of certiorari was denied by the United States Supreme Court on October 6, 2008. Stenson v. Sinclair, U.S. Supreme Court Cause No. 08-5328. The Ninth Circuit issued its mandate on October 17, 2008. Stenson v. Lambert, 504 F.3d 873 (9th Cir. 2007). Pursuant to RCW 10.95.160(2), the date of execution automatically reset for 30 judicial days after termination of the stay. Stenson will be executed on December 3, 2008.

1 **II. STATEMENT OF FACTS**

2 Stenson has been under sentence of death since 1994. His death sentence became
3 final in 1997. RCW 10.95.180 (amended by 1996 Wash. Laws c. 251, §1) went into effect
4 in March 1996 and requires that Stenson's sentence will be carried out by lethal injection
5 unless he selects the alternative method of hanging. Stenson has not selected the
6 alternative method of hanging, as of November 7, 2008. Exhibit 1, Declaration of Stephen
7 Sinclair.

8 On October 25, 2008, Department of Corrections (DOC) Policy 490.200, Capital
9 Punishment went into effect in its current format. Exhibit 2, Declaration of Dell-Autumn
10 Witten, Attachment A, DOC Policy 490.200. DOC Policy 490.200 Directive IX(1)(d)
11 requires that members of the Lethal Injection Team have "sufficient training or experience
12 to carry out the lethal injection process without any unnecessary pain" to the Inmate
13 Subject to the Death Penalty (ISDP). Id. Specifically, members of the Lethal Injection
14 Team must have minimum qualifications which include "one or more years of professional
15 experience as a certified Medical Assistant, Phlebotomist, Emergency Medical Technician,
16 Paramedic, military corpsman, or similar occupation." Id. Each member of the Lethal
17 Injection Team selected to participate in Stenson's execution, should he be executed by
18 lethal injection, meets this criteria. Exhibit 1.

19 DOC Policy 490.200 Directive VIII(A)(2) requires that briefings and rehearsals by
20 the Lethal Injection Team are "conducted as necessary to ensure adequate preparation for
21 the execution." Exhibit 2, Attachment A. Additionally, the Lethal Injection Team must
22 conduct "a minimum of 3 practice sessions preceding an execution that shall include the
23 siting of intravenous lines." Id. Since October 6, 2008, the Lethal Injection Team has
24 conducted three full practice sessions. Exhibit 1. The Lethal Injection Team members
25 have inserted intravenous (IV) lines six times (each time two have been inserted into the
26 person playing the role of the inmate), at the full practice sessions. Id.; Exhibit 3,

1 Declaration of Dan J. Pacholke. There have been no problems with the insertion of IV
2 lines at any one of these practice sessions. Id. The member of the Lethal Injection Team
3 who will site the IV lines during Mr. Stenson's execution regularly inserts IV lines as a part
4 of his/her professional duties. Exhibit 1. It is, therefore, reasonable to assign the task of
5 inserting the IV lines to this individual. Exhibit 4, Declaration of Mark Dershwitz, M.D.,
6 Ph.D. Additionally, the Escort Team has conducted 15 - 20 hanging practice sessions.
7 Exhibit 1. The hanging mechanism has functioned properly and without incident at each of
8 these practice sessions. Id.; Exhibit 3.

9 DOC Policy 490.200 Directive IX(A)(4)(b) requires the Lethal Injection Team to
10 site two IV lines in the ISDP. Exhibit 2, Attachment A. Each of those lines is sited using
11 an intravenous needle. Exhibit 1. The intravenous needle has a connector needle, which is a
12 fine-pointed needle, with a fine, plastic sheath around it, with the needle protruding
13 approximately an inch, and an approximately 3-inch length of connector tubing attached to it.
14 Id. The connector needle is inserted into the vein. Id. Once the connector needle enters the
15 vein there is a "flash" of blood which enters the hub of the needle. Id. The "flash" indicates
16 that a vein has been entered. Id. Once the connector needle has entered the vein, the sheath is
17 pushed down into the vein and the connector needle is removed. Id. A syringe is then attached
18 to the connector tubing and a "pull back" of the syringe's plunger is done to see if blood enters
19 the connector tubing, indicating a vein has been entered. Id. Once it is determined that a vein
20 has been entered, the syringe is removed and the connector tubing is attached to the
21 intravenous tubing and the saline flow begins. Id. The Lethal Injection Team members
22 ensure that a slow, normal saline flow is maintained through each IV line. Exhibit 2,
23 Attachment A. The Superintendent will observe the insertion of the IV lines and observe
24 the ISDP for signs that the intravenous line has not been properly inserted into a vein. Id.
25 If a vein is missed, the "flash" will not occur, the "pull back" will not work, and there will be
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1 swelling at the injection site once the saline begins to enter the subcutaneous muscle. Exhibit
2 1.

3 Once the IV lines have been sited in the arms of the ISDP, and the Superintendent
4 has determined that the execution is to proceed, the Superintendent signals for the
5 administration of the first chemical: 3 grams of thiopental sodium. Id.; Exhibit 2,
6 Attachment A. Thiopental sodium is an ultra-short acting barbiturate typically used as an
7 anesthetic and/or induction agent. Exhibit 5, Declaration of Fiona Jane Couper, Ph.D.
8 Thiopental sodium induces a deep, coma-like unconsciousness within 30-60 seconds, and
9 typical anesthetic/induction doses are approximately 100-250 mg, rarely more than 1 gram.
10 Id. Following a 3 gram dose, respiratory function would be significantly depressed or
11 stopped within approximately one to two minutes. Id. While unconscious, the ISDP will
12 have no sense of physical pain or suffering. Id. Death will likely occur as a result of the 3
13 gram dose of thiopental sodium alone. Exhibit 4. The proper application of the protocol,
14 as outlined in DOC Policy 490.200, will result in a rapid, painless and humane death and
15 the ISDP will not experience any unnecessary pain or suffering. Id.; Exhibit 5.

16 The Superintendent, who stands less than one foot away from the right arm of the
17 ISDP, observes the ISDP for signs of consciousness. Exhibit 1. If any signs of
18 consciousness are observed, after the thiopental sodium has been administered, the
19 Superintendent will direct that Lethal Injection Team to administer a second dose of 3
20 grams of thiopental sodium. Id.; Exhibit 2, Attachment A. When no signs of
21 consciousness are observed, the Superintendent will signal for the flushing of the IV line
22 with 50 cc normal saline, followed immediately by 100 milligrams of pancuronium
23 bromide, followed immediately by the flushing of the line with 50 cc normal saline,
24 followed immediately by 240 mEq potassium chloride. Id. Pancuronium bromide is a
25 neuro-muscular blocking agent that inhibits muscular-skeletal movements thereby
26 paralyzing the diaphragm and other respiratory muscles, and stopping respiration. Exhibit

1 5. Typical therapeutic doses are 0.04-0.10 mg/kg. Id. At a 100 mg dose, respiratory
2 paralysis should occur within 30-60 seconds of administration. Id. Additionally, the heart
3 would stop beating within approximately one to three minutes. Id. Potassium chloride is a
4 chemical compound that interferes with the electrical signals that stimulate the contractions
5 of the heart. Id. A dose of 240 mEq would be sufficient to cause death by cardiac arrest
6 within approximately one to three minutes. Id.

7 In each of the hanging practice sessions which have occurred since October 6, 2008,
8 either a mannequin has been “dropped” through the trap door or a metal container with weights
9 weighing 230 pounds (to simulate Mr. Stenson’s body weight) has been “dropped” through the
10 trap door. Exhibit 1; Exhibit 3. In each hanging practice session involving the mannequin, of
11 which there have been at least ten, the individual who will be placing the noose around the
12 ISDP’s neck has practiced the placing and tightening of the noose. Id. In order to ensure a
13 swift, painless death, the noose is placed tightly around the ISDP’s neck with the noose
14 directly behind the ISDP’s left ear and the running part of the noose (i.e. the part that moves
15 when the noose is tightened) placed along the front of the neck. Id. Four different ropes have
16 been “stretched” which includes wetting the rope and stretching it to eliminate any risk of
17 recoil once the trap door has opened and the ISDP has fallen the drop length of five feet.
18 Exhibit 1. In the practice sessions with the mannequin, after the noose has been securely
19 placed, the trap door is opened and the mannequin falls through and the rope is extended to the
20 full five feet. Id.; Exhibit 3. In each hanging practice session involving the metal crate
21 containing weights totaling 230 pounds, of which there have been at least five, the metal crate
22 has been placed on the trap door and the rope has been attached to the metal crate. Exhibit 1.
23 When the trap door drops, the metal crate falls through and the rope is extended its full five
24 feet. Id.

25 The Superintendent who will attend Stenson’s execution has personally witnessed
26 hanging practice sessions and the lethal injection practice sessions. Id.; Exhibit 3.

1 Additionally, the Superintendent who will attend Stenson's execution has acted as the
2 stand-in for the ISDP and has had two intravenous lines. Id. Additionally, the DOC Prison
3 Administrator has acted as the stand-in for the ISDP and has had two intravenous lines
4 sited. Id.

5 **III. ISSUES PRESENTED**

6 1. Whether lethal injection, as administered according to DOC Policy 490.200,
7 violates the Eighth Amendment to the United States Constitution and Article 1 sections 3
8 and 14 of the Washington State Constitution?

9 2. Whether hanging, as administered according to DOC Policy 490.200,
10 violates the Eighth Amendment to the United States Constitution and Article 1 sections 3
11 and 14 of the Washington State Constitution?

12 3. Whether allowing Stenson to choose his method of execution, according to
13 DOC Policy 490.200, violates the Fourteenth Amendment to the United States
14 Constitution?

15 4. Whether the Department has the authority to draft policies governing prison
16 administration and offender management?

17 5. Whether Stenson's claims are barred by the statute of limitations, laches, or
18 the doctrine of *res judicata*?

19 **IV. EVIDENCE RELIED UPON**

20 Defendants rely upon this motion with the attached declarations of Stephen Sinclair,
21 Dell-Autumn Witten, Daniel Pacholke, Dr. Mark Dershwitz M.D., Ph.D., and Fiona Jane
22 Couper, Ph.D., and attachments thereto and the records and files maintained herein.

23 **V. ARGUMENT**

24 **A. SUMMARY JUDGMENT STANDARD OF REVIEW.**

25 A motion for summary judgment should be granted where "there is no genuine issue
26 of material fact or if reasonable minds could reach only one conclusion on that issue based

1 upon the evidence in the light most favorable to the nonmoving party.” Weatherbee v.
2 Gustafson, 64 Wn. App. 128, 131, 822 P.2d 1257 (1992) (citing Sea-Pac Co. v. United
3 Food & Comm’l Workers Local Union 44, 103 Wn.2d 800, 802, 699 P.2d 217 [1985]); see
4 CR 56. As the moving party, Defendants bear the initial burden, however, a “moving
5 defendant may meet the initial burden by ‘showing’ . . . that there is an absence of evidence
6 to support the nonmoving party’s case.” Young v. Key Pharmaceuticals, 112 Wn.2d 216,
7 225 n.1, 770 P.2d 182 (1989) (citing Celotex Corp. v. Catrett, 477 U.S. 317, 325, 106 S.
8 Ct. 2548, 91 L. Ed. 2d 265 [1986]) (internal quotation marks omitted). The moving party
9 is entitled to summary judgment if the documentary evidence produced by the parties
10 permits only one conclusion. Anderson v. Liberty Lobby Inc., 477 U.S. 242, 251, 106 S.
11 Ct. 2505, 91 L. Ed. 2d 202 (1986). In the present case, even viewed in the light most
12 favorable to Stenson, there is insufficient evidence to support his claims.

13
14 **B. STENSON’S CHALLENGES TO LETHAL INJECTION FAIL AS A MATTER
OF LAW.**

15 Stenson alleges lethal injection as performed under DOC’s existing policy violates
16 both the Washington State Constitution and the United States Constitution. Stenson’s
17 claim fails as a matter of law.

18 The Legislature selected lethal injection as the primary method of execution for
19 Washington. RCW 10.95.180(1). As a legislatively chosen method of execution, lethal
20 injection is presumed constitutional. State v. Rupe, 101 Wn.2d 664, 698, 683 P.2d 571
21 (1984); State v. Frampton, 95 Wn.2d 469, 512-14 & 527, 627 P.2d 922 (1981); Gregg v.
22 Georgia, 428 U.S. 153, 174-76, 96 S. Ct. 2909, 49 L. Ed. 2d 859 (1976); Campbell v.
23 Wood, 18 F.3d 662, 682 (9th Cir. 1994) (en banc). Stenson bears the burden of rebutting
24 the presumption of constitutionality by presenting clear, objective evidence that lethal
25 injection is cruel punishment. See e.g. Frampton, 95 Wn.2d at 512-14 & 527; Campbell,
26 18 F.3d at 682; In re Kemmler, 136 U.S. 436, 447, 10 S. Ct. 930, 34 L. Ed. 519 (1890).

1 Stenson's speculation that DOC's method of lethal injection might cause an
2 unnecessary risk of pain because the policy allegedly does not set forth sufficient
3 safeguards, does not require sufficient qualifications, and does not ensure officials will not
4 commit errors when administering the lethal substances, does not demonstrate a violation
5 of either the Eighth Amendment to the United States Constitution or Article I, Section 14
6 of the Washington Constitution. Contrary to Stenson's claims, speculation of a possibility
7 of risk of pain does not render the method of execution unconstitutional. The possibility of
8 an accident "cannot and need not be eliminated from the execution process in order to
9 survive constitutional review." LaGrand v. Stewart, 133 F.3d 1253, 1265 (9th Cir. 1998)
10 (quoting Campbell, 18 F.3d at 668); see also Poland v. Stewart, 151 F.3d 1014, 1023 (9th
11 Cir. 1998) (rejecting claim that the Arizona method of lethal injection could cause severe
12 pain).

13 The Washington Supreme Court already has rejected the claim that lethal injection
14 is unconstitutional. In re Pirtle, 136 Wn.2d 467, 496, 965 P.2d 593 (1998); In re Lord, 123
15 Wn.2d 296, 325-26 & n.11, 868 P.2d 835 (1994). In addition, the United States Supreme
16 Court this past year rejected the very claim now presented by Stenson. Baze v. Rees, ___
17 U.S. ___, 128 S. Ct. 1520, 170 L. Ed. 2d 420 (2008). Therefore, Stenson's claim fails as a
18 matter of law.

19 The Baze Court began its analysis by noting that the Federal Government and 36
20 States, including Washington, have adopted lethal injection as the exclusive or primary
21 means of execution. Baze, 128 S. Ct. at 1526-27 & n.1. The Court then noted that at least
22 30 States (which includes Washington) use the same combination of the three drugs in their
23 lethal injection protocol – first the administration of sodium thiopental, then pancuronium
24 bromide, and then potassium chloride. Id. at 1527. The Court noted that the proper
25 administration of the first drug, sodium thiopental, "ensures that the prisoner does not
26 experience any pain associated with the paralysis and cardiac arrest caused by the second

1 and third drugs.” Id. Reviewing the protocol used in Kentucky, the Court noted that
2 Kentucky also uses this three drug protocol. Id. at 1528. The Court granted certiorari to
3 determine whether Kentucky’s lethal injection protocol satisfies the Eighth Amendment.
4 Id. at 1529. After considering Baze’s claims (which Stenson’s claims mirror), the Court
5 held the protocol was constitutional. Id. The Court further held that a lethal injection
6 protocol substantially similar to Kentucky’s protocol would not violate the Eighth
7 Amendment. Id. at 1537. Since Stenson’s claims are the same as the claims rejected by
8 the Court in Baze, the Court’s ruling disposes of Stenson’s claim as a matter of law.¹
9 Stenson’s case should be dismissed as a matter of law.

10 In reviewing Kentucky’s protocol, the Supreme Court began with the principle that
11 capital punishment is constitutional, and “[i]t necessarily follows that there must be a
12 means of carrying it out.” Baze, 128 S. Ct. at 1529. From this principle, the Court
13 recognized,

14 Some risk of pain is inherent in any method of execution – no matter how
15 humane – if only from the prospect of error in following the required
16 procedure. It is clear then, that the Constitution does not demand the
avoidance of all risk of pain in carrying out executions.

17 Baze, 128 S. Ct. at 1529.

18 The Supreme Court noted it has never held a method of execution to be
19 unconstitutional, and has upheld firing squads and electrocution as methods of execution.
20 Baze, 128 S. Ct. at 1530 (citing Wilkerson v. Utah, 99 U.S. 130, 25 L. Ed. 345 [1878]; In
21 re Kemmler, 136 U.S. 436, 10 S. Ct. 930, 34 L. Ed. 519 [1890]). These methods were
22 adopted to provide a more humane execution than previous methods and the Court noted

23 ¹ Stenson may argue that because Baze was a plurality opinion, it does not dispose of his claim.
24 However, since the fourth and fifth Justices joining the Court’s judgment (Justices Thomas and Scalia) would
25 apply a rule even more deferential to the State, and would find no violation unless the State deliberately inflicted
26 unnecessary pain, Stenson’s claims clearly fail under the reasoning of a majority of the Justices of the Court. See
U.S. v. Marks, 430 U.S. 188, 193, 97 S. Ct. 990, 51 L. Ed. 2d 260 (1977) (the holding of the Court is that position
taken by the justices who concurred on the narrowest grounds).

1 that what the types of punishment forbidden by the Constitution “had in common was the
2 deliberate infliction of pain for the sake of pain – ‘superadd[ing]’ pain to the death
3 sentence through torture and the like.” Baze, 128 S. Ct. at 1530. Addressing the
4 contention that lethal injection presents a risk of pain, the Court rejected Baze’s
5 “unnecessary risk” standard, and ruled that to establish an Eighth Amendment violation,
6 the conditions presenting risk must be “sure or likely” to cause needless suffering. Id. at
7 1530-32. The Court stressed “there must be a ‘substantial risk of serious harm,’” and that
8 “[s]imply because an execution method may result in pain, either by accident or as an
9 inescapable consequence of death, does not establish the sort of ‘objectively intolerable
10 risk of harm’ that qualifies as cruel and unusual punishment.” Id. at 1531. Because the
11 Supreme Court rejected the unnecessary risk standard, Stenson’s claim that lethal injection
12 under the Department’s policy is unconstitutional because it creates an unnecessary risk of
13 pain fails as a matter of law.

14 Like Stenson, Baze had also alleged the three-drug protocol created an unnecessary
15 risk of the infliction of pain because an alternative method (the one-drug protocol) would
16 eliminate a significant risk of harm.² Baze, 128 S. Ct. at 1531. Rejecting this argument,
17 the Court ruled a prisoner cannot successfully challenge a State’s method of execution by
18 simply showing the existence of a safer alternative. Id. Such a “safer alternative” rule
19 would improperly transform the courts into boards of inquiry charged with determining
20 “best practices” for executions, would improperly embroil the courts in ongoing scientific
21 controversies, and would improperly intrude upon the role of state legislatures to select a
22 method of execution. Id.

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25 ² Stenson repeatedly alleges that there is an alternative method, but he fails to specifically identify the
26 details of this alternative method. Defendants assume the alternative method is the untried one drug method that
the Baze Court held States need not adopt. Baze, 128 S. Ct. at 1534-35.

1 Baze also raised the other allegations now advanced by Stenson's complaint. The
2 Supreme Court rejected each claim. First, the Supreme Court found it is not "objectively
3 intolerable" for a State to use the three drug protocol for lethal injection that is employed
4 by thirty states. Baze, 128 S. Ct. at 1532 and 1534. Second, the Court found the risk that
5 the first drug, sodium thiopental, might be improperly prepared or administered was not
6 sufficient to establish a constitutional error. Id. at 1533. Thus, contrary to Stenson's
7 claim, speculation that prison officials might make an error in the preparation and
8 administration of the first drug is not sufficient to render the method unconstitutional. Id.
9 Third, the Court rejected the claim that states should omit the second drug, pancuronium
10 bromide. The Court ruled the use of the drug does not offend the Eighth Amendment. Id.
11 at 1535. The Court noted that the drug serves two legitimate state interests – it preserves
12 the dignity of the procedure, and it hastens death by stopping breathing. Id. The Court
13 rejected the argument that pancuronium bromide is barred for the use by veterinarians
14 because the argument "overlooks the States' legitimate interest in providing for a quick,
15 certain death." Id. The Court also noted the drug is used by officials in the Netherlands
16 for physician-assisted suicide in order to avoid a prolonged, undignified death. Id.

17 Finally, the Baze Court also rejected the proposition now advanced by Stenson, that
18 a method of execution is unconstitutional if additional safeguards could be, but are not,
19 utilized by the State to avoid risks of pain. Baze, 128 S. Ct at 1537. Stenson faults the
20 Department's policy, alleging it fails to set forth minimum qualifications, fails to require
21 specific training and practices, and fails to require other safeguards to prevent unnecessary
22 pain. However, the Court held "an inmate cannot succeed on an Eighth Amendment claim
23 simply by showing one more step the State could take as a failsafe for other, independently
24 adequate measures." Id. "[W]hat the [Eighth] Amendment prohibits is wanton exposure to
25 'objectively intolerable risk,' . . . not simply the possibility of pain." Id. "The risks of
26 maladministration they have suggested – such as improper mixing of chemicals and

1 improper setting of IVs by trained and experienced personnel – cannot remotely be
2 characterized as ‘objectively intolerable.’” Id. Stenson’s claims fail under the Supreme
3 Court’s decision in Baze.

4 In addition to the Supreme Court and the Washington Supreme Court, the numerous
5 state and federal courts that have considered the constitutionality of lethal injection have
6 overwhelmingly found it to be a constitutional method of execution. See LaGrand v.
7 Stewart, 133 F.3d 1253 (9th Cir. 1998); Woolls v. McCotter, 798 F.2d 695 (5th Cir. 1986);
8 Hill v. Lockhart, 791 F. Supp. 1388 (E.D. Ark. 1992), affirmed on other grounds, 927 F.2d
9 340 (8th Cir. 1991); United States ex rel. Silagy v. Peters, 713 F. Supp. 1246 (C.D. Ill.
10 1989), affirmed on other grounds, 905 F.2d 986 (7th Cir. 1990); Ex Parte Granviel, 561
11 S.W.2d 503 (Tex. Crim. App. 1978); People v. Stewart, 121 Ill.2d 93, 520 N.E.2d 348
12 (1988); State v. Moen, 309 Or. 45, 786 P.2d 111 (1990); Hopkinson v. State, 798 P.2d
13 1186, 1187 (Wyo. 1990); People v. Silagy, 116 Ill.2d 357, 507 N.E.2d 830 (1987); State v.
14 Deputy, 644 A.2d 411 (Del. Super. 1994); State v. Webb, 252 Conn. 128, 750 A. 2d 448
15 (2000); Sims v. State, 754 So. 2d 657 (Fla. 2000). In particular, since the decision in Baze,
16 multiple federal and state courts have rejected challenges to the constitutionality of lethal
17 injection. See Emmett v. Johnson, 532 F.3d 291 (4th Cir. 2008) (applying Baze and
18 rejecting claims identical to Stenson’s); Poland v. Stewart, 151 F.3d. 1014 (9th Cir. 1998);
19 Bennett v. State, 990 So. 2d 155, 160-61 & n.1 (Miss. 2008) (rejecting, without hearing,
20 lethal injection challenge in a collateral attack); Porter v. Commonwealth, 276 Va. 203,
21 661 S.E.2d 415, 431-32 (2008) (rejecting lethal injection challenge in direct appeal);
22 People v. Salcido, 44 Cal.4th 93, 186 P.3d 437, 494 (2008) (rejection of lethal injection
23 challenge on direct appeal); Sexton v. State, No. SC07-286, 2008 WL 4240155, at *12
24 (Fla. Sept. 18, 2008) (rejecting lethal injection challenge in a collateral attack); Ex Parte
25 Chi, 256 S.W.3d 702, 704 (Tex. Crim. App. 2008) (rejecting lethal injection challenge in
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1 writ of habeas corpus); Ex Parte Belisle, No. 1061071, 2008 WL 4447593 (Ala. Oct. 3,
2 2008) (lethal injection challenge rejected on direct review).³

3 Lethal injection is a constitutional method of punishment, and Stenson's challenge
4 to the particular procedures used in Washington fail as a matter of law as the Washington
5 policy is substantially similar to Kentucky's policy. DOC Policy 490.200, as amended
6 10/25/08, expressly requires minimum qualifications of members of the lethal injection
7 team (at least one or more years of experience in a profession that involves intravenous
8 injections), sufficient practice sessions (at least three of which will include the siting of
9 intravenous lines), the establishment of two intravenous lines with a normal flow of saline
10 through each line, the administration of 3 grams of sodium thiopental, the Superintendent
11 to observe the inmate for signs of consciousness after the administration of sodium
12 thiopental and before the administration of pancuronium bromide, and the administration of
13 an additional dose of 3 grams of sodium thiopental before the pancuronium bromide if the
14 Superintendent observes the inmate is conscious after the administration of the first dose of
15 sodium thiopental. The individual who will site the intravenous lines during Mr. Stenson's
16 execution regularly inserts intravenous lines as a part of his/her professional duties. Exhibit 1,
17 Declaration of Stephen Sinclair. It is, therefore, reasonable to assign the task of inserting
18 the IV lines to this individual. Exhibit 4, Declaration of Mark Dershwitz, M.D., Ph.D.
19 Additionally, the three practice sessions with the siting of IV lines, as required by policy,
20 have been completed. Exhibit 1.

21 The amended policy is substantially similar to Kentucky's protocol and is being
22 properly followed in anticipation of Mr. Stenson's December 3, 2008, execution.
23 Therefore, Stenson's allegations are now moot and Defendants should be granted judgment
24

25 ³ For the Court's convenience, a copy of these cases has been attached to the Bench Copy of this motion.
26 A copy of these cases has also been sent to Stenson's counsel via the United States Postal Service.

1 as a matter of law with regard to Stenson's challenges to the constitutionality of lethal
2 injection.

3 **C. STENSON'S CHALLENGE TO HANGING FAILS AS A MATTER OF LAW.**

4 Stenson also challenges the constitutionality of hanging. This claim fails as a
5 matter of law. First, Stenson lacks standing to challenge this method of execution since he
6 has not elected hanging as a method of execution. Second, as with his challenge to lethal
7 injection, this claim is also foreclosed by the holdings of the Washington Supreme Court
8 and other courts.

9 **1. Stenson Lacks Standing To Challenge Hanging.**

10 Washington law provides the sentence of death shall be carried out by lethal
11 injection unless the defendant elects hanging. RCW 10.95.180(1). As of this date, Stenson
12 will be executed by lethal injection. Consequently, Stenson lacks standing to challenge
13 hanging. As the Washington Supreme Court held in rejecting a similar claim:

14 The defendant contends that hanging constitutes cruel and unusual
15 punishment. . . . Moreover, the Legislature recently amended the death
16 penalty statute to require that death sentences be carried out by lethal
17 injection unless the defendant affirmatively elects hanging. RCW
18 10.95.180(1), as amended by Laws of 1996, ch. 251, § 1. [footnote omitted]
The defendant has not made that election and is therefore not facing a
method of execution he believes to be cruel. He therefore lacks standing to
raise this issue.

19 In re Benn, 134 Wn.2d 868, 933, 952 P.2d 116 (1998). In the absence of standing to
20 challenge hanging, Defendants should be granted judgment as a matter of law with regard
21 to this claim.

22
23 **2. Assuming Stenson Has Standing To Challenge Hanging, His Claim Fails As
A Matter Of Law.**

24 Even if Stenson has standing to challenge hanging, his claim fails as a matter of law
25 in light of the decisions of the Washington Supreme Court. The Washington Supreme
26 Court first determined hanging was constitutional in State v. Frampton, 95 Wn.2d at 512-

1 14 and 527. The Court reaffirmed this decision in State v. Campbell, 112 Wn.2d 186, 192,
2 770 P.2d 620 (1989), and has subsequently reaffirmed this conclusion by rejecting other
3 challenges to hanging. Pirtle, 136 Wn.2d at 496; Lord, 123 Wn.2d at 325-26. This Court
4 is bound by the decisions of the Washington Supreme Court.

5 The Ninth Circuit has also held that “judicial hanging, as conducted under the
6 Washington Field Instruction, does not involve the wanton and unnecessary infliction of
7 pain, and therefore does not violate the Eighth Amendment.” Campbell v. Wood, 18 F.3d
8 662, 687 (9th Cir. 1994). In reaching its decision, the court noted that the mechanisms of
9 death involved in hanging include:

- 10 (1) Occlusion of the carotid arteries, (2) occlusion of vertebral arteries, (3)
11 occlusion of the jugular veins, (4) reflexive cardiac arrest, (5) occlusion of
12 the airway, (6) tearing, transection, trauma, or shock to the spinal cord, (7)
fracture or separation of the cervical spinal column, (8) interruption of the
odontoid process, and (9) irreversible brain stem damage.

13 Campbell, 18 F.3d at 683.

14 The Ninth Circuit held the mere fact that “there is no way to predict with a high
15 degree of accuracy which of the various mechanisms will contribute to unconsciousness
16 and death in any given hanging” does not render hanging unconstitutional. Campbell, 18
17 F.3d at 684. The Ninth Circuit found that “these various mechanisms can, and probably
18 do, occur in concert; thus, there is no single ‘pathway’ to death by judicial hanging.” Id. at
19 1403. The court held that a hanging conducted pursuant to the Department’s policy will
20 cause rapid unconsciousness and death and will not cause the unnecessary and wanton
21 infliction of pain.

22 The Ninth Circuit also considered the claim that errors by officials in conducting
23 the hanging posed a risk of death by asphyxiation or decapitation that rendered hanging
24 cruel punishment. For the purposes of argument, the Ninth Circuit accepted the existence
25 of such a risk, but rejected the claim. The court held:

1 Campbell is not entitled to a painless execution, but only to one free of
2 purposeful cruelty. Resweber, 329 U.S. at 464. The risk of accident cannot
3 and need not be eliminated from the execution process in order to survive
4 constitutional review.

5 Campbell, 18 F.3d at 687 (citing Louisiana v. Resweber, 329 U.S. 459, 67 S. Ct. 374, 91 L.
6 Ed. 422 [1947]).

7 Finally, every state court to consider the issue has held that hanging is a
8 constitutional method of execution. See Deshields v. State, 534 A.2d 630 (Del. 1987);
9 State v. Coleman, 185 Mont. 299, 605 P.2d 1000 (1979); McKenzie v. Osborne, 195 Mont.
10 26, 640 P.2d 368 (1981); State v. Kilpatrick, 201 Kan. 6, 439 P.2d 99 (1968); State v.
11 Butchek, 121 Or. 141, 253 P. 367 (1927); State v. Burris, 194 Iowa 628, 190 N.W. 38
12 (1922).

13 Every court to consider the issue has found that hanging is a constitutional method
14 of execution. DOC Policy 490.200, with respect to hanging, is clear and the policy is being
15 followed in anticipation of the scheduled execution of Mr. Stenson on December 3, 2008.
16 Exhibits 1 and 3. The Washington Supreme Court has repeatedly held that hanging is
17 constitutional, and this Court is bound by that decision. Stenson fails to state a claim for
18 relief with regard to hanging and Defendants should be granted judgment as a matter of law
19 on this claim.

20 **D. THE CLAIM THAT STENSON IS DENIED DUE PROCESS BECAUSE HE IS
21 UNABLE TO MAKE AN INFORMED ELECTION AS TO THE METHOD OF
22 EXECUTION FAILS AS A MATTER OF LAW.**

23 Stenson claims the Department's alleged failure to adequately describe the manner and
24 methods of execution violates due process because he is unable to make an informed election of
25 the method of execution. This claim fails as a matter of law.

26 Under Washington law, the defendant is not required to participate in the selection of the
method of execution, and is not required to elect a method of execution. RCW 10.95.180;
Campbell v. Wood, 18 F.3d 662, 687 (9th Cir. 1994). The statute provides the defendant will be

1 executed by lethal injection if no election is made. RCW 10.95.180; Campbell, 18 F.3d at 687.
2 The defendant is not required to choose, and allowing the defendant the option to elect does not
3 violate the Constitution. State v. Rupe, 101 Wn.2d 664, 701-02, 683 P.2d 571 (1984); Campbell,
4 18 F.3d at 687; Poland v. Stewart, 117 F.3d 1094, 1105 (9th Cir. 1997).

5 Stenson's claim that he cannot make an informed election does not show he has been
6 denied a liberty interest protected by the Due Process Clause, especially where he is still allowed
7 the opportunity, but is not required, to elect hanging. The threshold question in any due process
8 challenge is whether the person is deprived of a protected liberty interest. In re Cashaw, 123
9 Wn.2d 138, 143, 866 P.2d 8 (1994); In re Meyer, 142 Wn.2d 608, 615, 16 P.3d 563 (2001). If the
10 state action in question does not deprive the person of a protected interest, there is no due process
11 violation. Meyer, 142 Wn.2d at 615-16. Stenson does not show the denial of a protected interest.

12 First, Stenson fails to show the opportunity to elect hanging even constitutes a protected
13 interest. A defendant has "no constitutionally protected interest in a choice of punishment."
14 Langford v. Day, 134 F.3d 1381, 1382 (9th Cir. 1998). The only protected interest a condemned
15 defendant has in the execution process is the interest in one's own life. The process due to the
16 defendant prior to taking this life interest was already provided by the trial court proceedings that
17 resulted in the conviction and sentence of death. See Meachum v. Fano, 427 U.S. 215, 224-25, 96
18 S. Ct. 2532, 49 L. Ed. 2d 451 (1976) (prisoner's liberty interest extinguished by criminal trial).
19 The defendant has no protected interest in the execution process itself. Langford, 134 F.3d at
20 1382; McKenzie v. Day, 57 F.3d 1461, 1469 (9th Cir. 1995) (quoting Holden v. Minnesota, 137
21 U.S. 483, 491 [1890] (matters governing the place and procedures for execution "are 'regulations
22 that do not affect [the prisoner's] substantial rights.'")). Second, even if Stenson has a protected
23 interest in electing hanging, he fails to show the alleged failure to provide him with information
24 deprived him of this interest since Stenson may still elect hanging. McKenzie, 57 F.3d at 1469
25 ("McKenzie's claim that he was denied due process of law because the state did not disclose the
26 identity of the executioner and gave him insufficient time and information to make a reasoned

1 selection of the method of execution is similarly without merit.”). Stenson fails to state a claim
2 for relief, and his challenge to the election of an execution method should be dismissed and
3 Defendants should be granted judgment as a matter of law.

4
5 **E. THE DEPARTMENT’S POLICY DOES NOT VIOLATE THE RULE AGAINST
6 THE UNLAWFUL DELEGATION OF LEGISLATIVE AUTHORITY.**

7 Stenson’s original complaint alleged the Department’s lethal injection policy was
8 unconstitutional. Stenson alleged he was not trying to prevent his execution, but was merely
9 challenging the particular procedure adopted by the Department for implementing lethal
10 injection. For example, Stenson complained the policy did not contain sufficient details and
11 lacked sufficient safeguards to guard against an unnecessary risk of pain. Stenson alleged that
12 because he was challenging only the particular procedure set forth in the existing policy, his
13 complaint was not an attack on the sentence imposed by the superior court. Subsequent to the
14 filing of the first complaint, the Department promulgated an amended policy that eliminated
15 the concerns raised by Stenson’s original complaint.⁴ Stenson has now filed an amended
16 complaint, adding a new claim that alleges the Department lacks authority to make any
17 changes to its existing execution policy. In addition to being without merit, the new claim
18 demonstrates Stenson’s true intentions in filing this action. Stenson does not merely wish to
19 challenge the particular procedures selected by the Department. Instead, Stenson wishes to
20 prevent his execution from ever occurring. Stenson’s complaint is a collateral attack to his
21 sentence because he is directly seeking to prevent the execution of the sentence. This
22 complaint is a collateral attack, and it is barred under RCW 10.73.090 and RCW 10.73.140.

23 Moreover, the claim is without merit. First, the “legislative delegation” rule cited by
24 Stenson does not apply. The Department was not acting in a quasi-legislative function when it

25 ⁴ Stenson alleges without any support that the Department amended its policy simply as a reaction to his
26 original complaint. In fact, the Department began the process of amending the policy once the Supreme Court
ruled in Baze v. Rees, long before Stenson filed his complaint.

1 amended the policy. The policy is not a “rule.” The policy is a directive governing the internal
2 operations of a prison; in particular, the operations at the penitentiary related to carrying out an
3 execution. “Unlike administrative rules and other formally promulgated agency regulations,
4 internal policies and directives generally do not create law.” Joyce v. Dept. of Corrections,
5 155 Wn.2d 306, 323, 199 P.3d 825 (2005) (citing Melville v. State, 115 Wn.2d 34, 40-41, 793
6 P.2d 952 [1990]). The policies are not an enactment of legislative power, and “they do not
7 have the force of law.” Joyce, 155 Wn.2d at 323 (citing State v. Brown, 142 Wn.2d 57, 62, 11
8 P.3d 818 [2000]). The policies governing the operation of prisons and the prisoners do not
9 even fall within the Administrative Procedures Act’s (APA) definition of a “rule.” RCW
10 34.05.010(16) (rule does not include “statements concerning only the internal management of
11 an agency and not affecting private rights or procedures available to the public.”). In fact, the
12 APA expressly exempts from its requirements any policy governing offenders and prison
13 operations. RCW 34.05.030(1)(c). Consistent with this statute, the Washington courts have
14 invoked a policy of judicial restraint designed to give prison administrators wide-ranging
15 deference in the adoption and execution of policies and practices governing internal operations
16 of prisons. Dawson v. Hearing Committee, 92 Wn.2d 391, 597 P.2d 1353 (1979) (prison
17 disciplinary proceeding not subject to APA); Foss v. DOC, 82 Wn. App. 355, 358-59, 918 P.2d
18 521 (1996) (decision denying teachers access to a prison facility is not subject to APA). The
19 execution policy is not a “quasi-legislative” rule, and the “legislative delegation” rule cited by
20 Stenson does not apply.

21 Second, even if the legislative delegation rule applied to this policy, the Department’s
22 amendment to the policy would not violate this rule. There are two requirements for lawful
23 delegation of legislative power. State v. Simmons, 152 Wn.2d 450, 455, 98 P.3d 789 (2004).
24 First, the Legislature must have described in general terms what is to be done and by which
25 agency. Id. Second, there must be adequate procedural safeguards to control arbitrary agency
26 action and abuse of discretion. Id. However, the safeguards need not be set out in the

1 delegating statutes, and the APA need not be followed; other statutory and common law
2 safeguards are sufficient to satisfy the need for “adequate procedural safeguards.” State v.
3 Crown Zellerbach, 92 Wn.2d 894, 901, 602 P.2d 1172 (1979); Simmons, 152 Wn.2d at 457.

4 Contrary to Stenson’s allegations, the Legislature has described in general terms what
5 is to be done and by which agency. The Legislature directed the Department to carry out
6 executions of death sentences, under the supervision of the Superintendent of the Washington
7 State Penitentiary, using either lethal injection or hanging:

8 (1) The punishment of death shall be supervised by the superintendent of the
9 penitentiary and shall be inflicted by intravenous injection of a substance or
10 substances in a lethal quantity sufficient to cause death and until the defendant
11 is dead, or, at the election of the defendant, by hanging by the neck until the
12 defendant is dead. In any case, death shall be pronounced by a licensed
13 physician.

14 (2) All executions, for both men and women, shall be carried out within the
15 walls of the state penitentiary.

16 RCW 10.95.180.

17 The Legislature further declared when and how executions are to be scheduled, and has
18 declared the sentence “shall be executed by the superintendent. . . .” RCW 10.95.160. The
19 Legislature directed the Superintendent to keep a record of every death warrant, and to keep
20 and provide to the superior court a record of all actions done in accordance with the death
21 warrant. RCW 10.95.190. The Legislature further provided the Department with statutory
22 authority to promulgate internal policies to carry out its statutory functions, including
23 executions of death sentences. See RCW 72.01.090 (“The department is authorized to make its
24 own rules for the proper execution of its powers. It shall also have the power to adopt rules
25 and regulations for the government of the public institutions placed under its control, and shall
26 therein prescribe, in a manner consistent with the provisions of this title, the duties of the
persons connected with the management of such public institutions.”); RCW 72.02.040 (“The
secretary of corrections acting for the department of corrections shall exercise all powers and
perform all duties prescribed by law with respect to the administration of any adult correctional

1 program by the department of corrections.”); RCW 72.09.050 (“The secretary shall manage the
2 department of corrections and shall be responsible for the administration of adult correctional
3 programs, including but not limited to the operation of all state correctional institutions or
4 facilities used for the confinement of convicted felons. . . . The secretary is authorized to
5 promulgate standards for the department of corrections within appropriation levels authorized
6 by the legislature.”); RCW 72.02.045(4) & (6) (“(4) The superintendent, subject to the
7 approval of the director of the division of prisons and the secretary, shall make, amend, and
8 repeal rules for the administration, discipline, and security of the institution.” And “(6) The
9 superintendent shall perform such other duties as may be prescribed.”).

10 In addition, adequate procedural safeguards exist to prevent arbitrary agency action.
11 Contrary to Stenson’s suggestion, “adequate procedural safeguards” does not require the full
12 panoply of procedural due process entitled to criminal defendants. It does not even require that
13 the Department’s policies be enacted pursuant to the APA. As noted above, the APA expressly
14 exempts from its requirements DOC policies concerning prisoners and prison operations.
15 RCW 34.05.030(1)(c); Foss v. DOC, 82 Wn. App. at 358-59; see also State v. Crown
16 Zellerbach, 92 Wn.2d 894, 602 P.2d 1172 (1979) (common law remedies, including those
17 accompanying criminal proceedings, are sufficient). “Adequate procedural safeguards” merely
18 require the protection against arbitrary and capricious agency action. State v. Simmons, 152
19 Wn.2d at 457 (citing Crown Zellerbach, 92 Wn.2d at 901) (recognizing the existence of
20 procedural safeguards where judicial review is available under the clearly erroneous standard).
21 Such protections exist under existing Washington law. See, e.g., RAP 16.2 (original action
22 against state official); RCW 7.16.150 (writ of mandamus where state agency or officer violates
23 clear legal duty); RCW 7.16.290 (writ of prohibition where state agency acts without or outside
24 of its jurisdiction); Foss, 82 Wn. App. at 359 (constitutional writ of certiorari where state
25 agency acts in arbitrary and capricious manner in violation of fundamental right). Since the
26 Legislature declared that DOC is to execute death sentences using lethal injection and has

1 declared that DOC may enact policies to carry out its duties, and since Washington law
2 contains adequate procedural safeguards to guard against arbitrary agency action, even if the
3 rule applies, Stenson cannot show an unlawful delegation of legislative authority. Therefore,
4 Defendants should be granted judgment as a matter of law on this claim.

5
6 **F. STENSON'S CLAIMS ARE BARRED UNDER THE STATUTE OF
LIMITATIONS, LACHES, AND *RES JUDICATA*.**

7 Stenson alleges a cause of action that accrued in 1997, with the conclusion of his
8 direct review. Stenson has known since 1997 that he will be executed by either lethal
9 injection or hanging. Stenson claims, in response to Defendants' motion to dismiss, this is
10 a civil rights action.⁵ Under 42 U.S.C. § 1983, the statute of limitations on the claim is
11 three years. Stenson waited 11 years, until the eve of his execution to raise this challenge.
12 His claim is now time-barred and this Court should adopt the reasoning of the Fifth, Sixth
13 and Eleventh Circuits in concluding that the State's interest in exercising its sovereign
14 power to finalize its judgment should not be delayed. See, e.g., McNair v. Allen, 515 F.3d
15 1168 (11th Cir. 2008); Cooley v. Strickland, 479 F.3d 412 (6th Cir. 2007); Cooley v.
16 Strickland, No. 08-4252, 2008 WL 4516091 (6th Cir. Oct. 9, 2008); Henyard v. Secretary,
17 No. 08-15396, 2008 WL 4328570 (11th Cir. Sept. 23, 2008).⁶

18 Similarly, Stenson's claim is barred under the doctrine of laches. Laches bars an
19 action when a plaintiff had reasonable opportunity to discover the basis of the cause of
20 action, unreasonably delayed commencing the cause of action, and the defendant has been
21 damaged by the delay. All of these factors are present in this case. Stenson knew of this
22 cause of action, at the latest, in 1997. Stenson unreasonably delayed commencing this

23
24 ⁵ Nowhere in his complaint does Stenson allege a civil rights action under 42 U.S.C. § 1983. See
Brutsche v. City of Kent, 78 Wn. App. 370, 898 P.2d 319, 375 (1995).

25 ⁶ These courts, in applying the statute of limitations, have found the cause of action accrues not when the
26 inmate is to be executed, but when the defendant's conviction becomes final or the method of execution is
adopted.

1 action until the eve of his execution. Defendants' interest in the exercise of the State's
2 sovereign power to enforce judgments is severely prejudiced by Stenson's challenge at this
3 late date. Finally, as argued above, the policy need not be subjected to detailed fact finding
4 as it is substantially similar to the protocol analyzed in Baze. Baze, 128 S. Ct. at 1537.

5 Finally, *res judicata* bars Stenson's untimely challenge to the constitutionality of
6 lethal injection and hanging. The doctrine of *res judicata* serves to bar a claim where there
7 is an identity of claims, a final judgment on the merits, and an identity or privity of parties.
8 Loveridge v. Fred Meyer, Inc., 125 Wn.2d 759, 763, 887 P.2d 898 (1995). The doctrine of
9 *res judicata* further bars "issues that were or could have been raised in the prior action."
10 Mellor v. Chamberlin, 100 Wn.2d 643, 645, 673 P.2d 610 (1983). There is privity of
11 parties in this case and Stenson's *habeas corpus* action as both name the superintendent of
12 the Washington State Penitentiary. Stenson could have challenged the constitutionality of
13 lethal injection and hanging in his personal restraint petitions. Thus, the orders denying the
14 personal restraint petitions and the federal *habeas corpus* petition, bar Stenson's claims in
15 this Court. This Court grant summary judgment as Stenson's challenges to lethal injection
16 and hanging are barred under the statute of limitations, laches, and the doctrine of *res*
17 *judicata*.

18 VI. CONCLUSION

19 For the reasons stated above, Defendants respectfully request the Court grant
20 Defendants' motion for summary judgment and dismiss the complaint with prejudice.

21 DATED this th 13 day of November, 2008.

22 ROBERT M. MCKENNA
23 Attorney General

24 
25 SARA J. OLSON, WSBA #33003
26 JOHN J. SAMSON, WSBA #22187
Assistant Attorneys General

1 CERTIFICATE OF SERVICE

2 I certify that I served a copy of the foregoing document on all parties or their counsel of
3 record as follows:

- 4 US Mail Postage Prepaid
5 United Parcel Service, Next Day Air
6 ABC/Legal Messenger
7 State Campus Delivery
8 Hand delivered by Vicky Woods

9 TO:

10 SHERILYN PETERSON
11 ELIZABETH D. GAUKROGER
12 PERKINS COIE, LLP
13 1201 THIRD AVE, SUITE 4800
14 SEATTLE, WA 98101-3099

15 EXECUTED this 13th day of November, 2008, at Olympia, Washington.

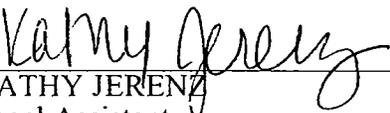
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KATHY JERENZ
Legal Assistant

EXHIBIT 1

DECLARATION OF STEPHEN D. SINCLAIR

I, STEPHEN D. SINCLAIR, make the following declaration:

1. I am currently employed as the Superintendent of the Washington State Penitentiary (WSP). I have been employed in this position for 2 months. Prior to assuming the position of Superintendent, I was employed as an Associate Superintendent at WSP for 3 years. I have worked for the Department of Corrections (DOC) for 20 years. Prior to my employment by DOC, I was an infantryman in the United States Army and stationed at various posts in and out of the country. During my enlistment I received training and certification as a Combat Life Saver and completed a course for Emergency Medical Technicians presented by Pikes Peak Community College in Colorado Springs, Colorado. In previous executions carried out at the Washington State Penitentiary I have participated in the transportation of the Inmate Sentenced to Death Penalty (ISDP) to the chamber holding cell and other security/escort functions.

2. As the Superintendent for WSP, I am personally and thoroughly familiar with DOC Policy 490.200, Capital Punishment. I am familiar with my responsibilities as well as the responsibilities of the Lethal Injection Team and the Escort Team.

3. Darold Stenson is an ISDP and is scheduled for execution on December 3, 2008. I have reviewed Mr. Stenson's medical records and know that his weight fluctuates between 230 and 233 pounds and that his veins have been examined and are considered "normal" in that there are no signs of collapsed veins. Additionally, Mr. Stenson does not have a history of intravenous (IV) drug use.

4. I am personally aware of the identities of all members of the Lethal Injection Team and the Escort Team and of their qualifications, training, and professional experience.

5. Each member of the Lethal Injection Team has sufficient training or experience to carry out the lethal injection process without any unnecessary pain to Mr. Stenson. All members of the Lethal Injection Team each have one or more year of professional experience as a certified Medical Assistant, Phlebotomist, Emergency Medical Technician, Paramedic, military corpsman, or similar occupation, as required by DOC Policy 490.200, Directive IX(A)(1)(d).

Additionally, the member of the Lethal Injection Team who will insert the IV lines regularly inserts IV lines as a part of his/her professional duties.

6. Pursuant to the requirements of DOC Policy 490.200, Directive VIII(1)(2) practice sessions have been conducted at WSP in anticipation of Mr. Stenson's scheduled execution.

7. The Lethal Injection team members have conducted three full lethal injection practice sessions since October 6, 2008. Each of these sessions involved a full walk-through of the entire lethal injection process and the insertion of IV lines in both arms of the person acting as the ISDP. I have personally acted in the role of the ISDP for two of these sessions and experienced the entire process to include the insertion of the needle and IV lines on both arms.

8. The lethal injection process includes the escorting in of the ISDP, the placing of the ISDP on the table, the securing of the ISDP to the table, and the insertion of the IV lines. There is 174" of tubing from the saline drip bag in the injection room to the arm of the ISDP in the execution chamber. Once the ISDP has been secured to the table and the IV lines have been inserted in both arms, with saline flowing through the IV lines, the members of the Lethal Injection Team enter and remain in the injection room. This room is approximately two feet from the head of the table to which the ISDP is secured. The injection room has a 9" by 7" door which is opened to the execution chamber to provide for direct, unobstructed, visual communication between myself and the Lethal Injection Team members. Once the Lethal Injection Team members have gone into the injection room, the witnesses are escorted into the witness room. Once the witnesses are seated, the curtain is opened. The witnesses sit six feet from the execution chamber window and have direct visual access to the execution chamber, me, and the ISDP. Once the witnesses have been brought in, the ISDP is permitted to give last words. I then orally communicate with the Deputy Secretary that there are no further stays. Once the Deputy Secretary has confirmed there are no further stays, I give a visual signal to the Lethal Injection Team to begin injection of the 3 grams of thiopental sodium. I observe the ISDP for signs of consciousness after the injection of the thiopental sodium. If any are seen, I instruct

the Lethal Injection Team to insert a second 3 gram dose of thiopental sodium. Once no signs of consciousness are observed, I signal to the Lethal Injection Team to inject the 50 cc normal saline, 100 mg pancronium bromide, 50 cc normal saline, and 240 mEq potassium chloride in succession. Throughout the injection of the drugs I am no more than one foot from the ISDP seated immediately next to his right arm. The execution chamber and the injection room are well lit and provide for clear sight and ample space for the movement of all staff participating in the execution.

9. I have received training on how to insert an IV line so that I am familiar with the process and how it is done effectively, although I will not be the individual inserting the IV lines during Mr. Stenson's execution.

10. I have also received personal, particularized training on recognizing the signs of an IV line that has not been properly sited. In an execution, an IV needle is used to site the IV lines. The IV needle has a connector needle, which is a fine pointed needle, with a fine, plastic sheath around it, with the needle protruding approximately an inch, and an approximately 3-inch length of connector tubing attached to it. The connector needle is inserted into the vein. Once the connector needle enters the vein there is a "flash" of blood which enters the hub of the needle. The "flash" indicates that a vein has been entered. Once the connector needle has entered the vein, the sheath is pushed down into the vein and the connector needle is removed. A syringe is then attached to the connector tubing and a "pull back" of the syringe's plunger is done to see if blood enters the connector tubing, indicating a vein has been entered. Once it is determined that a vein has been entered, the syringe is removed and the connector tubing is attached to the IV tubing and the saline flow begins. If a vein is missed, the "flash" will not occur, the "pull back" will not work, and there will be swelling at the injection site once the saline begins to enter the subcutaneous muscle. I have received training in witnessing the "flash", the "pull back", and looking for swelling at the injection site.

11. In each of the three full practice sessions, there were no difficulties with the insertion of the IV lines. The sessions were conducted without error or incident.

12. Prior to the execution, if Mr. Stenson does not elect hanging, the lethal injection drugs will be obtained by the WSP pharmacy. Once they arrive at the institution, they will be brought from the pharmacy at WSP to my office where they will be secured in a locked box, to which I have the only key. On the day of the execution, the drugs will be taken from the locked box in my office and given to the Lethal Injection Team. The Lethal Injection Team will follow the directions on the thiopental sodium box and will mix the powdered drug with saline to make a liquid to be injected into the ISDP. Both the pancronium bromide and the potassium chloride come in liquid form.

13. The Escort Team members and I have conducted fifteen to twenty hanging practice sessions in the last three weeks. In each of these practice sessions, either a mannequin has been "dropped" through the trap door or a metal container with weights weighing 230 pounds (to simulate Mr. Stenson's body weight) has been "dropped" through the trap door. In each hanging practice session involving the mannequin, of which there have been at least ten, the individual who will be placing the noose around the ISDP's neck has practiced the placing and tightening of the noose. In order to ensure a swift, painless death, the noose is placed extremely tightly around the ISDP's neck with the noose directly behind the ISDP's left ear and the running part of the noose, i.e. the part that moves when the noose is tightened, placed along the front of the neck. Four different ropes have been "stretched" which includes wetting the rope and stretching it to eliminate any risk of recoil once the trapdoor has opened and the ISDP has fallen the five feet. In the practice sessions with the mannequin, after the noose has been securely placed, the trapdoor is opened and the mannequin falls through and the rope is extended to the full five feet. In each hanging practice session involving the metal crate containing weights totaling 230 pounds, of which there have been at least five, the metal crate has been placed on the trapdoor and the rope has been attached to the metal crate. When the trapdoor drops, the metal crate falls through and the rope is extended its full five feet. In each of these fifteen to twenty sessions, the hanging mechanisms functioned without error or incident.

14. If an ISDP elects hanging, the ISDP will be brought into the execution chamber and escorted directly to the window over-looking the witness room. Once at the window, the curtain is opened approximately six inches to allow the ISDP to be visually seen by the witnesses as he makes his last words. Once he has finished his last words, the curtains are closed. Once the curtains are closed, the witnesses cannot see the ISDP directly; however, the room is backlit so that the ISDP's shadow is visible. The witnesses are able to see the ISDP being escorted back to the rope, by seeing his shadow, and can see the rope placed around his neck and tightened. From the witness room, the witnesses can see the trap door fall and can see the lower third of the ISDP's body once the rope has extended the full five feet.

15. As of this date, Mr. Stenson has not elected hanging as his execution method. As such, preparations are still under way for both hanging and lethal injection.

16. I will be present in the execution chamber during Mr. Stenson's execution and will ensure that DOC Policy 490.200 is followed.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge.

DATED this 7th day of November, 2008, at Walla Walla, Washington.


STEPHEN D. SINCLAIR

EXHIBIT 2

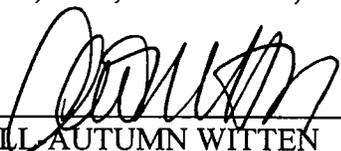
I, DELL-AUTUMN WITTEN, make the following declaration:

1. I am currently employed by the Washington State Department of Corrections (DOC) as a Program Specialist 5. As part of my job duties I am responsible for responding to requests for specific policies promulgated by the Department of Corrections.

2. A true and correct copy of the Department of Corrections Policy Directive 490.200, Capital Punishment, effective October 25, 2008, is attached to this Declaration as Attachment A. This is the current version of the policy.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge.

EXECUTED this 12th day of November, 2008, at Tumwater, Washington.



DELL AUTUMN WITTEN

ATTACHMENT A

| | | | |
|---|------------------------------------|------------------------|------------------------------|
|  STATE OF WASHINGTON DEPARTMENT OF CORRECTIONS | APPLICABILITY PRISON | | |
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| | TITLE CAPITAL PUNISHMENT | | |
| POLICY | | | |

REVIEW/REVISION HISTORY:

Effective: 9/3/93
 Revised: 6/15/98
 Revised: 8/10/01
 Revised: 6/21/07
 Revised: 10/25/08

SUMMARY OF REVISION/REVIEW:

Title and Team Name changes throughout
 I.A.1., II.C. & VIII.A.1., & VIII.C.2. – Added clarifying language
 III.B.3. – Added requirements for ISDP incoming mail
 III.B.4.b. & 5.b. – Added clarifying language regarding attorney of record
 Revised IV.A.1. to specify a single media event
 Added IV.B.1. & DOC 21-575 Acknowledgment of Visitor Search Requirements for searches of media representatives
 Revised V.F. regarding search requirement for witnesses
 VI.C. – Revised housing requirements for female ISDP
 VIII.A.2. – Added requirement for 3 practice sessions for lethal injections
 VIII.B. – Removed medical file review; revised physical examination requirement
 IX.A.1.d. – Added that Lethal Injection Team members must be trained; added qualifications
 IX.A.2.a. – Changed Director of Health Services to Superintendent
 IX.A.4.b. & d. – Revised requirements for lethal injection
 IX.A.4.h. – Removed requirement that Lethal Injection Team remove apparatus and saline
 X.A. – Calls to Headquarters will be made to the Department Emergency Operations Center
 X.F. – Removed requirement that Death Certificate be signed before removal of body
 Several changes to Attachment 1

APPROVED:

Signature on File

ELDON VAIL, Secretary
 Department of Corrections

10/23/08

 Date Signed

ATTACHMENT

 A

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REFERENCES:

DOC 100.100 is hereby incorporated into this policy; RCW 10.95.160-190; WAC 137-48-050; DOC 410.040 Incident Command System (ICS)

POLICY:

- I. The Department has established procedures governing capital punishment to meet the requirements of RCW 10.95.160-190. These procedures set forth:
 - A. Security requirements for an Inmate Subject to the Death Penalty (ISDP),
 - B. Protocol for conducting an execution,
 - C. The care provided the ISDP while a valid Death Warrant is in force, and
 - D. The method of execution by lethal injection or hanging.

- II. The Department Secretary designates the Assistant Secretary for Prisons to coordinate:
 - A. The responsibilities of the Washington State Penitentiary (WSP) Superintendent, and
 - B. A review of the procedures and all operational decisions in carrying out the execution, as well as the legal status of the Death Warrant.

DIRECTIVE:

- I. ISDP Housing
 - A. Upon receipt of an ISDP and prior to receipt of a Death Warrant:
 1. Male ISDPs shall be housed in a single person cell located in a segregated area of WSP.
 2. Female ISDPs shall be housed in a segregated area of the Washington Corrections Center for Women (WCCW). Prior to the execution date, the female ISDP will be transported to WSP for housing and execution.

- II. Pre-Execution Procedure
 - A. Consistent with RCW 10.95.190, a log shall be maintained with the Death Warrant in the Superintendent's Office.
 - B. Responsibilities are listed in the Execution Procedures and Assignments Checklist (Attachment 1).

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- C. Only staff assigned by the Superintendent will attend the execution. No facility staff will be required to participate in any part of the execution procedure.

III. Notification to ISDP

- A. After receiving confirmation of a valid Death Warrant, the Superintendent will designate an Associate Superintendent to personally interview the ISDP regarding procedures relating to the execution.
- B. The Associate Superintendent will provide the ISDP with a written summary of procedures, to include mail, visits, telephone usage, and available religious services. The ISDP will be informed of the following:
1. The date of the execution.
 2. The punishment of death shall be by lethal injection.
 - a. The ISDP may elect hanging as an alternate means of execution.
 - b. The procedure to be used will be determined 14 days prior to the execution and the method cannot be changed after that date. If the ISDP elects hanging, it must be stated in writing no later than 14 days prior to the execution date.
 3. Mail procedures for an ISDP with an active Death Warrant will be as follows:
 - a. The Mail Room Sergeant will be instructed, in writing, to forward all incoming mail, unopened, to the designated Associate Superintendent, who will screen and exclude any items which may threaten the order and security of the facility with regard to the ISDP.
 - 1) Mail intended to harass the ISDP will be considered a threat to the orderly operation of the facility and restricted per WAC 137-48-050.
 - 2) Legal mail will be screened, not read.
 - b. The Mail Room Sergeant will maintain a log of all incoming and outgoing mail, noting the date and time of receipt and delivery. A separate log will be maintained for all legal mail.
 4. All visits between the ISDP and authorized visitors will be no contact.

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- a. Visitation for an ISDP will be consistent with the visiting procedures of other offenders housed in the Intensive Management Unit (IMU).
 - b. Seven days prior to the execution, daily visits will be authorized in addition to visits with the attorney of record.
 - c. Twenty-four hours prior to the execution date, all visits and visitors require the approval/denial of the Superintendent.
 - d. After the ISDP is moved to the execution holding cell, visits will be restricted to approved clergy and the attorney of record.
5. The ISDP will have unlimited phone access during the daily yard period. Fourteen days prior to the execution date, an additional daily one hour yard will be provided.
- a. There will be no limit on the number or duration of calls to and from the attorney of record.
 - b. Only calls from the attorney of record will be authorized following transfer to the execution holding cell.

IV. Media Relations

- A. The Superintendent/designee will coordinate all requests for information concerning an execution.
 1. A single event to provide representatives of major and local media an opportunity to access the chamber will be authorized by the Superintendent and coordinated by designated staff.
- B. The Superintendent will establish procedures for selecting media witnesses as specified in the Witness Selection section of this policy.
 1. No audio/electronic/video equipment, cameras, telephones, or recording/communication devices will be permitted in the chamber. Media witnesses will be subject to an electronic and pat search. Written consent for search will be required using DOC 21-575 Acknowledgment of Visitor Search Requirements.
 2. The only items that are allowed in the chamber are pens, pencils, and writing tablets supplied by the facility.
- C. Requests from media representatives for access to the Information Center must be submitted in writing.



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1. Information Center access will not be permitted more than 3 hours prior to an execution.
 - D. Media access to a designated area of the facility parking lot will be permitted at a designated time the day prior to the execution.
 - E. Media will not be permitted to film or conduct interviews with facility staff without the prior authorization of the Superintendent/designee.
 - F. All normal facility security procedures will apply. Failure to comply with these procedures, Department policies, operational memorandums, or directions from authorized personnel may be cause for removal from the facility and/or facility grounds. The Superintendent may establish emergency rules and procedures.
- V. Witness Selection
- A. Not less than 20 days prior to an execution, individuals who wish to attend and witness the execution must submit a letter of request (e.g., application) to the Superintendent. The letter must designate the relationship to the ISDP and reason(s) for wishing to attend. Eligible individuals include:
 1. Judicial officers (i.e., the Judge who signed the Death Warrant for the ISDP, the current Prosecuting Attorney or a Deputy Prosecuting Attorney of the county from which the final Judgment and Sentence and Death Warrant were issued, and the most recent attorney of record representing the ISDP),
 2. Law enforcement representatives (i.e., officers responsible for investigating the crime for which the inmate was sentenced to death),
 3. Media representatives,
 4. Representatives of the families of the victims (i.e., immediate family or victim advocates of the immediate family), and
 5. Representatives from the ISDP's immediate family.
 - B. Not less than 15 days prior to the execution, the Superintendent shall determine the total number of individuals, other than Department employees, who will be allowed to attend and witness the execution.
 1. The Superintendent shall determine the number of witnesses allowed in each category of eligible individuals.

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- a. No less than 5 media representatives will be included, with consideration given to news organizations serving communities affected by the crimes or the execution.
 - b. Up to 2 law enforcement representatives will be included. The chief law enforcement officer of the jurisdiction where the crime was committed shall designate the law enforcement representatives.
2. Once the list is composed, the Superintendent shall serve the list on all parties who have submitted a letter (e.g., application) to witness the execution.
- C. Not less than 10 days prior to the execution, the Superintendent shall file the witness list with the Superior Court from which the conviction and Death Warrant were issued. The witness list will be filed with a petition asking that the court enter an order certifying the list as a final order identifying the witnesses to attend the execution. The final order of the court certifying the witness list shall not be entered less than 5 days after the filing of the petition.
 - D. Unless a show cause petition is filed with the Superior Court from which the conviction and Death Warrant were issued within 5 days of the filing of the Superintendent's petition, the Superintendent's list, by order of the Superior Court, will become final and no other party will have standing to challenge its appropriateness.
 - E. In no case may the Superintendent or the Superior Court order or allow more than 17 witnesses to a planned execution, excluding required staff.
 - F. All witnesses must adhere to the facility's search and security provisions in regards to witnessing an execution and may be subject to emergency rules and procedures. Written consent for search will be required using DOC 21-575 Acknowledgment of Visitor Search Requirements.
- VI. Execution Holding Cell
- A. Prior to the execution, but no sooner than 24 hours before, the ISDP will be moved to the execution holding cell.
 - B. The holding cell will contain:
 1. Bedding that includes a mattress, 2 sheets, 3 blankets, a pillow, and a pillow case,
 2. Personal hygiene items that include 2 towels, a washcloth, and a bar of soap,

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3. Approved personal items and clothing that include underwear, facility clothing, legal materials, religious items, jewelry, or other personal items as requested by the ISDP and approved by the Superintendent, and
 4. Other personal items as requested by the ISDP and approved by the Superintendent to be retained by holding cell staff and issued as requested by the ISDP.
- C. A female ISDP may be housed in the WSP Intensive Management Unit (IMU) prior to being moved to the execution holding cell.
- D. Two correctional staff will be posted at the holding cell at all times and a complete log of activities will be maintained.
- VII. Final Meal
- A. At the meal period just prior to the time of execution, the ISDP will be allowed to provide his/her meal selection from a menu prepared and provided by the Food Service Manager. The Food Service Manager will ensure preparation and delivery of the meal to the ISDP.
- VIII. Execution Preparation
- A. The Superintendent will appoint individuals to support the execution process.
1. No staff will be required to participate in any part of the execution procedure.
 2. Briefings and rehearsals will be conducted as necessary to ensure adequate preparation for the execution. For an execution by lethal injection, there shall be a minimum of 3 practice sessions preceding an execution that shall include the siting of intravenous (IV) lines.
- B. Medical Review
1. A physical examination of the ISDP may be conducted to determine any special problems (e.g., collapsed veins, obesity, deterioration of bone or muscular structure) that may affect the execution process. The ISDP's height and weight will be measured during the examination.
 2. Based upon the physical examination, the Superintendent may consult with appropriate experts to determine whether deviation from the policy is advisable to ensure a swift and humane death.
- C. Crowd Control

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1. The Superintendent will notify law enforcement agencies of the date of execution, enabling them to prepare for any traffic and crowd control issues that may arise.
2. Prior to the execution, the Superintendent will hold briefings for local and state law enforcement agencies to determine the manner and extent to which WSP and Department resources will support law enforcement in managing crowd control and potential external threats.
3. An area(s) will be designated for the general public.
4. The WSP Emergency Response Team (ERT) will provide crowd control for the protection of the WSP grounds.
 - a. The ERT Commander(s) will be briefed by the Superintendent prior to the execution.
 - b. In the event that protesters and/or onlookers gather, law enforcement assistance will be requested to direct them to the designated area.

IX. Execution Procedure

A. Lethal Injection

1. Lethal Injection Materials/Personnel
 - a. All tubing, syringes, saline solution, and other apparatus will be on site and verified no later than 7 days prior to the execution.
 - b. The Superintendent will direct the acquisition of the appropriate quantities of lethal substances. These will be available and on site 7 days prior to the execution date.
 - c. The Superintendent will ensure the security and continued verification of all materials.
 - d. Lethal Injection Team members will have sufficient training or experience to carry out the lethal injection process without any unnecessary pain to the ISDP. Minimum qualifications include one or more years of professional experience as a certified Medical Assistant, Phlebotomist, Emergency Medical Technician, Paramedic, military corpsman, or similar occupation.
2. Lethal Injection Table



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- a. The Superintendent, in conjunction with the Plant Manager, will examine and verify that the lethal injection table is in working order with all restraints available.
3. Preparation of the Execution Area
 - a. The Lethal Injection Team will inspect the area designated for lethal injection and make any final recommendations to the Superintendent.
 - b. The Lethal Injection Team will assemble all necessary materials for transport to the chamber no less than one hour prior to the time of execution. The Lethal Injection Team Leader will secure the lethal substances and personally transport them to the chamber.
 - c. The solutions for injection will be prepared not more than 30 minutes prior to administration.
 4. Execution Process
 - a. The Superintendent will direct that the ISDP be brought to the chamber. The Escort Team will place the ISDP on the lethal injection table and appropriately secure the ISDP to the table. The Escort Team will then leave the room.
 - b. The Lethal Injection Team will establish 2 IV lines and start a normal flow of saline through each line. The Lethal Injection Team will ensure that a slow, normal saline flow is maintained through each line.
 - c. The Superintendent will ask the ISDP if s/he has any last words.
 - d. Upon notification from the Superintendent, the Lethal Injection Team will introduce the following lethal solutions using a bolus injection into the tubing in the order specified:
 - 1) 3 g thiopental sodium
 - 2) 50 cc normal saline
 - 3) 100 mg pancuronium bromide
 - 4) 50 cc normal saline
 - 5) 240 mEq potassium chloride (KCl)
 - e. Either line may be used for injection of solutions as required. The Superintendent shall observe the ISDP for signs of consciousness before the Lethal Injection Team administers the pancuronium

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bromide. If the Superintendent observes that the ISDP is conscious following the first dose of thiopental sodium, s/he shall direct the Lethal Injection Team to administer an additional 3 g dose of thiopental sodium.

- f. The Lethal Injection Team Leader will signal the Superintendent when all of the solutions have been administered.
- g. At a time deemed appropriate by the Superintendent, the curtains will be closed. The Superintendent will call for the physician to examine the body and make a pronouncement of death.
- h. After the pronouncement of death, the Lethal Injection Team will remain in the area until directed to leave.
- i. Post-execution procedures will be followed.

B. Hanging

- 1. The gallows area trap door(s) and release mechanisms will be inspected for proper operation.
- 2. A determination of the proper amount of drop of the ISDP through the trap door will be made. The following standard military execution drop chart will be used:

| <u>WEIGHT (Pounds)</u> | <u>DROP DISTANCE</u> |
|------------------------|----------------------|
| 120 | 8'1" |
| 125 | 7'10" |
| 130 | 7'7" |
| 135 | 7'4" |
| 140 | 7'1" |
| 145 | 6'9" |
| 150 | 6'7" |
| 155 | 6'6" |
| 160 | 6'4" |
| 165 | 6'2" |
| 170 | 6'0" |
| 175 | 5'11" |
| 180 | 5'9" |
| 185 | 5'7" |
| 190 | 5'6" |
| 195 | 5'5" |

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| 200 | 5'4" |
| 205 | 5'2" |
| 210 | 5'1" |
| 220 and over | 5'0" |

3. Equipment

- a. Hood – The hood will be a neutral color with an outer surface made of rough material, split at the open end so that it will come down over the chest and back.
- b. Collapse Board – A board will be provided for use in case the ISDP collapses.
- c. Restraints – Restraints will be used to ensure that the hands and arms of the ISDP are securely held to his/her front and sides.
- d. Rope –The rope will be manila hemp, at least ¾ inch and not more than 1¼ inches in diameter and approximately 30 feet in length. The rope will be soaked and then stretched while drying to eliminate any spring, stiffness, or tendency to coil. The knot will be treated with wax, soap, or clear oils ensuring a smooth sliding action through the knot. The knot will be tied according to Army regulations.

4. Execution Process

- a. Restraints will be placed on the ISDP by assigned staff.
- b. The Escort Team will escort the ISDP to the gallows area. The ISDP will be placed, standing, in the spot designated by the Superintendent. The Superintendent will ask the ISDP if s/he has any last words.
- c. The hood will be placed on the ISDP and leg restraints applied. If a collapse board appears to be necessary, the Escort Team will put the board in place.
- d. The noose will be placed snugly around the ISDP's neck in such a manner that the knot is directly behind the left ear.
- e. The Superintendent will direct the trapdoor be released.
- f. The Escort Team will move to the lower floor location to assist with removal of the deceased ISDP. The curtains will be closed.

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- g. At a time deemed appropriate by the Superintendent, the physician will be called to make a pronouncement of death.

X. Post-Execution Procedure

- A. The Assistant Secretary for Prisons will notify the Secretary and Incident Command Center of the time of death. Necessary calls to Headquarters will be made to the Department Emergency Operations Center.
- B. The Superintendent will inform a designated staff of the time of death, who will then inform the witnesses.
- C. The witnesses will be escorted out of the execution area immediately after the pronouncement of death.
- D. The media witnesses will be escorted to the Information Center.
- E. The Chaplain will provide official notification to the family of the time of death.
- F. The body will be removed from the facility by a pre-determined route.
- G. A post-trauma specialist and the Chaplain will be available to staff preceding, during, and after the execution. Staff will also be provided a confidential list of off-site locations where counseling and/or spiritual support will be available.
- H. Within 20 days after the execution, the Superintendent shall return the Death Warrant to the clerk of the trial court from which it was issued, along with the log identified in the Pre-Execution Procedure section of this policy.

DEFINITIONS:

Words/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

ATTACHMENTS:

Execution Procedures and Assignments Checklist (Attachment 1)

DOC FORMS:

DOC 21-575 Acknowledgment of Visitor Search Requirements

**DEPARTMENT OF CORRECTIONS
WASHINGTON STATE PENITENTIARY
EXECUTION PROCEDURES AND ASSIGNMENTS CHECKLIST**

Inmate:

Date of Execution:

| DATE COMPLETED/ STAFF INITIALS | TASK | ASSIGNED PERSONNEL |
|--|---|-----------------------|
| Compliance Date: Approximately 30 days prior to the scheduled execution | | |
| | Superintendent appoints an Execution Incident Commander. | |
| | Execution Incident Commander determines the Incident Command System (ICS) objectives, strategies, tactical direction, and organizational structure needed for the execution event and identifies planning elements required. | |
| | Execution Incident Commander develops a draft Incident Action Plan (IAP) for the execution and submits to the Superintendent for approval. The IAP will contain, at a minimum, all elements identified in this checklist. | |
| | ISDP is informed of the statutory requirements regarding the method of execution and is advised the Superintendent will request s/he submit his/her election of alternate method in writing. | |
| | ISDP is given opportunity to designate family members as witnesses. | |
| | ISDP has been provided a written summary of the procedures governing mail, visitation, telephone use, and available religious services. | |
| | Mail Room Supervisor is informed, in writing, of the ISDP's name and execution and instructed that: <ul style="list-style-type: none"> <input type="checkbox"/> All incoming mail addressed to ISDP will be forwarded unopened to a designated Associate Superintendent <input type="checkbox"/> A log will be maintained of all incoming/outgoing mail noting date and time of receipt and distribution <input type="checkbox"/> A separate log will be maintained for legal mail | |

| DATE COMPLETED/ STAFF INITIALS | TASK | ASSIGNED PERSONNEL |
|--|--|-----------------------|
| | The facility Public Information Officer has been informed of scheduled date and directed to prepare a media plan. | |
| | The Intensive Management Unit (IMU) Manager has been informed of mail, visit, telephone use, and available religious services as they apply to the ISDP. | |
| | ISDP is placed on 30 minute check. Observed behavior is entered in designated log. | |
| | Chaplain is assigned as Religious Specialist and briefed. | |
| | Sources and procedures for acquiring the substances necessary for lethal injection have been investigated. Plans being made for acquiring all necessary equipment essential to carry out either mode of execution. | |
| | Coordination meeting with local law enforcement is scheduled. | |
| | Lethal Injection Team or Hanging Team, as necessary, is identified and notified. | |
| | Individuals eligible to witness execution are identified. Appropriate letters sent. | |
| Compliance Date: Not less than 20 days prior to the execution | | |
| | Superintendent completes changes to IAP and returns to the Execution Incident Commander. | |
| | Staff assigned an organizational role within the ICS structure are identified and briefed. | |
| | ICS organization completes identified planning elements, required forms, and documentation for the IAP. | |
| | Letters received from potential witnesses have been processed. | |

| DATE COMPLETED/ STAFF INITIALS | TASK | ASSIGNED PERSONNEL |
|--|--|-----------------------|
| | The chamber has been inspected to ensure the following systems are functional: <input type="checkbox"/> Plumbing <input type="checkbox"/> Lighting <input type="checkbox"/> Emergency Lighting <input type="checkbox"/> Mechanical Systems <input type="checkbox"/> Locking Systems <input type="checkbox"/> Telephones <input type="checkbox"/> Sanitation <input type="checkbox"/> Furnishings <input type="checkbox"/> Toilet Facilities | |
| | Execution Incident Commander ensures all staff assigned to positions within the chamber receive a briefing and notification of the date and time of "on-site" rehearsal. | |
| | Execution Incident Commander ensures a written report detailing the condition of the chamber has been submitted to the Superintendent citing any deficiencies. A schedule of corrective actions will be provided. | |
| Compliance Date: 15 days prior to the execution | | |
| | All changes, improvements, or renovations to the chamber have been completed. | |
| | Total number of individuals to attend/witness the execution, other than staff, has been identified. | |
| | Witness applicants have been notified of the final witness list. | |
| Compliance Date: 14 days prior to execution | | |
| | ISDP is authorized one additional hour of yard time each day. | |
| | ISDP is provided final opportunity to choose alternate method of execution. | |
| | All equipment has been procured for either mode of execution. | |
| | Notification to staff/ISDP for program changes if needed (e.g., visiting, etc.). | |
| | Arrangements made to ensure Death Certificate will be available. Superintendent is advised. | |
| Compliance Date: Not less than 10 days prior to the execution | | |

| DATE COMPLETED/ STAFF INITIALS | TASK | ASSIGNED PERSONNEL |
|---|---|-----------------------|
| | List of authorized witnesses is filed with Superior Court in county of conviction from which Death Warrant issued. | |
| | Physical examination is conducted, if needed. | |
| | The following have been checked: <input type="checkbox"/> All equipment required for lethal injection <input type="checkbox"/> All equipment required for hanging, if necessary. | |
| | Conduct at least 3 lethal injection practice sessions, if necessary, including siting of IV lines. | |
| | Gallows area trap door(s) and release mechanisms are inspected for proper operation, if necessary. | |
| | Proper amount of drop of ISDP through the trap door is determined, if necessary. | |
| | IAP specifically details crowd control strategies and tactics and identifies the operational supervisor/leader. | |
| Compliance Date: 7 days prior to the execution | | |
| | Execution Incident Commander submits final IAP to the Superintendent and receives signature approval. | |
| | ISDP is authorized daily visits (in addition to with attorney of record). | |
| | Instructions are provided to staff on entrance and egress routes. | |
| | Mobile restroom facilities are placed in the designated demonstration area. | |
| | Post-execution handling of ISDP is coordinated. | |
| | Lethal solutions, if required, have been obtained and placed in security lock box. | |
| | The specific route and mode of body removal is determined and information transmitted to: <input type="checkbox"/> Superintendent <input type="checkbox"/> Execution Incident Commander <input type="checkbox"/> Captain <input type="checkbox"/> Shift Commander <input type="checkbox"/> Washington State Patrol | |
| | Menu for final meal is prepared and presented to Superintendent for approval. | |
| Compliance Date: Approximately 5 days prior to the execution | | |

| DATE COMPLETED/ STAFF INITIALS | TASK | ASSIGNED PERSONNEL |
|---|--|-----------------------|
| | On-site rehearsal has been conducted with all Execution Event staff participating. | |
| | The holding cell area has been inspected and is ready for occupancy. | |
| | Security inspections of the entire chamber have been conducted. | |
| | The holding cell is prepared and equipped with: <input type="checkbox"/> 1 Mattress <input type="checkbox"/> 2 Sheets <input type="checkbox"/> 3 Blankets <input type="checkbox"/> 1 Pillow <input type="checkbox"/> 1 Pillowcase <input type="checkbox"/> 2 Towels <input type="checkbox"/> 1 Washcloth <input type="checkbox"/> 1 Bar of Soap | |
| | Chamber and all systems have been checked for operation and readiness. All equipment present and functional. | |
| | Notices are issued to any contract/volunteer staff and/or construction workers of planned suspension of their activities. | |
| | Arrangements for Death Certificate are confirmed and communicated to the Superintendent/Execution Incident Commander. | |
| Compliance Date: Approximately 4 days prior to the execution | | |
| | Coordination briefings with local law enforcement agencies have been conducted. | |
| | All staff assignments made: <input type="checkbox"/> Chamber Security Team <input type="checkbox"/> Correctional Program Managers <input type="checkbox"/> Captain <input type="checkbox"/> Chamber Media Escort Team <input type="checkbox"/> Visiting Room Media Monitor <input type="checkbox"/> Chaplain <input type="checkbox"/> Transport/Restraining Team <input type="checkbox"/> Holding Cell Security Team <input type="checkbox"/> Health Care Manager 2 <input type="checkbox"/> Incident Command Post Staff (Security/Communication) <input type="checkbox"/> Specialty Team Group Supervisor/ERT Leader <input type="checkbox"/> Specialty Team Group Supervisor/SERT Leader | |

| DATE COMPLETED/ STAFF INITIALS | TASK | ASSIGNED PERSONNEL |
|---|---|-----------------------|
| | Staff escorts assigned for all non-WSP individuals attending. | |
| Compliance Date: 24 hours prior to execution | | |
| | Superintendent approves all visitors. | |
| | ISDP is requested to designate disposition of his/her property/remains in writing. | |
| | A thorough security inspection of the entire chamber area, including search of cells, has been conducted. | |
| | Clocks are coordinated. | |
| | ISDP is moved from IMU to holding cell. Visitors limited to approved clergy and attorney of record. | |
| | Upon arrival at the holding cell, ISDP is informed of conditions of confinement. | |
| | The IAP is initiated and Incident Command Post opened and staffed. | |
| | Main facility is briefed at roll call of extraordinary security measures. | |
| | A designated staff to operate PBX reports for work. | |
| Execution Day | | |
| | Chamber Access Security Team (Shift A) reports to duty station in chamber. | |
| | Cell Security Team (Shift A) reports to duty station in chamber. | |
| | Lethal solutions, if needed, are transferred to the injection room in the chamber. | |
| | Final meal is prepared and served to ISDP. | |
| | Chamber Access Security Team Shift B relieves Shift A. | |
| | Cell Security Team Shift B relieves Shift A. | |
| | Authorized media representatives are allowed access to the facility and are briefed by the Superintendent/designee. | |
| | All witnesses have been assigned escorts and allowed access to the facility. | |
| | All traffic through information desk area, visitor tunnel is cleared. | |
| | All staff designated as participants are at duty stations in the chamber. | |

| DATE COMPLETED/ STAFF INITIALS | TASK | ASSIGNED PERSONNEL |
|-----------------------------------|---|-----------------------|
| | Department Secretary has been contacted by telephone from the Incident Command Post/Communications Center and an open line from the Department Emergency Operations Center to the chamber is established. | |
| | Incident Command Post/Communications Center contacts the Attorney General's Office by telephone and maintains an open line. | |
| | Lethal Injection Team enters and the equipment for injection mode and back-up equipment is tested, if necessary. | |
| | Hanging Team enters the gallows area and the equipment and back-up equipment is tested, if necessary. | |
| | Open line participants verify and concur no stay has been received. The time is _____ or later and the execution is to proceed. | |
| | Superintendent is in place in chamber. | |
| | ISDP is placed in restraints and escorted to the appropriate execution area. | |
| | All pre-execution preparations are completed. All participants are in place. | |
| | Assistant Secretary confirms that no stays have been granted. | |
| | Assistant Secretary informs Superintendent that there are no stays. | |
| | Superintendent signals the execution to proceed. | |

EXHIBIT 3

DECLARATION OF DAN J. PACHOLKE

I, DAN J. PACHOLKE, make the following declaration:

1. I am currently employed as the Prison Administrator for the Department of Corrections (DOC). As the Prison Administrator, I supervise the operation of a number of Washington State prisons, including the Washington State Penitentiary (WSP). I am over the age of eighteen and competent to testify as a witness. The declaration set forth below is based on my personal knowledge.

2. Before I became the Prison Administrator, I was a prison superintendent at the following DOC prison facilities: Cedar Creek Corrections Center (2003-2006), Stafford Creek Correction Center (2007-2008), and interim superintendent at the Monroe Correctional Complex (2008). I have worked for DOC for 26 years.

3. As the DOC Prison Administrator, I supervise the WSP Superintendent, Stephen Sinclair. I am familiar with DOC Policy 490.200, Capital Punishment.

4. Superintendent Sinclair has reported to me that each member of the lethal injection team has sufficient training or experience to carry out the lethal injection process without any unnecessary pain to Mr. Stenson. Superintendent Sinclair has reported to me the individual team members who will assist in the execution by lethal injection will each have one or more years of professional experience as a certified Medical Assistant, Phlebotomist, Emergency Medical Technician, Paramedic, military corpsman, or similar occupation, as required by DOC Policy 490.200, Directive IX(A)(1)(d).

5. Pursuant to the requirements of DOC Policy 490.200, Directive VIII(1)(2) practice sessions have been conducted at WSP in anticipation of Mr. Stenson's scheduled execution. I have been present during at least two sessions for lethal injection and two sessions for hanging.

6. Regarding lethal injection, I attended two practice sessions on October 14, 2008, in the execution chamber at WSP. Each of these sessions involved a full walk-through of the

entire lethal injection process and the insertion of intravenous lines in both arms of two individuals. The lethal injection process includes the escorting in of the inmate subject to the death penalty, the placing of this person on the table, and the insertion of the intravenous lines. In one practice session, I assumed the role of the inmate subject to the death penalty. I was placed on the gurney in the execution chamber and strapped to the gurney. From there, I observed the actions of the lethal injection team. In the other practice session, I assumed the role of the superintendent while Superintendent Sinclair assumed the role of the inmate subject to the death penalty. Again, I observed the actions of the lethal injection team. In both practice sessions, two separate intravenous lines were inserted into either my arms or the arms of Superintendent Sinclair, one intravenous line on each arm, and flows of saline were initiated. Thereafter, members of the lethal injection team went through the tasks of simulating the application of the substances called for under the DOC Policy 490.200, sodium thiopental, pancuronium bromide, and potassium chloride. When I assumed the role of an inmate, I felt little or no pain during the practice session. The insertion of the needle and catheter occurred very much like when I have given blood. The lines were inserted with no apparent difficulty. I also observed nothing indicating that Superintendent Sinclair experienced any pain as the intravenous lines were inserted into his arms during the practice session in which he assumed the role of the inmate. Lethal injection team members performed their respective roles without any apparent difficulty. They all appeared to know their assignments and performed them without any difficulty.

7. I attended two practice sessions for hanging on October 19, 2008, at WSP. During both sessions, I was present on the upper floor of the execution chamber where the inmate subject to the death penalty would be escorted prior to an execution by hanging. In each of the practice sessions I witnessed, a mannequin was "dropped" through the trap door. Both practice sessions occurred without any difficulty and the steps leading up to and including the execution occurred according to DOC Policy 490.200.

8. In the practice sessions involving the mannequin, the noose was placed tightly around the mannequin's neck with the noose knot directly behind the mannequin's left ear and the running part of the noose (or the loop) placed in the front of the mannequin's neck. After the noose has been securely placed, the trap door is opened and the mannequin falls through and the rope is extended to five full feet. In each of these sessions, the hanging mechanisms functioned without error or incident.

9. Based on my observations of the execution practice sessions discussed above and on my conversations with Superintendent Sinclair, I observed nothing indicating any inability by either the execution team or Superintendent Sinclair in carrying out DOC Policy 490.200.

10. I will be present in the execution chamber during Mr. Stenson's execution and will ensure that DOC Policy 490.200 is followed.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge.

DATED this 7 day of November, 2008, at Olympia, Washington.



DAN J. PACHOLKE

EXHIBIT 4

DECLARATION OF MARK DERSHWITZ, M.D., Ph.D.

1. I am a medical doctor with a Ph. D. in Pharmacology. A true and accurate copy of my curriculum vitae is attached as Exhibit A. I am licensed to practice medicine in the states of Massachusetts and Maine. I am currently an anesthesiologist at the University of Massachusetts and I am certified by the American Board of Anesthesiology. I am currently Professor of Anesthesiology and Biochemistry & Molecular Pharmacology at the University of Massachusetts.
2. I have done extensive research and written numerous review articles and research papers on the use of anesthetics and I regularly practice medicine in that capacity. My research includes the study of pharmacodynamics and the pharmacokinetics of drugs. Pharmacokinetics is the study of the time course of a drug, while pharmacodynamics refers to the effects of a drug. Prior to my current appointment at the University of Massachusetts, I was an Instructor, Assistant Professor and Associate Professor at Harvard Medical School.
3. I have testified as an expert witness concerning the pharmacokinetics and the pharmacodynamics of anesthetic drugs and other medications. I have testified in court as an expert witness on seventeen occasions. I have given thirty-six depositions as an expert witness.
4. I have reviewed the protocols for the lethal injections used in the states of Arkansas, Alabama, California, Florida, Georgia, Kentucky, Maryland, Missouri, Montana, North Carolina, Ohio, Oklahoma, South Carolina, Texas and Virginia and by the federal government. In addition, I have reviewed the document from

the State of Washington Department of Corrections entitled, "Capital Punishment," and numbered "DOC 490.200." Each of the states and the federal government employ similar protocols for carrying out lethal injections. While the protocols and the jurisdictions differ in terms of the doses of the three medications used, each of these protocols will render an inmate unconscious quickly and cause the inmate's rapid and painless death.

5. Some medical paraprofessionals, such as nurses, emergency medical technicians, and paramedics, may be trained to insert intravenous catheters. If a medical paraprofessional routinely inserts intravenous catheters as a part of his or her regular job, it is reasonable to assign the task of inserting the intravenous catheter in an inmate to this person.
6. The protocol used in Washington states that medications will be administered as follows:
 - a. Thiopental sodium, 3 grams, will be injected.
 - b. Saline, 50 mL, will be injected to flush the IV line.
 - c. The Superintendent will observe the inmate for signs of consciousness. If the Superintendent observes that the inmate is conscious, an additional dose of thiopental sodium, 3 grams, will be injected.
 - d. Pancuronium bromide, 100 mg, will be injected.
 - e. Saline, 50 mL, will be injected to flush the IV line.
 - f. Potassium chloride, 240 mEq, will be injected.
 - g. The superintendent will direct the physician on site to examine the inmate

and pronounce death.

7. I have performed a pharmacodynamic analysis to predict the probability of response as a function of the predicted brain concentration of thiopental. This analysis is attached as Exhibit B. There are two responses to thiopental depicted in Exhibit B. The first response is the probability of unconsciousness. In this context, unconsciousness is defined as the drug-induced inability to perform a simple command such as "raise your right arm." An unconscious person is unable to perceive his or her environment. The second response is the probability of burst suppression. Burst suppression is a state of the brain as measured by an electroencephalograph (EEG) in which the EEG demonstrates the periodic absence of electrical activity. This state is readily demonstrable during the administration of clinical anesthesia for surgical procedures by using available clinical monitors. While burst suppression is easy to measure, it is a state of anesthesia that is deeper than that required for the performance of surgery.
8. I have performed a pharmacokinetic analysis to predict the brain concentration of thiopental in a man weighing 106 kg following the administration of a 3-gram dose of thiopental sodium. I assumed that the thiopental solution was injected at a rate of 50 mg/sec (50 milligrams per second). My pharmacokinetic analysis is attached as Exhibit C. This pharmacokinetic graph shows the predicted concentration of thiopental in the brain of a 106-kg man as a function of time following a dose of 3 grams. The y-axis is the predicted concentration of

thiopental in the brain measured in mcg/mL (micrograms per milliliter). The x-axis is time in minutes. As shown in Exhibit C, after the administration of 3 grams of thiopental sodium, the brain concentration of thiopental would peak at a concentration of about 84 mcg/mL about 3.5 minutes after beginning the injection.

9. The lower dashed line in Exhibit C indicates the brain concentration at which there is an approximately 95% probability of unconsciousness. This predicted concentration is exceeded for more than an hour following the beginning of the injection, assuming that the inmate continued to breathe.
10. The upper dashed line in Exhibit C indicates the brain concentration at which there is an approximately 95% probability of burst suppression. This predicted concentration is exceeded for approximately ten minutes following the beginning of the injection, assuming that the inmate continued to breathe.
11. A dose of 3 grams of thiopental sodium will cause virtually all persons to stop breathing. Thus, although the subsequent administration of pancuronium bromide, a paralytic agent, would have the effect of paralyzing the person and preventing him or her from being able to breathe, virtually every person given 3 grams of thiopental sodium will have stopped breathing prior to the administration of pancuronium bromide. Thus, even in the absence of the administration of pancuronium bromide and potassium chloride, the administration of 3 grams of thiopental sodium by itself would cause death to almost everyone.

12. I have co-authored a recently published article discussing in much greater detail the pharmacology of the medications used in lethal injection. This article is appended as Exhibit D.
13. Therefore, it is my opinion to a reasonable degree of medical certainty that there is an exceedingly small risk that a condemned inmate to whom 3 grams of thiopental sodium is properly administered pursuant to the lethal injection protocol of the State of Washington would experience any pain and suffering associated with the administration of lethal doses of pancuronium bromide and potassium chloride.
14. It is my opinion to a reasonable degree of medical certainty, the proper application of the of the State of Washington lethal injection protocol will result in the condemned inmate undergoing a rapid, painless and humane death, and furthermore, the inmate will not experience any unnecessary pain or suffering.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 3, 2008

By  M.D.
Mark Dershwitz, M.D., Ph.D.

EXHIBIT A
CURRICULUM VITAE
(prepared 3 November 2008)

NAME: Mark Dershwitz

ADDRESS: 33 Wildwood Drive
Sherborn, MA 01770
Telephone (508) 651-1120

PLACE OF BIRTH: Dearborn, MI

EDUCATION:

1974 B.A. cum laude
Chemistry, with Departmental Honors
Oakland University, Rochester, MI 48063

1982 Ph.D. (Pharmacology)
Northwestern University, Evanston, IL 60201

1982 M.D. Northwestern University, Chicago, IL 60611

POSTDOCTORAL TRAINING:

INTERNSHIPS AND RESIDENCIES:

1983 Transitional Resident
Carney Hospital, Boston, MA 02124

1984-1986 Resident in Anesthesia
Massachusetts General Hospital, Boston, MA 02114

RESEARCH FELLOWSHIPS:

1986-1988 Department of Anesthesia
Massachusetts General Hospital, Boston, MA 02114

LICENSURE AND CERTIFICATION:

1984 Massachusetts
1987 American Board of Anesthesiology
1990 Maine
2005 American Board of Anesthesiology, Maintenance of Certification
in Anesthesiology

ACADEMIC APPOINTMENTS:

| | |
|-----------|---|
| 1977-1979 | Lecturer in Pharmacology, Illinois College of Podiatric Medicine |
| 1979-1982 | Lecturer in Pharmacology, Illinois College of Optometry |
| 1984-1987 | Clinical Fellow in Anæsthesia, Harvard Medical School |
| 1987-1990 | Instructor in Anæsthesia, Harvard Medical School |
| 1990-1997 | Assistant Professor of Anæsthesia, Harvard Medical School |
| 1997-2000 | Associate Professor of Anæsthesia, Harvard Medical School |
| 2000- | Professor and Academic Vice Chair of Anesthesiology Professor of Biochemistry & Molecular Pharmacology University of Massachusetts Medical School |

HOSPITAL APPOINTMENTS:

| | |
|-----------|--|
| 1986-1990 | Assistant in Anesthesia, Massachusetts General Hospital |
| 1990-1996 | Assistant Anesthetist, Massachusetts General Hospital |
| 1996-2000 | Associate Anesthetist, Massachusetts General Hospital |
| 2000-2002 | Clinical Associate in Anesthesia, Massachusetts General Hospital |
| 2000- | Anesthesiologist, UMass Memorial Medical Center |

AWARDS AND HONORS:

| | |
|-----------|--|
| 1972 | Michigan Higher Education Association Scholarship |
| 1972-1974 | Oakland University Competitive Scholarship |
| 1973-1974 | National Merit Scholarship |
| 1979 | American Society for Pharmacology and Experimental Therapeutics Travel Award |
| 1981 | Biophysical Society Samuel A. Talbot Award |
| 1982 | Alpha Omega Alpha Research Award |
| 1986-1988 | NIH National Research Service Award |
| 2001 | Distinguished Alumnus Award Oakland University Department of Chemistry |
| 2002 | Outstanding Teacher Award University of Massachusetts Department of Anesthesiology |
| 2003 | Outstanding Medical Educator Award University of Massachusetts Medical School |
| 2003 | Outstanding Teacher Award University of Massachusetts Department of Anesthesiology |
| 2004- | Listed in Who's Who in America |
| 2005 | Teaching Recognition Award, Honorable Mention International Anesthesia Research Society |

MEMBERSHIPS IN PROFESSIONAL SOCIETIES:

Association of University Anesthesiologists
 American Society of Anesthesiologists
 American Society for Pharmacology and Experimental Therapeutics
 American Society for Clinical Pharmacology and Therapeutics
 International Anesthesia Research Society
 Biophysical Society
 International Society for Anesthetic Pharmacology
 Massachusetts Medical Society
 Anesthesia History Association

RESEARCH INTERESTS:

Intravenous anesthetics
 Antiemetics
 Monitoring depth of anesthesia
 Malignant hyperthermia

RESEARCH FUNDING:

| | |
|-----------|---|
| 1986-1988 | National Institutes of Health GM11656 (PI) The role of glutathione in malignant hyperthermia |
| 1988-1989 | Anaquest, Inc. (PI) Comparison of the sedative effects of midazolam and butorphanol |
| 1989-1990 | Glaxo, Inc. (Co-I) A randomized, double-blind comparison of intravenous ondansetron and placebo in the prevention of postoperative nausea and vomiting in female patients undergoing abdominal gynecological surgical procedures |
| 1990-1991 | Glaxo, Inc. (Co-I) A randomized, double-blind, placebo-controlled study of the effects of two dose levels of intravenous ondansetron on respiratory depression induced by alfentanil in healthy male volunteers |
| 1991-1992 | Glaxo, Inc. (Co-I) A dose finding and comparative trial of GI87084B and alfentanil for anesthesia maintenance |
| 1992-1993 | Glaxo, Inc. (Co-I) Pharmacokinetics and pharmacodynamics of GI87084B in subjects with hepatic impairment compared to subjects with normal hepatic function |

- 1993-1994 Marion Merrell Dow, Inc. (PI)
A randomized, double-blind, placebo-controlled, dose response trial to assess single dose intravenous dolasetron mesylate in patients experiencing postoperative nausea and vomiting
- 1993-1994 Marion Merrell Dow, Inc. (PI)
A randomized, double-blind, placebo-controlled, dose response trial to assess single dose intravenous dolasetron mesylate in preventing postoperative nausea and vomiting
- 1993-1994 Glaxo, Inc. (Co-I)
Pharmacokinetics and pharmacodynamics of GI87084B in subjects with renal impairment compared to subjects with normal renal function
- 1995-1996 Glaxo, Inc. (PI)
A randomized, double-blind, dose-response study of ondansetron in the prevention of postoperative nausea and vomiting in inpatients
- 1996-1997 Aradigm Corporation (Co-I)
Comparison of the pharmacokinetics and pharmacodynamics of inhaled versus intravenous morphine sulfate in healthy volunteers
- 1999-2000 Searle, Inc. (PI)
Clinical Protocol for a Double-blind, Placebo-Controlled, Randomized Study of the Efficacy of Parecoxib 20 mg IV and Parecoxib 40 mg IV Given Postoperatively to Determine Narcotic-Sparing Effectiveness in a Post-General Surgery Pain Model

CLINICAL RESPONSIBILITIES:

- 1986-1988 Attending Anesthesiologist (20% clinical responsibility)
Massachusetts General Hospital
- 1988-2000 Attending Anesthesiologist (50% clinical responsibility)
Massachusetts General Hospital
- 1994-1997 Team Leader, East-West Anesthesia Service
Massachusetts General Hospital
- 1997-2000 Team Leader, General Surgery Anesthesia Service
Massachusetts General Hospital
- 2000- Attending Anesthesiologist (45% clinical responsibility)
UMass Memorial Medical Center

TEACHING EXPERIENCE:

| | |
|-----------|--|
| 1976-1980 | Dental Hygiene Pharmacology Northwestern University Dental School 5 hours and Course Director |
| 1977-1979 | Medical Pharmacology Illinois College of Podiatric Medicine 22 hours and Course Director |
| 1978-1981 | Dental Pharmacology Northwestern University Dental School 3 hours |
| 1979-1982 | General Pharmacology Illinois College of Optometry 20 hours and Course Director |
| 1979-1982 | Ocular Pharmacology Illinois College of Optometry 10 hours and Course Director |
| 1980-1981 | Nursing Pharmacology, Northwestern University 5 hours |
| 1994- | HST 150 Introduction to Pharmacology Harvard-MIT Program in Health, Science and Technology 4 hours |
| 1996- | Harvard Anesthesia Review and Update 1-2 hrs |
| 2001- | Medical Pharmacology University of Massachusetts Medical School 11-16 hrs and Course Co-Director |
| 2007- | Medical Biochemistry University of Massachusetts Medical School 2 hrs |

VISITING PROFESSORSHIPS:

| | |
|--------------------|---|
| April 6-7, 1994: | University of Pennsylvania |
| May 17-18, 1994: | University of North Carolina at Chapel Hill |
| Sept. 20-22, 1994: | State University of New York at Stony Brook |
| April 5-6, 1995: | Albany Medical College |
| May 8-10, 1997: | University of Texas Southwestern Medical Center |
| Dec. 8-9, 1998 | Temple University |
| Dec. 16-17, 1998 | University of Pittsburgh |

COMMITTEE MEMBERSHIPS:

LOCAL:

| | |
|--------|--|
| 2000 - | Pharmacy and Therapeutics Committee UMass Memorial Medical Center |
| 2001 - | Physician Health and Well-Being Committee UMass Memorial Medical Center |
| 2001 - | Educational Policy Committee University of Massachusetts Medical School |
| 2008 - | Ethics Committee University of Massachusetts Medical School |

NATIONAL:

| | |
|------------|---|
| 1999 -2002 | Subcommittee on Anesthetic Action and Biochemistry American Society of Anesthesiologists |
| 2001 - | Subcommittee on Drug Disposition American Society of Anesthesiologists |

EDITORIAL BOARD MEMBERSHIPS:

| | |
|--------|--|
| 2000 - | International Anesthesiology Clinics |
| 2008 - | AccessAnesthesiology (Editor-in-Chief) |

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ORIGINAL REPORTS:

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2. Novak RF, Dershwitz M, Novak FC. Characterization of the interaction of the aromatic hydrocarbons benzene and toluene with human hemoglobin. **Mol. Pharmacol.** 1979; 16:1046-58.
3. Dershwitz M, Novak RF. Lack of inhibition of glutathione reductase by unnitrated derivatives of nitrofurantoin. **Biochem. Biophys. Res. Commun.** 1980; 92:1313-19.
4. Dershwitz M, Novak RF. Lack of inhibition of glutathione reductase by anthracycline antibiotics. **Biochem. Pharmacol.** 1981; 30:676-8.
5. Dershwitz M, Novak RF. Generation of superoxide anion via the interaction of nitrofurantoin with human hemoglobin. **J. Biol. Chem.** 1982; 257:75-9.
6. Dershwitz M, Novak RF. Studies on the mechanism of nitrofurantoin-mediated red cell toxicity. **J. Pharm. Exp. Ther.** 1982; 222:430-4.
7. Dershwitz M, Ts'ao CH, Novak RF. Metabolic and morphologic effects of the antimicrobial agent nitrofurantoin on human erythrocytes *in vitro*. **Biochem. Pharmacol.** 1985; 34:1963-70.
8. Dershwitz M, Sréter FA, Ryan JF. Ketamine does not trigger malignant hyperthermia in susceptible swine. **Anesth. Analg.** 1989; 69:501-3.
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10. Dershwitz M, Sréter FA. Azumolene reverses episodes of malignant hyperthermia in susceptible swine. **Anesth. Analg.** 1990; 70:253-5.
11. Dershwitz M, Rosow CE, Di Biase PM, Zaslavsky A. Comparison of the sedative effects of butorphanol and midazolam. **Anesthesiology** 1991; 74:717-24.
12. Dershwitz M, Sherman EP. Acute myocardial infarction symptoms masked by epidural morphine? **J. Clin. Anesth.** 1991; 3:146-8.
13. Dershwitz M, Rosow CE, Di Biase PM, Joslyn AF, Sanderson PE. Ondansetron is effective in decreasing postoperative nausea and vomiting. **Clin. Pharmacol. Ther.** 1992; 52:96-101.

14. Dershwitz M, Di Biase PM, Rosow CE, Wilson RS, Sanderson PE, Joslyn AF. Ondansetron does not affect alfentanil-induced ventilatory depression or sedation. *Anesthesiology* 1992; 77:447-52.
15. McKenzie R, Sharifi-Azad S, Dershwitz M, Miguel R, Joslyn A, Tantisira B, Rosenblum F, Rosow C, Downs J, Bowie J, Odell S, Lessin J, Di Biase P, Nations M. A randomized, double-blind pilot study examining the use of intravenous ondansetron in the prevention of postoperative nausea and vomiting in female inpatients. *J. Clin. Anesth.* 1993; 5:30-6.
16. Dershwitz M, Randel GI, Rosow CE, Fragen RJ, Connors PM, Librojo ES, Shaw DL, Peng AW, Jamerson BD. Initial clinical experience with remifentanyl, a new opioid metabolized by esterases. *Anesth. Analg.* 1995; 81:619-23.
17. Dershwitz M, Hoke JF, Rosow CE, Michałowski P, Connors PM, Muir KT, Dienstag JL. Pharmacokinetics and pharmacodynamics of remifentanyl in volunteer subjects with severe liver disease. *Anesthesiology* 1996; 84:812-20.
18. Dershwitz M, Rosow CE. The pharmacokinetics and pharmacodynamics of remifentanyl in volunteers with severe hepatic or renal dysfunction. *J. Clin. Anesth.* 1996; 8:88S-90S.
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PROCEEDINGS OF MEETINGS:

1. Kharasch ED, Dershwitz M, Novak RF. Differential hemeprotein involvement in microsomal and red cell lysate quinone and nitro group reduction. In: Sato R, Kato R, eds. *Microsomes, Drug Oxidations, and Drug Toxicity*. New York: Wiley Interscience, 1982:237-8.

BOOKS:

1. Stelmack TR, Dershwitz M. **Manual for the Use of Pharmaceutical Agents for Ocular Diagnostic Purposes**, ICO Press, Chicago, 1980.
2. Dershwitz M, ed. **The MGH Board Review of Anesthesiology**. 4th ed. Norwalk, CT: Appleton & Lange, 1994.
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EXHIBIT B

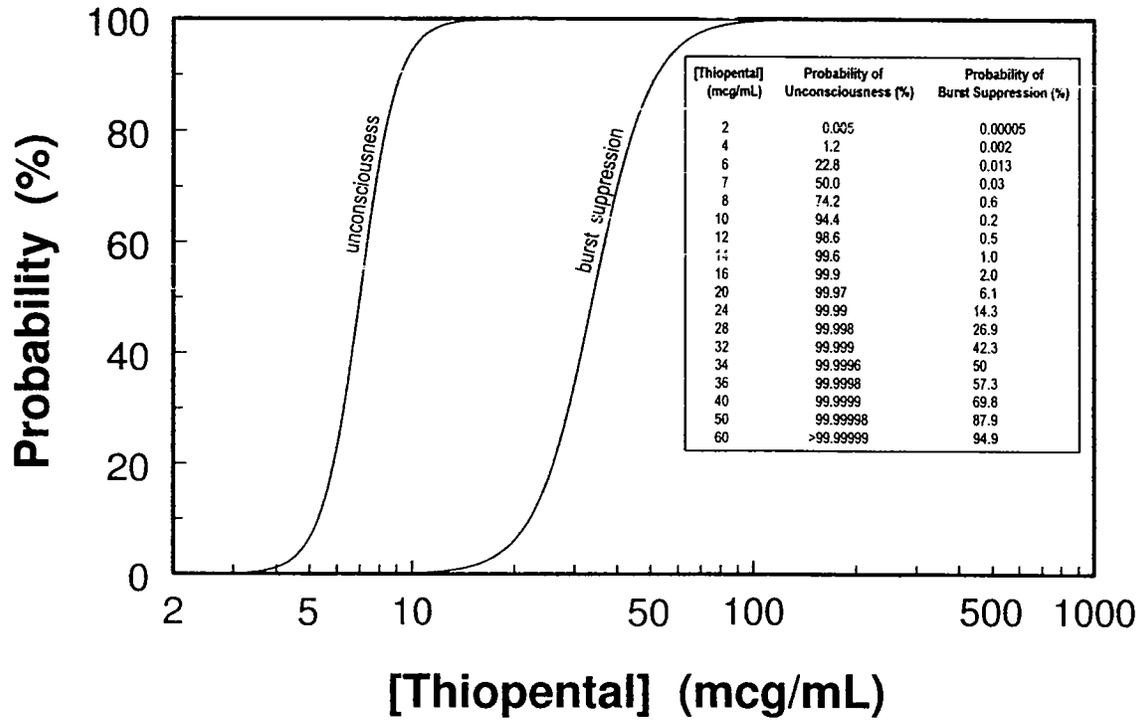


EXHIBIT C

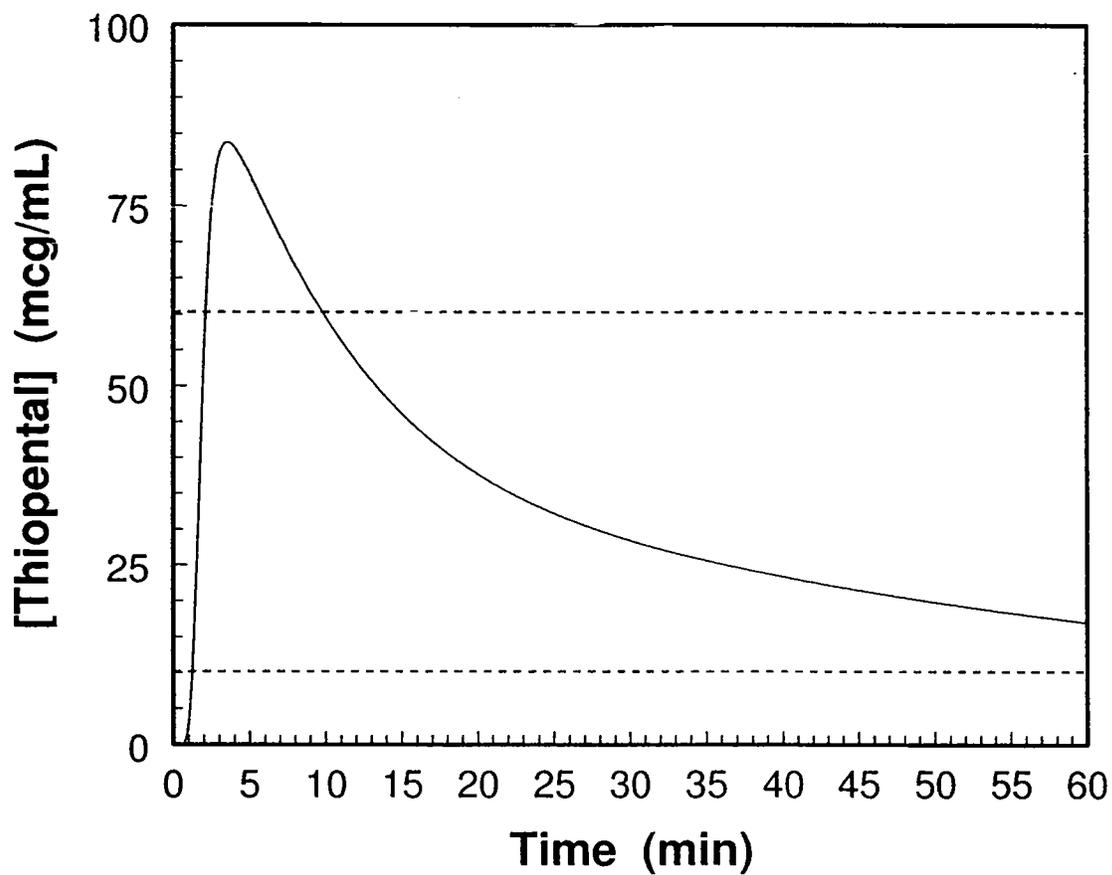
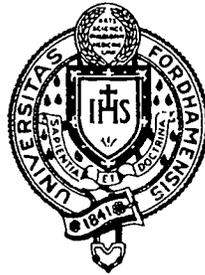


Exhibit D

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THE PHARMACOKINETICS AND PHARMACODYNAMICS OF THIOPENTAL AS USED IN LETHAL INJECTION

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Thiopental (sometimes called, although inaccurately, Sodium Pentothal) was the most commonly used intravenous anesthetic agent for about fifty years, beginning in the mid-1940s.¹ As states began to discuss and develop protocols for lethal injection in the 1970s, thiopental was the logical choice as the medication to render the inmate unconscious prior to the administration of subsequent medications, most commonly pancuronium (a medication that paralyzes skeletal muscle and results in cessation of breathing) followed by potassium chloride (a salt that is a necessary component of the diet but when given intravenously in large doses results in the cessation of electrical activity in the heart).

It is virtually unanimously accepted by physicians, particularly anesthesiologists, that the administration of lethal doses of pancuronium and/or potassium chloride to a conscious person would result in extreme suffering. For this reason, all of the protocols for lethal injection that we have reviewed precede the administration of pancuronium and potassium chloride with a dose of thiopental intended to render the inmate unconscious for a period of time far in excess of that necessary to complete the execution.² When implemented as written, meaning the correct doses of the correct medications are administered in the correct order into a properly functioning intravenous delivery system and with sufficient time for thiopental to produce its effect, all of the protocols we have reviewed are intended to result in the rapid death of the inmate without undue pain or suffering.

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1. See A.S. Evers et al., *General Anesthetics*, in GOODMAN & GILMAN'S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 341, 342 (Laurence L. Brunton et al. eds., McGraw-Hill, 11th ed. 2006).

2. One or both of the authors has reviewed the protocols used by Alabama, Arkansas, California, Delaware, Florida, Georgia, Kentucky, Maryland, Missouri, Montana, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and the federal government.

This paper will concentrate on the pharmacokinetics and pharmacodynamics of thiopental. As applied here, pharmacokinetics is the study of the concentration of thiopental as a function of time in tissues (particularly brain), while pharmacodynamics is the study of the effects of thiopental (particularly the production of unconsciousness and impairment of the heart's ability to circulate blood).³ By using generally accepted computer modeling techniques, and considering the wealth of published studies on the pharmacology of thiopental, we can prepare predictions of such relevant parameters as the onset (how long it takes for the inmate to become unconscious) and duration (how long the inmate would remain unconscious) of the pharmacological effects of thiopental.⁴

Thiopental is usually described as an "ultra-short acting" sedative/hypnotic agent in pharmacology and anesthesiology texts.⁵ This description is semantically correct, but only when thiopental is compared to other barbiturates. Indeed, when thiopental was used to induce (i.e., begin) a general anesthetic, the typical adult dose was about 300 mg and the typical patient would remain unconscious for 5 to 10 minutes.⁶ The usual anesthetic regimen would involve the subsequent administration of anesthetic gases that would keep the patient unconscious for the duration of the surgical procedure. The protocols for lethal injection mandate doses of thiopental ranging from 2000 to 5000 mg, i.e., about seven to sixteen times higher than those used to begin a typical anesthetic.⁷ However, the relationship between the dose of thiopental and its duration of action is *not* linear. For example, as the dose of thio-

3. K.B. Johnson & Talmage D. Egan, *Principles of Pharmacokinetics and Pharmacodynamics: Applied Clinical Pharmacology for the Practitioner*, in ANESTHESIOLOGY 821, 821 (D.E. Longnecker et al. eds., McGraw-Hill 3d ed. 2008).

4. See generally Colin A. Shanks et al., *A Pharmacokinetic-Pharmacodynamic Model for Quantal Responses with Thiopental*, 21 J. PHARMACOKINETICS & BIOPHARMACODYNAMICS 309, 309-21 (1993) (providing the pharmacokinetic model for thiopental and the pharmacodynamic model for burst suppression); see also Robert J. Telford et al., *Fentanyl does not Alter the "Sleep" Plasma Concentration of Thiopental*, 75 ANESTHESIA & ANALGESIA 523, 523-29 (1993) (providing the pharmacodynamic model for unconsciousness).

5. Thiopental is "ultra-short acting" only in comparison to the barbiturates that are classified as "short-acting," "intermediate-acting," and "long-acting." This differentiation is primarily of historical interest. See, e.g., LOUIS S. GOODMAN & ALFRED GILMAN, *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 138 (Macmillan Co., 2d ed. 1955).

6. Mark Dershwitz & C.E. Rosow, *Intravenous Anesthetics*, in ANESTHESIOLOGY, *supra* note 3, at 849, 856.

7. See *supra* note 2 for the list of states whose protocols the authors have reviewed.

pental is increased sevenfold to 2000 mg, the duration of unconsciousness is *not* also increased sevenfold but actually much more, as described later. The pharmacological term "sedative/hypnotic" means that at low doses (e.g. 25 - 100 mg), thiopental causes sedation (i.e., sleepiness), while at higher doses it produces hypnosis (i.e., unconsciousness).⁸ At sedative doses, it produces no analgesia (pain relief) and in fact probably increases the perception of painful stimuli. When a person is rendered unconscious by thiopental, the conscious perception of pain is abolished. The body may, however, react in a reflex manner to pain and exhibit such phenomena as movement, a fast heart rate, sweating, or tearing. Additionally, the state of consciousness produced by a drug is also affected by the strength of applied stimuli. Thus, at the threshold of unconsciousness pain may reverse the state and produce consciousness, making it difficult to distinguish between reflex responses to pain and conscious response. Therefore, it has been argued by some that deep unconsciousness, as defined by burst suppression on the electroencephalogram ("EEG"), be the level of unconsciousness produced in lethal injection.⁹

We will present models to describe the onset and duration of unconsciousness as a function of the dose of thiopental. For example, with the administration of 2000 mg of thiopental to an 80-kg person, loss of consciousness will occur within approximately 1.0 to 1.5 minutes, while duration of unconsciousness will last approximately two hours. The time for onset of burst suppression in the same individual would be approximately 1.5 to 2.5 minutes and would reliably last only seven minutes. Larger doses of thiopental will be shown to result in further prolongation of the duration of unconsciousness and burst suppression.

There is an enormous body of anesthesiology literature supporting the use of mathematical modeling of the pharmacokinetic and pharmacodynamic behavior of intravenous anesthetic agents like thiopental.¹⁰ Such modeling underlies the commonly utilized tech-

8. Dershwitz & Rosow, *Intravenous Anesthetics*, *supra* note 6, at 850.

9. See Testimony of Thomas K. Henthorn, Taylor vs. Crawford et al., No. 05-4173-CV-S-FJG, 2006 WL 1779035, slip op at *7 (W.D. Mo. June 26, 2006).

10. See, e.g., such comprehensive review articles and book chapters as: Dershwitz & Rosow, *supra* note 6, at 849-68; J. Sear, *Total Intravenous Anesthesia*, in ANESTHESIOLOGY, *supra* note 3, at 897, 897-917; Thomas K. Henthorn, *The Effect of Altered Physiological States on Intravenous Anesthetics*, 182 HANDB. EXP. PHARMACOL. 363, 363-77 (2008); Thomas K. Henthorn, *Recirculatory Pharmacokinetics: Which Covariates Affect the Pharmacokinetics of Intravenous Agents?*, 523 ADV. EXP. MED. BIOL. 27, 27-33 (2003); Harmut Derendorf et al., *Pharmacokinetic/Pharmacodynamic Modeling in Drug research and Development*, 40 J. CLIN. PHARMACOL. 1399, 1399-

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nique of target-controlled intravenous drug infusions. Mathematical modeling of intravenous anesthetics has been extensively studied and has been validated in the real world practice of target-controlled infusions ("TCI").¹¹ TCI couples a small computer with an infusion pump so that multi-compartment models are used to predict and adjust anesthetic drug infusion rates on a second-by-second basis to reach and maintain plasma concentrations determined by the practitioner.¹² TCI devices are in common use in anesthetic practice worldwide. Median absolute performance errors for TCI of predicted versus actual drug concentrations are in the range of $\pm 30\%$ when literature values for pharmacokinetic parameters are used to drive the TCI device.¹³ Therefore, similar errors can be expected when applying the simulations presented here to any given individual. Thus the methodology employed in performing the pharmacological simulations employed herein has undergone peer review and its application to the actual practice of anesthesia is well studied.

I. THE ONSET TIMES FOR THIOPENTAL ADMINISTERED AT VARIOUS RATES

No drug, including thiopental, has an effect the moment it is injected. It must first be transported by circulating blood to the site of action, i.e., the brain in the case of thiopental. The drug must then cross the blood-brain barrier to reach drug receptors in the neural cells of the brain. The drug-receptor interaction then triggers a cellular response resulting in the drug effect. As thiopental concentrations at the site of action continue to rise, more intense drug responses are seen. The interval between injecting the drug, and seeing an effect, i.e. the process of accumulating adequate drug concentrations in the blood and subsequently the brain, is called hysteresis.¹⁴ A good way to think about hysteresis is to compare it to using a stove. Turning the flame on is akin to injecting the drug; transporting the heat to the surface of the pan is analogous to the

1418 (2000); D.R. Stanski, *Pharmacodynamic Modeling of Anesthetic EEG Drug Effects*, 32 ANNU. REV. PHARMACOL. TOXICOL. 423, 423-47 (1992).

11. See Talmage D. Egan, *Target-Controlled Drug Delivery: Progress Toward an Intravenous "Vaporizer" and Automated Anesthetic Administration*, 99 ANESTHESIOLOGY 1214, 1215 (2003).

12. *Id.*

13. See *id.* at 1216-17; see also Robert A. Veselis et al., *Performance of Computer-Assisted Continuous Infusion at Low Concentrations of Intravenous Sedatives*, 84 ANESTHESIA & ANALGESIA 1049, 1053-57 (1997).

14. Johnson & Egan, *supra* note 3, at 825.

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circulation delivering the drug to the site of action; and cooking the food in the pan is akin to producing the drug effect. Your dinner can range from undercooked to well done, depending on how long it's exposed to the flame "dose" the stove is delivering. Similarly the heating effect continues for some time even after the flame is turned off. Therefore, with hysteresis it is possible to have the same effect at two different plasma drug concentrations just as it is possible for a pan to be at the same temperature at two different flame settings, once during heating and again during cooling. Pharmacokinetic-pharmacodynamic modeling is able to mathematically describe this hysteresis and fully explain how the same blood drug concentration can produce variable effects.¹⁵

In a lethal injection setting, once an injection of thiopental has begun, the drug must pass through the IV tubing from the "injection room" to the "death chamber" before reaching the vein of the condemned inmate. For instance, if the tubing is ten feet long with a typical tubing volume of 1.8 mL/foot, then the total volume is 18 mL. Assuming fluid traveling in a tube as a perfect cylinder and an injection speed of 2 mL/sec, it would take a full 9 seconds for the drug to reach the vein.

After entering the bloodstream the drug must circulate with the blood to reach the brain before concentrations at the site of effect can begin to rise. Depending on where the intravenous catheter is placed in the inmate, it could take up to 15 seconds for the drug to reach the right-sided chambers of the heart and thus be considered within the central circulation where the flow of blood is at its greatest. From the right side of the heart, the blood flows through the pulmonary arteries to the capillaries of lungs, recollects in the pulmonary veins and flows back to the left side of the heart. The powerful left ventricle of the heart then pumps the blood out through the aortic arch into all of the arteries of the body, including the carotid and vertebral arteries leading to the brain.

The principles governing the time required for an injected drug to pass through IV tubing to reach the vein also apply to the drug within the bloodstream. That is, the time elapsed is directly related to the volume of the system and the flow rate of the fluid in the system. The volume of the central circulation as a percentage of the body's total blood volume is near maximum when lying flat, approximately one third of the total blood volume or 1.7 L for the typical male inmate. It would be higher tilted head down and

15. See generally *id.* at 825.

lower when standing. In a sedated adult it would be reasonable to assume a total blood flow (or cardiac output) of 5 L/min. Thus the time required for drug just arriving in the right side of the heart to pass through the central circulation to reach the brain would be 1.7 L divided by 5 L/min, which is approximately 20 seconds.

Adding the 15 seconds for venous transit (times vary greatly with the distance from the heart and the flow in the particular vein selected for the intravenous catheter) to the 20 seconds for central circulation transit, one can appreciate the concept of arm-brain circulation time, which is empirically spoken of among anesthesiologists as being approximately one-half minute. Again, there will be an additional 9 seconds or so added to time required to see the initial thiopental response due to the very long length of intravenous tubing leading from the "injection room" to the "death chamber."

In the fluid medium of the body, drug diffuses from areas of high concentration to adjacent areas where the concentration is lower. During the onset of effect, thiopental diffuses from the blood where the concentrations become quite high, after the initial 35 seconds required for transit, into the brain where the thiopental concentration starts at zero. Without continued thiopental administration, diffusion continues in this direction for approximately 2.5 minutes, at which time blood and brain concentrations are momentarily equal. Then diffusion reverses direction and the drug begins to move from the brain back into the blood. Brain concentrations will continue to fall at a rate governed by the decrease in blood concentrations since brain concentrations will never fall below those of the blood during this phase. Figure 1 depicts the probability of unconsciousness or burst suppression as a function of the brain concentration of thiopental.

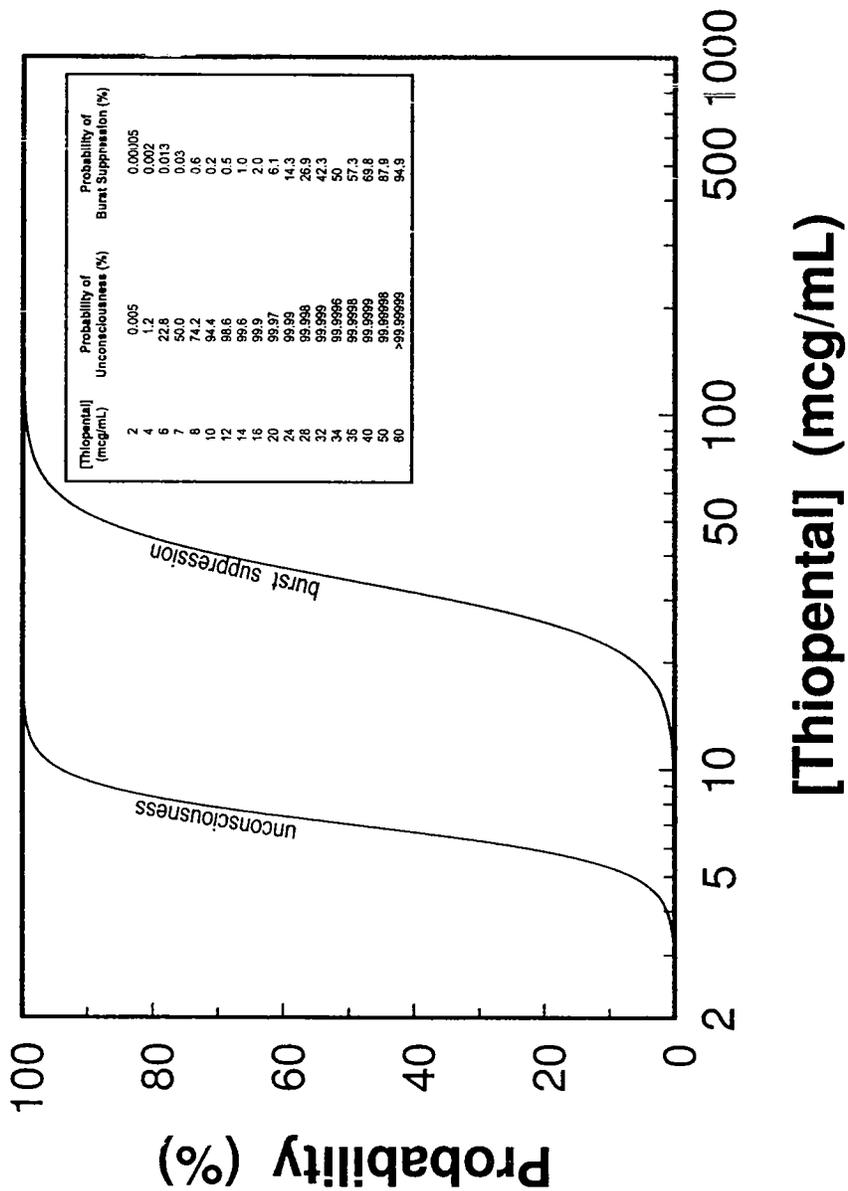


Figure 1: The probability that a person will experience unconsciousness or burst suppression on the EEG as a function of the brain concentration of thiopental. Note that the x-axis is shown as a logarithmic scale for clarity.¹⁶

16. See, e.g., *supra* note 4 and accompanying text.

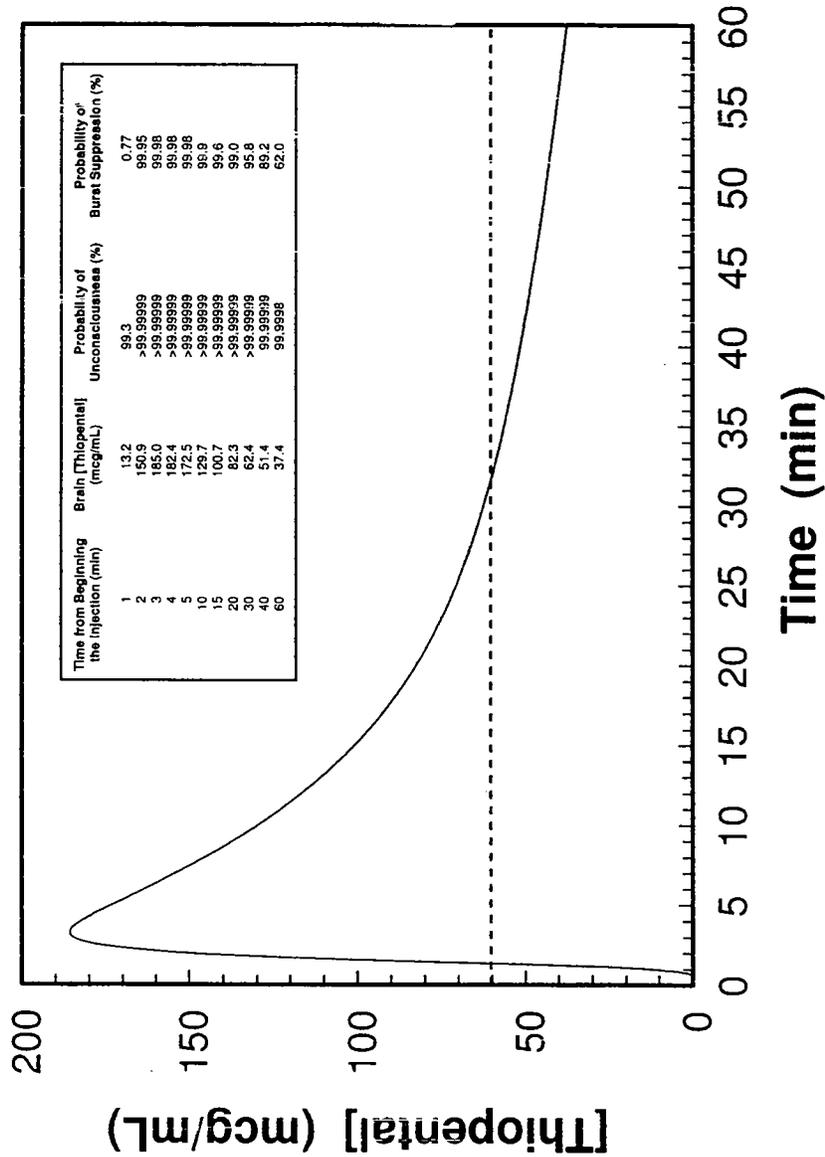


Figure 2: The predicted brain concentration of thiopental following the administration of a dose of 5000 mg given at a rate of 167 mg/sec to an average 80-kg person. The dashed line indicates the brain concentration above which 95% of persons will experience burst suppression on the EEG.¹⁷

17. See Dershwitz & Rosow, *supra* note 6, at 850.

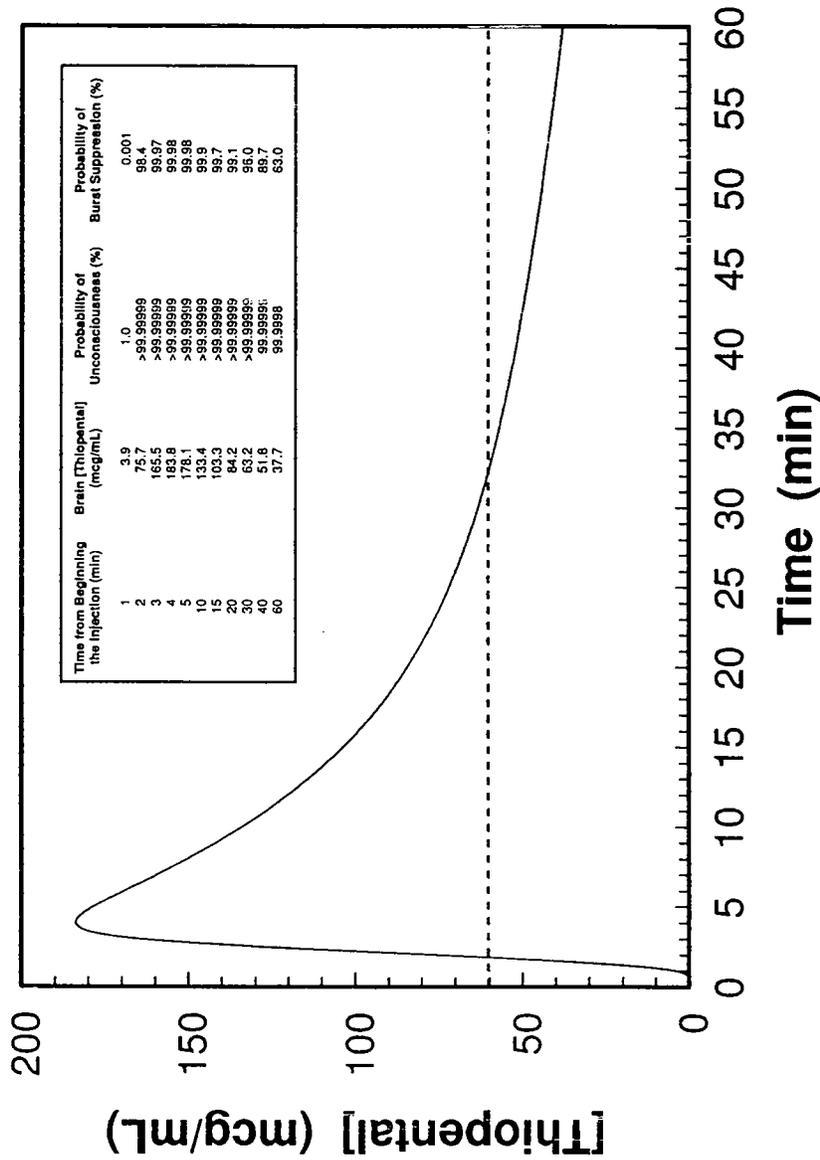


Figure 3: The predicted brain concentration of thiopental following the administration of a dose of 5000 mg given at a rate of 50 mg/sec to an average 80-kg person. The dashed line indicates the brain concentration above which 95% of persons will experience burst suppression on the EEG.¹⁸

18. The pharmacodynamic model for unconsciousness is in Telford et al., *supra* note 4, at 523-29. See Shanks et al., *supra* note 4, at 309-21 for the pharmacodynamic model for burst suppression.

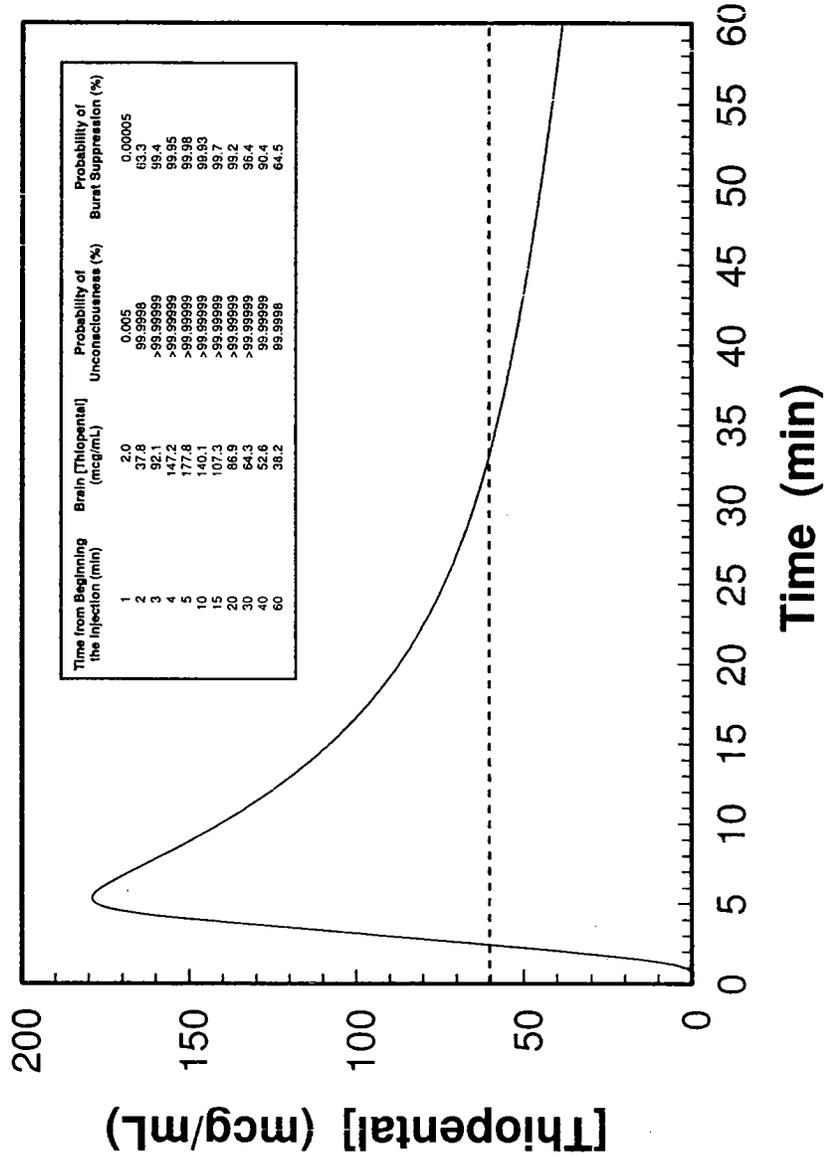


Figure 4: The predicted brain concentration of thiopental following the administration of a dose of 5000 mg given at a rate of 25 mg/sec to an average 80-kg person. The dashed line indicates the brain concentration above which 95% of persons will experience burst suppression on the EEG.¹⁹

19. The pharmacokinetic model for thiopental used in Figures 2-8 is in Shanks et al., *supra* note 4, at 309-21.

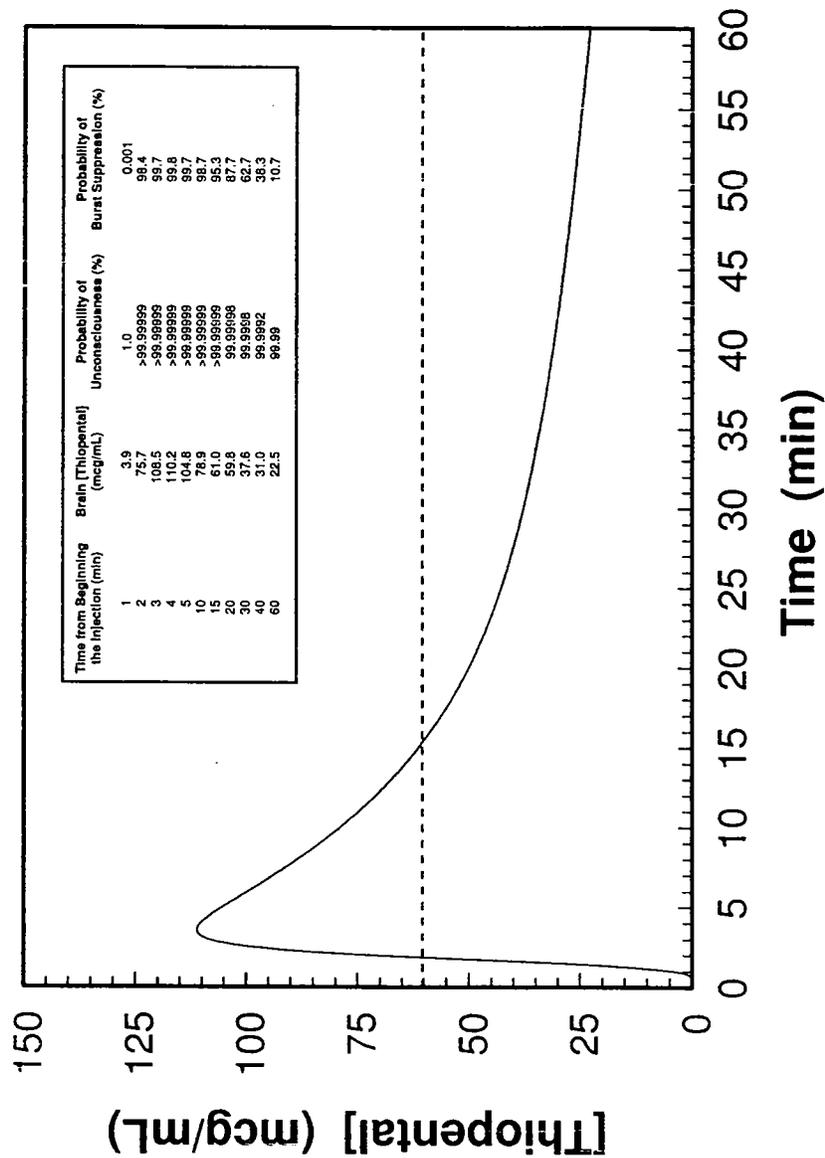


Figure 5: The predicted brain concentration of thiopental following the administration of a dose of 3000 mg given at a rate of 50 mg/sec to an average 80-kg person. The dashed line indicates the brain concentration above which 95% of persons will experience burst suppression on the EEG.²⁰

20. See *id.*

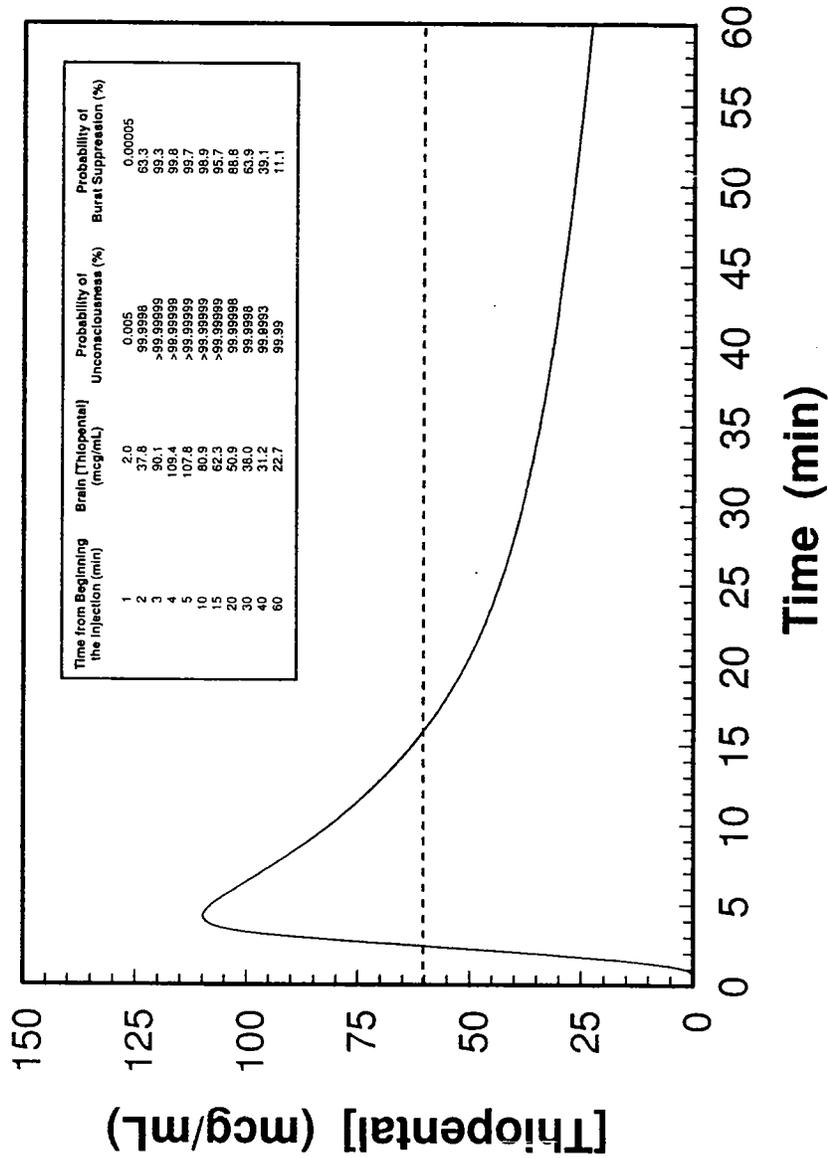


Figure 6: The predicted brain concentration of thiopental following the administration of a dose of 3000 mg given at a rate of 25 mg/sec to an average 80-kg person. The dashed line indicates the brain concentration above which 95% of persons will experience burst suppression on the EEG.²¹

21. See id.

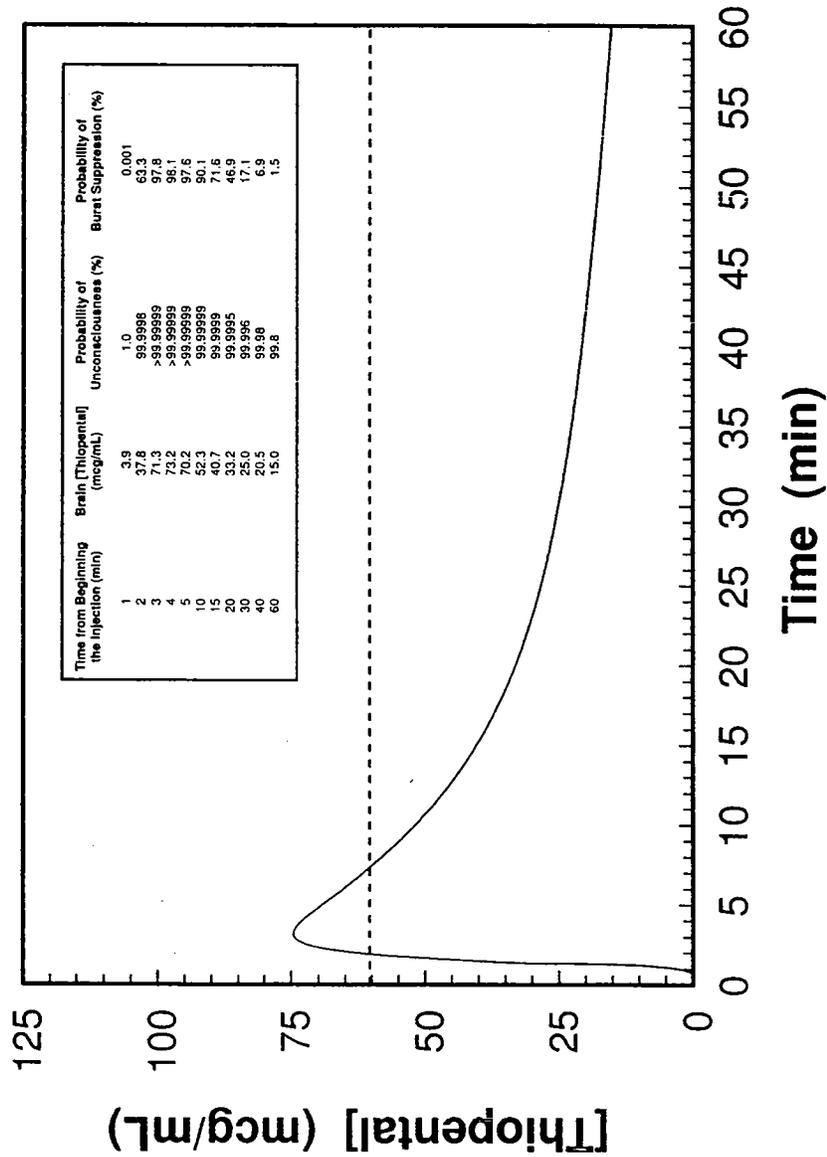


Figure 7: The predicted brain concentration of thiopental following the administration of a dose of 2000 mg given at a rate of 50 mg/sec to an average 80-kg person. The dashed line indicates the brain concentration above which 95% of persons will experience burst suppression on the EEG.²²

22. See *id.*

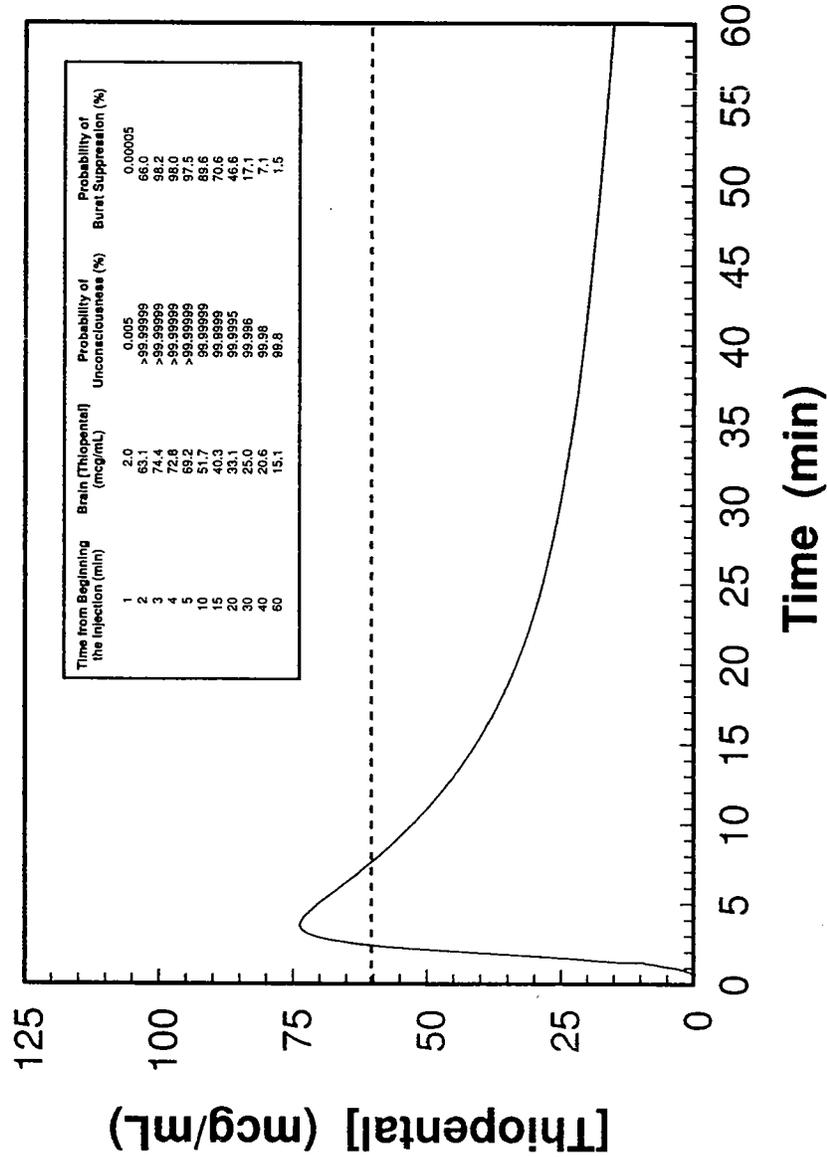


Figure 8: The predicted brain concentration of thiopental following the administration of a dose of 2000 mg given at a rate of 25 mg/sec to an average 80-kg person. The dashed line indicates the brain concentration above which 95% of persons will experience burst suppression on the EEG.²³

23. See *id.*

| Injection Rate (mg/sec) | Time to 95% probability of unconsciousness (min, normal C.O.) | Time to 95% probability of burst suppression (min, normal C.O.) | Time to 95% probability of unconsciousness (min, C.O. ↓ by 75%) | Time to 95% probability of burst suppression (min, C.O. ↓ by 75%) |
|-------------------------|---|---|---|---|
| 25 | 1.6 | 2.6 | 2.3 | 3.1 |
| 50 | 1.4 | 2.1 | 2.0 | 2.7 |
| 167 | 1.1 | 1.5 | 1.8 | 2.2 |

These principles along with published data regarding the timing of drug onset can be used to construct models to simulate the onset of thiopental effect from any given dose or injection speed.²⁴ Figures 2 to 8 depict the onset of thiopental effect to the endpoints of unconsciousness and burst suppression for 2000 mg, 3000 mg, and 5000 mg doses at varying injection speeds. Since the onset of effect is rate-limited by blood circulation and diffusion, injection speed matters little. The table above shows the times required, from the beginning of the injection process, to reach a 95% probability of unconsciousness or burst suppression as a function of the injection rate for a 5000-mg dose. The standard solution of thiopental as used clinically is a 2.5% solution, or 25 mg/mL.²⁵ Therefore, injecting this solution at a rate of 1 mL/sec or 2 mL/sec yields injection rates of 25 mg/sec and 50 mg/sec, respectively. An injection rate of 167 mg/sec (6.7 mL/sec) is achieved by administering a 5000-mg dose over 30 seconds.

Since a 5000-mg dose of thiopental is expected to produce a substantial decrease in the cardiac output (C.O.),²⁶ the table also shows how the times to reach a 95% probability of unconsciousness or burst suppression are prolonged by a 75% decrease in cardiac output.

II. THE DURATION OF THIOPIENTAL FOLLOWING VARIOUS DOSES

We shall now consider the *duration* of the effect of the thiopental once it has been administered. The duration of its action should exceed the amount of time required to administer the remaining

24. *See id.*

25. *See id.*

26. *See infra* notes 28-29 and accompanying text.

medications as well as the time required for the potassium chloride to stop the inmate's heart and to cause his or her death.

The amount of time required to administer all of the medications will depend on the doses specified by the protocol as well as the speed of the injection (i.e. how rapidly the executioner injects each syringe) as well as allowing some time to change syringes by removing one from the intravenous tubing and replacing it with the next one. The following hypothetical three-drug protocol involves using doses at the high end of those used by the various states:

- thiopental, 5000 mg (25 mg/mL, 200 mL)
- saline flush, 50 mL
- pancuronium, 100 mg (1 mg/mL, 100 mL)
- saline flush, 50 mL
- potassium chloride, 240 mEq (2 mEq/mL, 120 mL)
- saline flush, 50 mL

The largest commercially-available syringes used in medicine are 60 mL. The above protocol therefore requires eleven syringes. Assuming ten seconds for each syringe change, the total time to change syringes is 100 seconds. Considering the size of the syringes used (it becomes harder to push the plunger of a syringe as its diameter increases) and the length of the intravenous tubing required to go from the "injection room" to the "death chamber," it is difficult to inject such syringes at a rate greater than 2 mL/sec (or 50 mg/sec when the standard 2.5% solution is used). On the other hand, there is no reason to inject more slowly than 1 mL/sec, so the total volume of the drugs and flushes as listed above, 570 mL, should require no more than approximately eleven minutes to inject.

The potassium chloride should cause cessation of cardiac electrical activity within two minutes of its injection (although see below for a discussion on the effects of thiopental on cardiac output). Therefore, a time period of fifteen minutes should be more than enough to complete an execution, from the beginning of the injection of the thiopental until cessation of electrical activity. Some states mandate a period of time, e.g. five minutes, of continuous electrical inactivity on the electrocardiogram ("ECG"), but that additional time does not need to be considered here.²⁷

27. North Carolina, for example, requires such a five-minute period of electrical inactivity prior to the pronouncement of death. See North Carolina Department of Correction, Execution Method, <http://www.doc.state.nc.us/dop/deathpenalty/method.htm> (last visited Apr. 15, 2008).

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Figures 2 through 4 depict the predicted concentration of thiopental in the brain following a dose of 5000 mg given at various rates of injection. Referring to Figures 2 to 4, it is apparent that fifteen minutes following the beginning of the thiopental injection, an average person will have essentially a 100% probability of being unconscious and having burst suppression on the EEG. These probabilities are not affected by the speed of the injection.

Figures 5 and 6 depict the predicted brain concentration of thiopental following a dose of 3000 mg given at a rate of 25 mg/sec (1 mL/sec) or 50 mg/sec (2 mL/sec). Fifteen minutes following the beginning of the thiopental injection, an average person will have essentially a 100% probability of being unconscious and about a 95% probability of having burst suppression on the EEG. These probabilities are not affected by the speed of the injection.

Figures 7 and 8 depict the predicted brain concentration of thiopental following a dose of 2000 mg given at a rate of 25 mg/sec (1 mL/sec) or 50 mg/sec (2 mL/sec). The 2000-mg dose of thiopental requires less time to inject than the 5000-mg dose (40 seconds vs. 100 seconds using an injection rate of 50 mg/sec). It will also have a lesser effect in decreasing cardiac output permitting the potassium chloride to circulate more quickly. With the 2000-mg dose, the time required to complete the injection and achieve cardiac arrest will be approximately 7 to 10 minutes with injection rates of 25-50 mg/sec and an additional two minutes to observe cardiac arrest on the ECG. At these time points, a person will have essentially a 100% probability of being unconscious, and a 90-95% probability of having burst suppression on the EEG.

III. OTHER EFFECTS OF THIOPENTAL

The aforementioned predictions of duration of unconsciousness are based upon the persons continuing to breathe (or have their breathing assisted as during surgery). The doses of thiopental used in lethal injection will cause most persons to stop breathing and to have their blood pressures substantially decreased.²⁸ Thus, even in the absence of the administration of pancuronium and/or potassium chloride, doses of thiopental of 2000 mg and above will be lethal in most persons due to the impairment of delivery of oxygen to critical organs such as the heart and brain. The largest dose of thiopental used in clinical medicine, about 3000 mg, is occasionally used for "brain protection" when there is the planned and deliber-

28. See generally, Dershwitz & Rosow, *supra* note 6, at 853.

ate interruption of blood flow to the brain.²⁹ Such an interruption of blood flow may occur during certain brain surgeries to repair an aneurysm or arteriovenous malformation. During such surgical procedures, patients are mechanically ventilated so that the effect of thiopental on ventilation is not relevant. However, a dose of 3000 mg of thiopental will decrease the cardiac output and the blood pressure to a dramatic, and dangerous, degree. Such patients require the aggressive administration of medications to maintain adequate blood pressure and oxygen delivery to organs. While neither of us, nor any other physician we know, has ever given a 3000-mg dose of thiopental to a patient who was not mechanically ventilated nor had his or her circulation supported, it is difficult for us to imagine that the administration of 3000 mg of thiopental to an inmate, by itself, is survivable.

We are unaware of any indication in clinical medicine in which a 5000-mg dose of thiopental is given to an 80-kg patient. The negative cardiac effects of such a huge dose of thiopental are necessarily larger than those following a 3000-mg dose. In fact, there is circumstantial evidence that a 5000-mg dose of thiopental may have caused, in some inmates, virtual cessation of the circulation. California is one of the states that uses a 5000-mg dose of thiopental as well as an ECG to monitor the electrical activity of the heart. There have been several executions in California in which a second dose of potassium chloride was given, as mandated by the protocol, because cessation of electrical activity on the ECG did not occur after the first dose.³⁰ One possible explanation is that the potassium chloride was not injected through a working intravenous catheter. Another more plausible explanation is that the potassium chloride did not circulate to the heart from the site of the intravenous injection.

IV. ASSESSING THE PRESENCE OR ABSENCE OF CONSCIOUSNESS

As previously described, all of the lethal injection protocols that we have reviewed are intended to render the inmate unconscious prior to the administration of pancuronium and potassium chloride

29. See W.A. Kofke, *Protection of the Central Nervous System in Surgical Patients*, in *ANESTHESIOLOGY*, *supra* note 3, at 1939-40.

30. For example, the execution log of Robert L. Massey, who was executed on March 27, 2001, indicates he was given a second dose of potassium chloride five minutes after the first dose failed to produce a flat ECG, and the execution log of Stephen Wayne Anderson who was executed on January 29, 2002, indicates he was given a second dose of potassium chloride four minutes after the first dose failed to produce a flat ECG.

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and to maintain unconsciousness until death occurs.³¹ The greatest risk to the inmate, in terms of the humaneness of an execution, is the administration of pancuronium and/or potassium chloride to an inmate who is conscious. Based upon the history of those executions that did not go as intended, the most frequent problem in such executions has been an intravenous catheter that was not actually within a vein.³²

If the intravenous catheter was not positioned correctly from the beginning, all of the medications will be delivered to the subcutaneous tissues and the inmate will not lose consciousness as rapidly as expected. A less plausible, but still possible, scenario is one in which the thiopental is delivered subcutaneously but then the intravenous catheter begins functioning properly and the remaining medications are delivered intravenously. In such a scenario, the inmate could be conscious and experience the paralytic effects of pancuronium and the pain associated with the injection of potassium chloride.

Such a risk could be lessened if the inmate were demonstrated to be unconscious following the administration of thiopental and before the administration of the pancuronium and potassium chloride. This sort of assessment is mandated by some protocols and makes use of either a physical examination or an EEG monitor.³³

Assessing the *depth* of anesthesia is a complex examination requiring both significant training and experience, which is obligatory in clinicians who administer anesthesia. Assessing the *presence of unconsciousness*, in contrast, is something many paramedical personnel do routinely. Such an examination typically involves the application of graded stimuli and the assessment of the response to:

- a spoken command (e.g. "open your eyes")
- a tactile reflex (e.g. gently stroking an eyelash)
- gentle shaking
- a noxious stimulus (e.g. a strong pinch)

31. See *supra* note 2 and accompanying text.

32. The executions of Joseph Clark on May 2, 2006, in Ohio and of Angel Diaz on December 13, 2006, in Florida were characterized by prolonged periods following the administration of thiopental during which the inmates did not lose consciousness as would have been expected had the medication been introduced intravenously.

33. For example, the protocols used by Missouri and the federal government include an assessment of consciousness by physical examination. The protocol used by North Carolina employs a type of EEG monitor. See, e.g., Connor v. N.C. Council of State, Nos. 07-GOV-0238, 07-GOV-0264 (N.C.O.A.H. Aug. 9, 2007) (describing North Carolina's lethal injection protocol).

The lack of any response to these graded stimuli is strong evidence that a person is indeed unconscious.

One state, North Carolina, uses the bispectral index ("BIS") monitor in its lethal injection protocol.³⁴ This is a type of EEG monitor commonly used by anesthesiologists to assess the depth of anesthesia and decrease the incidence of intraoperative awareness.³⁵ It involves placing an electrode array on the forehead and connecting these electrodes to the monitor. Although the monitor displays much neurophysiological information, the parameter of greatest interest is the bispectral index, or BIS. This is a dimensionless number that ranges from zero to 100.³⁶ Zero corresponds to complete electrical inactivity of the EEG (i.e. "flatline") while 100 corresponds to the completely awake state.³⁷ Many clinical studies have shown that a BIS value of 40-60 is associated with a clinically appropriate depth of anesthesia and a very low probability of intraoperative awareness.³⁸

North Carolina has utilized the BIS monitor in several executions. The monitor is viewed by a nurse. The executioner pauses after the administration of thiopental (3000 mg in this state) and awaits a signal from the nurse before giving the pancuronium and potassium chloride. In each execution in which it has been used, the BIS value was 0-10 *before* the thiopental administration was complete.

V. POSTMORTEM DETERMINATION OF THIOPENTAL

Some states routinely perform autopsies on executed inmates and such autopsies may include drawing blood for the measurement of the thiopental concentration.³⁹ Unfortunately, in far too many of these autopsies the blood samples have been improperly

34. See *id.*; *Brown v. Beck*, 2006 U.S. Dist. LEXIS 60084, at *4 (E.D.N.C. Apr. 7, 2006).

35. See Paul S. Myles et al., *Bispectral Index Monitoring to Prevent Awareness During Anaesthesia: The B-Aware Randomised Controlled Trial*, 363 LANCET 1757, 1757 (2004); Y. Punjasawadwong et al., *Bispectral Index for Improving Anaesthetic Delivery and Postoperative Recovery*, 1 THE COCHRANE LIBRARY 1, 2 (2008) (reprinted by The Cochrane Collaboration).

36. See Lee A. Kearsse et al., *Bispectral Analysis of the Electroencephalogram Predicts Conscious Processing of Information During Propofol Sedation and Hypnosis*, 38 ANESTHESIOLOGY 25, 25-34 (1998).

37. *Id.*

38. See Myles et al., *supra* note 35, at 1757, 1763; Punjasawadwong et al., *supra* note 35, at 6.

39. Leonidas G. Koniaris et al., *Inadequate Anaesthesia in Lethal Injection for Execution*, 365 LANCET 1412, 1412-14 (2005).

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obtained and the results have therefore been erroneously interpreted.

Thiopental undergoes postmortem redistribution. This means that the blood concentration of thiopental continues to decrease even after the inmate's death and the cessation of circulation.⁴⁰ There is unfortunately very little information on the postmortem kinetics of thiopental because historically thiopental has been of little importance to forensic toxicologists. There are no peer-reviewed papers in the medical literature that have evaluated the postmortem redistribution of thiopental. Medical examiners in several jurisdictions have drawn paired blood samples following executions in order to assess the presence and degree of post-mortem redistribution.⁴¹ The first blood sample was obtained soon after the execution, while the second blood sample was obtained hours later at the time of autopsy. We are aware of the following sets of paired blood samples that demonstrate that postmortem redistribution of thiopental does indeed occur:

| Jurisdiction | Inmate | Date | [Thiopental] mcg/ mL Obtained soon after death | [Thiopental] mcg/ mL Obtained at autopsy |
|--------------|---------|----------|---|---|
| CT | Ross | 5/13/05 | 29.6 | 9.7 |
| NC | McHone | 11/11/05 | 21 | 1.5 |
| NC | Syriani | 11/18/05 | 12 | 4.4 |
| NC | Boyd | 12/2/05 | 29 | 11 |
| NC | Simpson | 1/20/06 | 42 | 12 |
| MT | Dawson | 8/11/06 | 21 | 3 |

In each case, "soon" after death means that the blood sample was drawn within an hour of completing the execution. Autopsies were performed at various times following the executions, ranging from about seven to eighteen hours.

Some persons have argued that this table represents nothing more than a group of random numbers.⁴² There are indeed *pooled* data that are purported to demonstrate no time-dependent de-

40. See A.L. Pélissier-Alicot et al., *Mechanisms Underlying Postmortem Redistribution of Drugs: A Review*, 27 J. ANAL. TOXICOL. 533, 533-44 (2003).

41. Such postmortem analyses have been performed following executions in Connecticut, Montana, and North Carolina.

42. See generally Susi Vassallo, *Thiopental In Lethal Injection*, 35 FORDHAM URB. L.J. 957 (2008); Teresa A. Zimmers & Leonidas Koniaris, *Peer-reviewed Studies Iden-*

crease in the thiopental concentration in blood following death.⁴³ The table above is, however, the only example of *paired* data in which blood samples were drawn from the *same* inmate at *different* times following death. Applying Student's t-test for paired data to the data in the above table yields a *p* value of 0.0013. The interpretation of this statistical result is that there is a 99.9987% probability of a significant *decrease* in the blood thiopental concentration as a function of time following death by lethal injection where death closely follows a single rapid infusion of the drug and pseudoequilibrium with the majority of the body's tissues did not have time to be completed.⁴⁴ These data confirm the process of postmortem redistribution and would suggest that a rise in blood thiopental concentrations would be seen if similar paired postmortem samples were obtained when death occurred much longer after a dose of thiopental (as might occur in a clinical situation) at a time well after pseudoequilibrium between blood and tissue drug concentrations when the concentration gradient would be expected to be reversed.

In addition to the process of postmortem redistribution, another possible source of misleading postmortem thiopental data is the difference in the concentration of thiopental in arteries and veins. Pathologists most commonly draw postmortem blood samples from the femoral vein in the groin. Located immediately next to the femoral vein is the femoral artery. During life, it is usually easy to locate the femoral artery because it is typically the strongest peripheral pulse in the body. Following death, this landmark is lost. Since the femoral vein has a greater diameter, when a needle is inserted blindly in the groin, the femoral vein is more likely to be entered. However, Figure 9 shows that there may be substantial and clinically meaningful differences between the arterial and venous concentrations of thiopental. Assuming a normal cardiac output, differences between the arterial and venous concentrations of thiopental are expected for approximately four minutes following the beginning of thiopental administration. In contrast, if thiopental were to cause a large decrease in cardiac output (as is expected with the large doses used in lethal injection protocols), the differ-

tifying Problems in the Design and Implementation of Lethal Injection for Execution, 35 FORDHAM URB. L.J. 919 (2008).

43. See Koniaris et al., *supra* note 39, at 1412-14; Teresa A. Zimmers et al., *Authors' Reply, Inadequate Anaesthesia in Lethal Injection for Execution*, 366 LANCET 1073, 1074-76 (2005).

44. See Stanton Glantz, PRIMER OF BIOSTATISTICS 322-25 (McGraw-Hill, 6th ed. 2005).

ence in the arterial and venous concentrations will persist until well after the expected occurrence of death.

The accurate differentiation between the femoral artery (lacking a pulse) and the femoral vein following death requires dissection and visualization of both vessels. Many medical examiners are unwilling to perform such a procedure at a prison on an inmate who has just been executed. Were a state to decide that the acquisition of a blood sample from a known blood vessel is a prudent idea, they might consider hiring a funeral director to perform the procedure. Since the process of embalming involves dissection and visualization of arteries and veins so that the embalming fluid can be injected, funeral directors should readily be able to obtain accurately femoral arterial and femoral venous blood for analysis.

We believe that there should be as much transparency as possible in the lethal injection procedure. Therefore, we support the practice of obtaining postmortem blood samples for thiopental analysis as a routine procedure. It is, however, crucial to obtain the blood sample properly and that means drawing it soon after the inmate's death, preferably within a few minutes and definitely within an hour.

VI. CONCLUSIONS

In summary, our pharmacokinetic and pharmacodynamic predictions of the effects of thiopental as used in the lethal injection protocols we have reviewed suggest that these protocols, if implemented as written, will result in the rapid death of the inmate without undue pain or suffering.

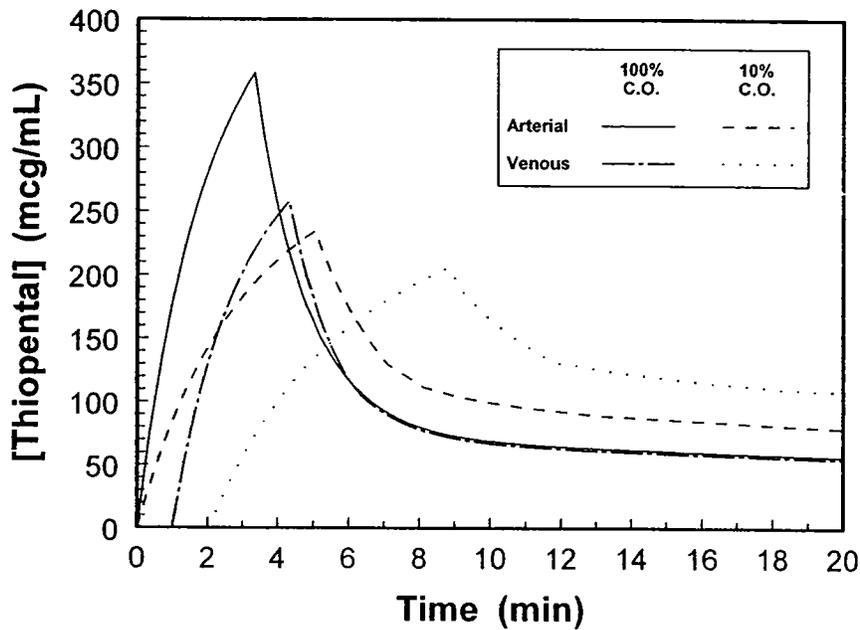


Figure 9: The effect of thiopental-induced decrease in cardiac output on the time course of the arterial and venous concentrations of thiopental. The predicted arterial blood concentration of thiopental following the administration of a dose of 5000 mg given at a rate of 1 mL/sec to an average 80-kg person is depicted by the solid line. The simultaneous venous blood concentration is depicted by (— - —). The two other lines assume a 90% decrement in cardiac output caused by thiopental. The dashed line depicts the predicted arterial concentration, while the dotted line depicts the predicted venous concentration.⁴⁵

Implementing a protocol as written means the correct doses of the correct medications are administered in the correct order into a properly functioning intravenous delivery system and allowing sufficient time for thiopental to produce its effect.

We previously discussed that the cardiovascular and respiratory effects of thiopental given by itself in doses of 2000 mg and above are likely to be lethal in virtually everyone. Much has been written and said about adopting lethal injection protocols that rely on a single drug alone such as thiopental. As clinical pharmacologists, we can describe the advantages and disadvantages in comparing the current three-drug protocol with a protocol consisting of thio-

45. The pharmacokinetic model for thiopental used in Figure 9 is in T.D. Homer & D.R. Stanski, *The Effect of Increasing Age on Thiopental Disposition and Anesthetic Requirement*, 62 ANESTHESIOLOGY 714, 714-24 (1985). Some of the cardiovascular modeling was performed using the program A-ware, Springer Electronic Media.

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pental as the only medication. We cannot, however, state which option is “better” because in this context “better” is based not upon pharmacological considerations but is actually a public policy decision best made by well-informed policy makers.

Some persons have contended that a large dose of thiopental given by itself does not reliably produce death.⁴⁶ In the Netherlands, where euthanasia and physician-assisted suicide are both legal, the Royal Dutch Society for the Advancement of Pharmacy wrote, “For intravenous administration, thiopental receives most consideration. It is not possible to administer so much of it that a lethal effect is guaranteed, but the substance is quite suitable for producing coma, after which termination may be effected using a muscle relaxant.”⁴⁷ In the same article, the thiopental dose to be used was stated as, “intravenous administration of 1 g thiopental sodium, if necessary, 1.5-2 g of the product in case of strong tolerance to barbiturates.”⁴⁸ Apparently the largest dose of thiopental used in the Netherlands was only 2 g (or 2000 mg) and it is therefore not surprising that such a dose was found to be less than 100% lethal.

The primary advantage of the three-drug protocol is that there is a definite and rapid end-point to the protocol and that is the onset of a flat-line ECG that can be assessed remotely by viewing an ECG monitor. The primary disadvantage is that there is the risk that the inmate could experience pain and suffering if the dose of thiopental is not properly administered for whatever reason and the pancuronium and potassium chloride are then administered to a conscious person. Another disadvantage to the three-drug protocol is that the potassium chloride, in addition to its action in stopping the heart, also causes widespread stimulation of nerve and muscle tissue throughout the body. Such stimulation is often manifested as involuntary muscle contractions that may have in the past been misperceived by lay witnesses as consistent with pain or suffering, or experiencing a seizure. In fact, it is most unlikely that someone given a large dose of thiopental, an excellent anticonvulsant medication, could suffer a seizure. One action of the pancuronium is to mitigate these involuntary muscle contractions.

46. Teresa A. Zimmers et al., *Lethal Injection for Execution: Chemical Asphyxiation?* 4(4) PLoS MEDICINE 646, 646-47 (2007).

47. For an English translation of the article, see *Administration and Compounding of Euthanasic Agents*, The Hague (Royal Dutch Society for the Advancement of Pharmacy 1994), available at <http://wwwweek.com/html/euthanasics.html>.

48. *Id.*

The primary advantage of a protocol in which a large dose of thiopental is given by itself is that there is no risk whatsoever of the inmate experiencing pain or suffering due to the effects of pancuronium or potassium chloride. If the intravenous catheter were to malfunction and the thiopental were deposited next to, instead of inside of, the vein, the inmate might experience some pain at the injection site but in fact this is a potential risk to which any patient given thiopental for anesthesia is subjected. The primary disadvantage of this single-drug protocol is that, although the inmate will likely die within a few minutes, his death will not be immediately reflected on the ECG monitor. In fact, following a large dose of thiopental that causes the inmate to stop breathing, experience a huge drop in blood pressure, and therefore a fatal decrease in oxygen delivery to critical tissues, it might very well take a half hour or longer for the ECG to become flat. In this case, it would be imprudent to wait for the ECG to become flat, and death would need to be ascertained by a physical examination that demonstrated the absence of a heartbeat or evidence of circulation. Whether this physical examination is performed by a physician or a paraprofessional credentialed to pronounce death (such as a nurse or a paramedic), either the person would be visible to the witnesses or the curtains in the death chamber would need to be drawn for the pronouncement of death to maintain this person's anonymity. Once again, we are unable to state, based upon pharmacological principles, which of these options is "better," however, we believe that those policy makers responsible for making such decisions are entitled to accurate scientific information in order to make an informed policy decision.

EXHIBIT 5

DECLARATION OF FIONA JANE COUPER, Ph.D

I, FIONA JANE COUPER, make the following declaration:

1. I am over the age of eighteen years and am competent to testify to the matters set forth below.

2. I am employed as the Washington State Toxicologist. I have held this position since March 2008. My professional and educational qualifications are set forth in my curriculum vitae, a copy of which is provided as Attachment A to this declaration. As the Washington State Toxicologist, I oversee the Toxicology Laboratory Division, which includes a staff of 16 full time toxicologists and provides drug and alcohol testing for coroners, medical examiners, law enforcement agencies, and prosecuting attorneys. This position also involves supervision of the Washington State Patrol's Impaired Driving Section, consisting of the Breath Test Program, Drug Recognition Program and the Ignition Interlock Program. This involves overseeing the training and certification of technicians, operators and instructors, and the approval of all policies and procedures. I am also responsible for the supervision of the blood alcohol analyst program for Washington State, and I provide expert testimony on the effects of alcohol and drug intoxication, driving under the influence of alcohol and/or drugs, and blood and breath testing for alcohol and drugs.

3. I have reviewed the Department of Corrections Policy Directive 490.200, Capital Punishment, effective October 25, 2008.

4. Thiopental sodium is an ultra-short acting barbiturate typically used as an anesthetic and/or induction agent. It induces a deep, coma-like unconsciousness within 30-60 seconds, and typical anesthetic/induction doses are approximately 100-250 mg, rarely more than 1 gram. Following a 3 gram dose, respiratory functions would be significantly depressed or stopped within approximately one to two minutes. While unconscious, the subject would have no sense of physical pain or suffering.

5. Pancuronium bromide is a neuromuscular blocking agent (paralytic agent). It inhibits muscular-skeletal movements thereby paralyzing the diaphragm and other respiratory muscles, and stopping respiration. Typical therapeutic doses are 0.04-0.10 mg/kg. At a 100 mg dose, respiratory paralysis should occur within 30-60 seconds of administration. Additionally, the heart would stop beating within approximately one to three minutes.

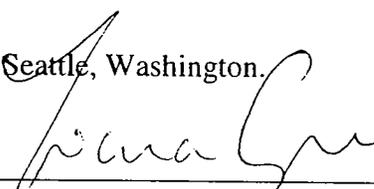
6. Potassium chloride is a chemical compound that interferes with the electrical signals that stimulate the contractions of the heart. A dose of 240 mEq would be sufficient to cause death by cardiac arrest within approximately one to three minutes.

7. Based on my professional experience and review, it is my opinion that the proper administration of the three drugs listed under Section IX.A.4(d) of the policy, in the sequence and dosages specified, would be a fatal combination resulting in a swift and painless death.

8. It is my professional opinion that flushing the intravenous (IV) lines with 50 cc of normal saline solution after the administration of each of the first two drugs specified (thiopental sodium and pancuronium bromide) should prevent clogging in the IV lines.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Signed this 7th day of November, 2008, at Seattle, Washington.



FIONA JANE COUPER, Ph.D.