NO. 11-35940

IN THE

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

PAUL EZRA RHOADES,

Petitioner-Appellant,

vs.

BRENT REINKE, *et al*.,

Respondents-Appellees.

Appeal from the United States District Court
for the District of Idaho
The Honorable Ronald E. Bush

PETITIONER-APPELLANT'S OPENING BRIEF

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I. STATEMENT OF JURISDICTION

The district court exercised jurisdiction over this case pursuant to 42 U.S.C. § 1983 and 28 U.S.C. § 2201. This Court has jurisdiction to hear this appeal pursuant to 28 U.S.C. §1292(a).

II. STATEMENT OF THE ISSUES

1. Whether a Stay of Execution and Preliminary Injunctive Relief Should be Issued.
2. Whether Idaho's Lethal Injection Protocol Violates the Eighth and Fourteenth Amendments:
    A. By Not Implementing the *Baze* Safeguards, Including Installing and Administering IV Lines and Performing Consciousness Checks by Qualified, Credentialed and Experienced Personnel.
    B. By Using a Three-Drug Protocol Instead of the Known Alternative of a One Barbiturate-Drug Protocol.

III. THE PARTIES

Mr. Rhoades, Appellant, resides at the Idaho Maximum Security Institution ("IMSI"), an Idaho Department of Corrections ("IDOC") prison, under sentence of death. Respondent Brent Reinke, sued in his official capacity, is the Director of IDOC. Respondent Reinke has ultimate authority over the contents and

implementation of IDOC lethal injection protocol ("SOP 135"). ER Vol. IV, pp. 398-450. Respondent Blades, sued in his official capacity, is the Warden of IMSI. Respondents are referred collectively hereafter is "IDOC."

IV. STATEMENT OF THE CASE

Mr. Rhoades filed his initial district court Complaint on September 22, 2011, at which time his execution was not scheduled. ER 856**.** On October 14, 2011, the IDOC filed a motion to dismiss the Complaint. *Id*. In its motion, the IDOC apprised Mr. Rhoades of the "completely revised" protocol that would be used for his execution, SOP 135, adopted the same day the motion to dismiss was filed. *Id*.

On October 19, the State of Idaho obtained a warrant for Mr. Rhoades's execution for November 18, 2011. On October 28, 2011, Mr. Rhoades filed a motion to stay his execution. ER 857.

On November 1, 2011, Mr. Rhoades filed an Amended Complaint, addressing the newly minted protocol as described in its October 14, 2011, motion to dismiss. *Id***.** Mr. Rhoades also filed an opposition to IDOC's motion to dismiss his Complaint. *Id*.

On November 2, 2011, in light of Mr. Rhoades's Amended Complaint, the court ordered IDOC to withdraw its motion to dismiss or proceed to their scheduled reply in support of the motion. *Id*. On November 4, 2011, in

compliance with court's orders, IDOC withdrew its motion to dismiss Mr. Rhoades's Complaint. ER 858.

In the meantime, on November 3, 2011, IDOC filed a response to Mr. Rhoades's motion to stay his execution. *Id*. On November 9, 2011, the court scheduled a limited evidentiary hearing on Mr. Rhoades's motion for stay of execution for the next day at 1:00 p.m. ER 859.

In advance of the hearing, on November 9, 2011, Mr. Rhoades filed a motion to expedite discovery and a supplemental motion to expedite discovery. *Id*. In his motions to expedite discovery, Mr. Rhoades moved for disclosure of the identities of execution team members. *Id*.

On November 10, 2011, the court denied Mr. Rhoades's motion for disclosure of identities of execution team members. ER 860. The court held an evidentiary hearing on Mr. Rhoades's motion for stay of execution later on November 10, 2011. *Id.*

On November 13, 2011, Mr. Rhoades filed an emergency renewed motion for discovery and an emergency motion for a stay of execution, based in part on the November 10, 2011, evidentiary hearing. *Id*. On November 14, 2011, the IDOC filed a response to Mr. Rhoades's emergency renewed motion for discovery and an emergency motion for stay of execution. On November 14, 2011, at 5:16 p.m., the court denied Mr. Rhoades's motion to stay execution. ER 861.

V. STATEMENT OF FACTS

Paul Rhoades began seeking information about Idaho's lethal injection protocol in 2008. In response to his grievance requests, IDOC informed Rhoades that the protocol was, alternatively, beyond the scope of a grievance or subsequently being revised. ER Vol. IV, p. 395.

In March 2011, IDOC denied Rhoades's public records request for the execution protocol. ER Vol. V, p. 592. Two months later, IDOC granted a request by the University of California at Berkeley for a copy of the protocol, releasing what it labeled a "draft." ER Vol. V, p. 532; ER Vol. VI, p. 743. That protocol was never enacted. ER Vol. VI, p. 743.

Rhoades filed suit on September 22, 2011, claiming that his execution would violate the Eighth and Fourteenth Amendments without ever having been granted access to the protocol that would be used to execute him. ER Vol. V, pp. 454-511. The IDOC adopted a policy statement governing executions on October 13, 2011, and a "completely revised" protocol was approved on October 14, 2011 and released publicly for the first time in this action. ER Vol. IV, p. 357. That revised protocol is SOP 135. ER Vol. IV, pp. 398-450. It provides for the use of a three-drug protocol that includes an initial anesthetic, either sodium thiopental or pentobarbital, followed by the paralytic pancuronium bromide and the cardiac arrest-inducing potassium chloride.

SOP 135 contemplates the creation and use of three Specialty Teams to implement the protocol: the Execution Escort Team, the Medical Team and the Injection Team. ER Vol. IV, pp. 405-07. Specific members of the Medical Team are responsible for establishing and maintaining the IVs through which the three drugs are administered, as well as assessing whether the prisoner is unconscious. ER Vol. IV, p. 406.

At the evidentiary hearing, Rhoades's expert anesthesiologist, Dr. Mark Heath, testified to various shortfalls in SOP 135, including the lack of an adequate consciousness check. ER Vol. VI, pp. 700-03. Dr. Heath also testified that the source of unconstitutional suffering and pain in executions is from the second and third drugs. ER Vol. VI, pp. 686, 87. Heath explained that multiple executions with no risk of pain have been accomplished in Ohio and Washington using just the initial anesthetic, either pentobarbital or thiopental. ER Vol. VI, pp. 686-88, 691-92, 712-13, 717, 718, 720, 727.

In contrast, IDOC Deputy Chief of the Bureau of Prisons, Jeffrey Zmuda ("Zmuda"), the official tasked with developing the execution protocol, admitted knowledge of "botched" executions occurring with a three-drug protocol. ER Vol. VI, p. 785. He also admitted being aware of the successful use of one-drug executions but not considering that method for Idaho. ER Vol. VI, p. 781. He did not even discuss Ohio's implementation and experience of 13 successful one-drug

executions when he contacted the Ohio corrections department in an information gathering process. ER Vol. VI, pp. 782-83.

IDOC waited to select an execution team until late October, 2011. ER Vol. VI, p. 755. The selection process was abbreviated. Zmuda, tasked with selecting the team, never independently checked the credentials, training or experience of the executioners. Instead, in selecting team members he relied exclusively upon the applicants' self reports. ER Vol. VI, pp. 750, 752, 753, 758, 759.

The execution facility was "completed" on October 20, 2011, but lacked almost all of the critical equipment, including IV lines, the "three way, three gang manifold," to which the syringes attach, the defibrillator, microphone, and camera. ER Vol. VI, pp. 769-71. By the time of the November 10, 2011 evidentiary hearing, one week from the scheduled execution, the execution team had conducted only five training sessions but not each using this equipment. ER Vol. VI, p. 829. The first of these training sessions had occurred sometime in late October. ER Vol. VI, p. 755. With one week remaining, the team had never placed an IV in a live person nor conducted a consciousness check on an unconscious person. ER Vol. VI, p. 755, 773-75. The Medical Team Leader, tasked with assessing the prisoner's depth of unconsciousness, will not have conducted a consciousness check on any unconscious person before the actual execution. ER Vol. VI, pp. 773-76.

VI. SUMMARY OF ARGUMENT

A stay is required where the applicant "establish[es] that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008). In *Baze v. Rees*, 553 U.S. 35 (2008), the Supreme Court held that a stay may not be granted unless the applicant shows that the lethal injection protocol "creates a demonstrated risk of severe pain" and "that the risk is substantial when compared to the known and available alternatives." *Id.* at 61. Further, a state "with a lethal injection protocol substantially similar to the protocol we uphold today would not create a risk that meets this standard." *Id.*

For the reasons below, Idaho's execution procedures create a demonstrated risk of severe pain, lack the safeguards relied upon in *Baze*, and are not substantially similar to the Kentucky protocol upheld in *Baze*. The court's findings to the contrary was an abuse of discretion. Mr. Rhoades meets the standard for a stay. This Court should enter an order enjoining or staying his execution pending resolution of his lawsuit in the district court.

VII. STANDARD OF REVIEW

A district court's grant of preliminary injunction is evaluated under an abuse of discretion standard. *Lopez v. Candaele*, 630 F.3d 775, 785 (9th Cir. 2010)

(citing *Johnson v. Couturier*, 572 F.3d 1067, 1078 (9th Cir.2009)). The same standard is applied when evaluating stays of executions. *Beardslee v. Woodford,* 395 F.3d 1064, 1070 (9th Cir. 2005). A district court "necessarily abuses its discretion when it bases its decision on an erroneous legal standard or on clearly erroneous findings of fact." *Id.* A finding of fact is "clearly erroneous" when "although there is evidence to support it, the reviewing body on the entire evidence is left with the definite and firm conviction that a mistake has been committed ." *Anderson v. City of Bessemer City, N.C.*, 470 U.S. 564, 573 (1985).

VIII. ARGUMENT

A. Rhoades is Likely to Succeed on the Merits.

Incorporating the *Baze* safeguards into SOP 135 or adopting a one-drug protocol is a feasible, readily implemented procedure which would significantly reduce the substantial risk of severe pain created by SOP 135. *Baze*, 553 U.S. at 52. Either the alternative one-drug or the approved three-drug method correctly implemented would substantially reduce the demonstrated risk of severe pain that exists with a three-drug protocol. Because the alternatives significantly reduce the risk of severe pain, Mr. Rhoades is likely to succeed in his challenge of the IDOC protocol.

1. SOP 135 Creates A Demonstrated Risk Of Severe Pain.

It is undisputed that if an inmate is not properly anesthetized, he will experience significant pain and suffering during subsequent drug administration. ER Vol. II, p. 75.

2. SOP 135 Fails *Baze* Safeguards.

In *Baze v. Rees*, the Supreme Court approved the Kentucky lethal injection protocol but only because it included "several important safeguards to ensure that an adequate dose of sodium thiopental is delivered to the condemned prisoner." *Baze*, 553 U.S. at 55. Absent those safeguards, there is a substantial risk of serious harm in violation of the Eighth Amendment. *Id.* at 55. These safeguards are: adequate in-house training; relevant credentials; one year of contemporary and continuing daily experience; and a meaningful consciousness check. *Id.* The effectiveness of these safeguards is closely connected to the effectiveness of the applicant's screening process.

The court found that Zmuda's efforts to appropriately verify applicants were sufficient. ER Vol. II, pp. 100-02. This was an abuse of discretion and clear error. In this case, IDOC "hiring" process fell woefully short of any meaningful screening effort. Deputy Chief Zmuda did not inquire of any licensing body whether any of the individuals he approved had valid licenses or certifications. ER Vol. VI, p. 750. He did not verify any employment experience. ER Vol. VI, pp. 752, 759. Nor did he confirm degrees or diplomas with any education institution.

ER Vol. VI, p. 758. He accepted at face value whatever documentation was provided by the candidates. *Id*. And, he destroyed all documentation after he selected the team members. ER Vol. VI, p. 753. He did not write a report or a file memorandum regarding his selection process or decisions. ER Vol. VI, p. 764.

Zmuda, who has no medical education or training[1] but testified that he has an expired CPR certificate, selected the Medical and Injection Team leaders and the alternate team leaders. ER Vol. VI, pp. 746-47. He also ultimately approved all other members of the Medical and Injection Teams. ER Vol. VI, p. 746. He reviewed applications from seven candidates and whittled it down to five. ER Vol. VI, p. 752.

Zmuda testified that he "verified" that members had the requisite skills by observing various team members' performance at the initial three training sessions. ER Vol. VI, pp. 754-56. In finding this method of verification adequate, the court below abused its discretion. These first three training sessions had little to do with the skills of the team members. The first training session was an orientation on the protocol and did not involve demonstrating any practical skills. ER Vol. VI, p. 756. The second training included additional orientation and involved some limited practical skills. ER Vol. VI, pp. 756-57. The third training involved use of

[1] Zmuda testified that he began working for the IDOC in an entry level position doing maintenance and construction and that he has worked his way through the Department. ER Vol. 6, p. 763.

a mannequin arm to site IVs. ER Vol. VI, p. 757. Zmuda related that a mannequin arm, "[r]equires you to have proficiency to find the vein." *Id*. No fluid was pushed through IVs in any of the first three trainings. *Id*. Team members did not insert an IV into a live volunteer. ER Vol. VI, pp. 757-58. However, from these orientations and preliminary "training," Zmuda "verified" team members' abilities and proficiencies. The court found these sessions appropriate to confirm the "actual, hands-on, competencies of the team." ER Vol. II, p. 101. This was an abuse of discretion.

However, even if the three initial training sessions included meaningful demonstration of the protocol tasks, no critical evaluation was applied to the observation. Zmuda had no education or training to allow him to appropriately assess medical skills. As the court pointed out, Zmuda relied exclusively upon the Medical Team Leader to assess the qualifications of the team members. ER Vol. II, p. 102. However, as Zmuda reveals in his affidavit, the Medical Team Leader does not have venous access currency, and thus is unqualified to initiate and maintain IVs. ER Vol. II, p. 131. The validation of the credentials of the Medical Team Leader was, again, limited to the reading of an application. The Medical Team Leader had dated experience in certain clinical practices and work experience divided between clinical and administrative practice. *Id*. Zmuda drew no distinction between the type or length of work done as an administrator versus a

clinician. ER Vol. VI, pp. 778-79; ER Vol. II, pp. 124, 131. However, significant distinctions exist: clinical work focuses almost exclusively on hands-on provision of care and administration typically focuses on paperwork, regulations and forms. ER Vol. VI, pp. 706-07. The total lack of verification implicates the effectiveness of the subsequent "safeguards." The court ignored these flaws in IDOC's implementation of the *Baze* safeguards. This was an abuse of discretion.

a. Inadequate in-house training.

The court found that five in-house trainings provide significant safeguards against the demonstrated risk of pain. ER Vol. II, p. 86. This was an abuse of discretion. Under SOP 135, the in-house training, SOP 135 is inadequate. The training of team members has been perfunctory due to delays in constructing and equipping the Execution Unit, adopting an execution protocol and selecting execution team members.

Execution Specialty Team members did not start training until the end of October. ER Vol. VI, p. 755. The first training session was an orientation. ER Vol. VI, p. 756. At the second training, much of the equipment was still not installed or available in the unit. Zmuda did not think that the monitoring system was installed. ER Vol. VI, pp. 756-58, 770, 772. He was uncertain whether the cameras or microphones used to assess consciousness were installed. ER Vol. VI, pp. 770-71. Much of the equipment, including the three-way manifold was not

available for the training. ER Vol. VI, p. 771. Instead of the proper equipment, the teams used substitutes including identifying color-coded syringes on a table or counter instead of in the manifold. *Id*.

As of November 10, 2011, the team members had practiced setting IVs only on a mannequin arm. ER Vol. VI, pp. 757-58. Dr. Heath, however, noted that:

> If a person does not possess proficiency, experience, currency, and appropriate credentialing to establish and maintain an IV, that person cannot learn how to establish and maintain an IV on a live human being by practicing on a mannequin arm alone. Such an individual would also need to have many practice sessions on live human beings.

ER Vol. VI, p. 851. Dr. Heath explained that the difference between mannequin arms and human arms preclude learning how to establish IVs in humans by training on mannequin arms only. Zmuda represented that the team members would use live volunteers for the first time at the next, sixth, training session. *Id*. There will be only a total of ten training sessions (including the two full rehearsal sessions) before the executions, so only five at which IVs will be established in live volunteers. ER Vol. VI, p. 829. Four trainings on how to establish an IV in humans is insufficient. Zmuda was uncertain whether team members had pushed chemicals into the mannequin arm at any of the trainings. ER Vol. VI, p. 774.

In attempting to mirror *Baze*, IDOC included in SOP 135 the requirement of 10 training sessions annually. ER Vol. IV, p. 407. The protocol calls for weekly training in the month before the execution. *Id*. Due to delays in adopting SOP 135

and selecting team members, all ten training sessions have been scheduled in the four weeks before Mr. Rhoades's execution date. ER Vol. VI, pp. 755, 773. Zmuda testified that the team members would have five more training sessions in the seven days remaining before the scheduled execution. This training schedule does not allow sufficient time to make adjustments to the protocol if problems are uncovered during the sessions. ER Vol. VI, pp. 831-32.

This compressed schedule elevates form over substance. If all one needed to demonstrate proficiency was to "show up" at these sessions would meet the standard. But, reliably demonstrating a medical skill, combined with an exacting administration of lethal chemicals requires more. It requires sufficient time to complete a training session, review and debrief the tasks and revise as necessary. Instead, execution team members will show up for five sessions within a span of seven days and thus check off another "safeguard."

Once team members do show up for training, the scope of that training is uncertain. SOP 135 does not provide instructions for execution team training. ER Vol. VI, pp. 776-77. There are no memos or manuals detailing training. *Id*. Additionally, the people overseeing the training of team members lack the requisite experience or training to run these sessions. Zmuda has no medical experience. ER Vol. VI, pp. 738, 832-33. The Medical Team Leader is unqualified to establish or maintain IVs as he lacks venous access currency. ER Vol. II, p. 131.

The court found that IDOC had training underway and the sessions were sufficient under *Baze*. ER Vol. II, p. 89. The court would find pause only if the facts show a training structure and schedule but no actual training. *Id*. No pause was taken here.

However, the evidence presented should have given the court "pause" and, ultimately, cause to issue the stay. While a detailed timeline is set out by SOP 135, no meaningful training had occurred. At best, the limited training sessions included an orientation, a procedural review, and use of a mannequin to set IVs. ER, Vol. VI, 755-77. Notwithstanding the compressed nature of the training, the court found this schedule substantially similar to *Baze*. ER Vol. VI, p. 90. This was an abuse of discretion. The fact that IDOC scheduled ten sessions prior to an execution, to include inititation of IVs in humans during only the last week, is insufficient to comply with *Baze*'s training requirement. IDOC's compressed schedule does not allow for meaningful, productive training.

b. SOP 135 does not contain one year of current professional experience.

The "most significant" safeguard on which the *Baze* court relied was that members establishing the IV must have "at least one year of professional experience as a certified medical assistant, phlebotomist, EMT, paramedic, or military corpsman[.]" *Baze*, 533 U.S. at 55. SOP 135's Medical Team is responsible for establishing the IV lines and "ensur[ing] the line is functioning

properly through the procedure." ER Vol. IV, p. 406. Though SOP 135 mandates that the Medical Team is responsible for IV initiation and maintenance as well as supervision of administering chemicals via IV, it does *not* require that Medical Team members "have at least one year of professional experience." The court below found that the protocol complies with *Baze* based on Zmuda's testimony that all members of the Medical Team actually have at least one year of professional medical experience. ER Vol. II, p. 84-85. This was an abuse of discretion. The court in relying upon Zmuda's testimony ignored the total lack of any independent verification by Zmuda. SOP 135 does not state that medical providers must be currently licensed or have any actual experience in initiating IV catheters but the court found Zmuda's testimony and affidavit effectively amended the protocol. ER, Vol. II, p. 83. There is no way to verify Zmuda's testimony that the medical providers have the qualifications they claimed because he did not verify these qualifications.

c. SOP 135 does not contain a meaningful consciousness check.

The court found that the consciousness check provided under SOP 135 is a meaningful one under *Baze*. ER Vol. II, p. 92. This finding is clearly erroneous and an abuse of discretion. The consciousness check falls short of a meaningful check under *Baze*.

The consciousness check is potentially the most important safeguard to prevent substantial risk of severe pain. Dr. Heath testified that if an inadequate dose of the first drug is administered, the person could be deemed unconscious and may, in fact, be unconscious but then in a few tens of seconds, be fully awake. ER Vol. VI, p. 695.

SOP 135 provides for a consciousness check, which is to be performed after the administration of thiopental or pentobarbital and heparin/saline but before the administration of pancuronium bromide:

> The Medical Team leader, dressed in a manner to preserve his anonymity, will enter into the room where the IMSI warden and offender are located to physically confirm the offender is unconscious by using all necessary medically appropriate methods.

ER Vol. IV, p. 437. SOP 135 does not delineate the type of method of consciousness check used to determine if the prisoner is sufficiently anesthetized before administering the paralytic and cardiac-arrest inducing chemicals.

Zmuda's testimony and affidavit, again, effectively amends the protocol without providing specific direction. Zmuda testified that the Medical Team Leader will use verbal stimulus and touch to determine consciousness. ER Vol. VI, pp. 761-62. Visual and aural consciousness checks are inadequate to determine whether the offender is sufficiently unconscious to allow the administration of

pancuronium bromide and potassium chloride without his experiencing the severe pain associated with those chemicals. ER Vol. VI, pp. 701-02.

Other stimuli like a strong pinch or sternal rub may be sufficient if done properly but there is nothing in SOP 135 that requires that the check be done in a certain way. Whether a pinch or a sternal rub is sufficient depends on the intensity. ER Vol. VI, pp. 702-03. There is no post order which addresses consciousness checks and nothing in SOP 135 or Attachment A describes what type of pinch or sternal rub must be given. ER Vol. VI, pp. 762.

Zmuda testified that the Medical Team Leader determined the protocol for consciousness checking. ER Vol. VI, pp. 760-61. Zmuda assumed that the Medical Team Leader is competent to assess consciousness simply because he is a registered nurse. ER Vol. VI, p. 759. No specific experience or training was given to support his assumption. *Id*. At most, the nurse had some undefined work experience at some level of emergency services. ER Vol. II, p. 124. Additionally, even if this nurse had at some past time consciousness check experience, Zmuda conceded that this individual does not have daily experience in assessing consciousness. ER Vol. VI, pp. 797-98.

A person experienced and adequately trained in conducting depth of consciousness checks is necessary to adequately assess an individual's consciousness following the administration of anesthesia. The Court in *Baze*

rejected "rough-and ready tests" of consciousness which purported to make "fine distinctions" among various levels of consciousness. *Baze*, 553 U.S. at 60. In the context of an execution, fine distinctions are unimportant. What matters is that the individual is sufficiently unconscious so as not to suffer the pain from the last two drugs. Sufficient unconsciousness is determined by administration of a sufficiently strong and adequate stimulus.

Dr. Heath testified that the "surgical plane" of anesthesia is the depth of unconsciousness that one must be to not experience the pain from potassium chloride. ER Vol. VI, pp. 697-98. This is the level of unconsciousness where one could undergo surgery and not feel pain. ER Vol. VI, p. 698. Determining this level of unconsciousness requires competency in assessing depth of unconsciousness in people who have been given anesthesia. ER Vol. VI, p. 705. This is different than assessing depth of unconsciousness in people who have suffered head injuries. This distinction requires less expertise in an emergency situation than is necessary in surgical practice. *Id*.

In order to ensure that Mr. Rhoades does not suffer pain, a sufficiently strong consciousness check must be administered. Requiring an appropriate consciousness check by an adequately trained experienced individual would significantly reduce the risk of needless severe pain inherent in administering the remaining two chemicals. The court ignored the undisputed expert testimony

regarding the importance of depth of consciousness when accepting the modified protocol. This does not safeguard against the known risk of severe pain. ER Vol. II, pp. 91-94. This was an abuse of discretion.

B. IDOC's Hurried Response to the Certiorari Denial

To prevail on a claim of future harm as cruel and unusual punishment, "there must be a 'substantial risk of serious harm,' an 'objectively intolerable risk of harm' that prevents prison officials from pleading that they were 'subjectively blameless for purposes of the Eighth Amendment.' *Farmer v. Brennan*, 511 U.S. 825, 842, 846, and n.9 (1994)." *Baze*, 553 U.S. at 50. In stating "a lethal injection protocol substantially similar to the protocol we uphold today would not create a risk that meets this standard[,]" the *Baze* Court was referring to the "demonstrated risk of severe pain" standard which it grounded in *Farmer*. *Baze*, 553 U.S. at 61. As the Court held, "[T]he proffered alternatives must effectively address a 'substantial risk of serious harm.' *Farmer*, [511 U.S.] at 842." *Id.* at 52. Where the risk of severe pain is increased due to unattended matters within the prison's control, such as last minute, inadequately timed and rehearsed procedures due to inexplicable delays in crafting a protocol and constructing an execution chamber, the prison officials are not subjectively blameless. Their actions contributed to a substantial risk of serious harm or an objectively intolerable risk of harm. Where

the prison officials were not subjectively blameless, the prison officials' failures constitute evidence meeting Rhoades's burden.

IDOC officials are not subjectively blameless. They have known since 2008 that they needed to establish execution procedures in compliance with *Baze.* Yet they adopted SOP 135 on October 14, 2011. IDOC officials have known for several years that the protocol needed revisions to comply with *Baze*. Yet they chose to remodel an execution facility on a timetable precluding the SOP 135 required training of execution teams in time for an execution in accord with SOP 135. ER Vol. VI, pp. 740-41. IDOC officials are not subjectively blameless where their delayed protocol revision and execution unit construction prevented compliance with the SOP 135 in a way which increases the likelihood of a substantial risk of harm.

Here, IDOC officials' failure to adopt SOP 135 until October 14, 2011, and their failure to have a facility at which the Medical and Injection Teams may conduct meaningful training unquestionably increases the likelihood of a substantial risk of harm. Together with IDOC officials' failures, the evidence Mr. Rhoades presented demonstrates a likelihood of success on the merits. Finding otherwise is an abuse of discretion.

C. One-Drug Protocol is a Known Alternative.

IDOC protests that "there is no risk of severe pain" because its three-drug protocol will be implemented correctly. ER Vol. VI, pp. 838-39. Deputy Chief Zmuda admitted awareness of the botched executions using both thiopental and pentobarbital. ER Vol. VI, p. 785. *See*, e.g., ER Vol. II, pp. 199-200; ER Vol. V, p. 557. Some of those executions occurred post-*Baze*. Despite this knowledge, Zmuda did not discuss the one-drug protocol in his conversations with Ohio Department of Corrections officials and did not inquire into the time of death using Ohio's one-drug protocol. ER Vol. VI, p. 689. *See* ER Vol. I, pp. 31-45.

IDOC chooses to accept the known risk of agonizing pain, while hoping to ameliorate it with a proper dose of the first drug, either thiopental or pentobarbital. In light of the evolving standards of decency that inform the Eighth Amendment, *Roper v. Simmons*, 543 U.S. 551, 561-61 (2005); *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958), and the successful development of a known alternative which has no risk of severe pain, IDOC's choice of a three-drug protocol is unconstitutional.

As an untested method, and without factual support in the record, the one-drug protocol addressed in *Baze* was too theoretical to substantially reduce the risk of severe harm entailed in the three-drug protocol. *Baze*, 553 U.S. at 53. *Baze*'s rejection of a one-drug protocol is limited to its facts which were substantially different than the evidence in this case which includes fourteen one-drug executions.

This Court addressed a similar issue in *Dickens*, but on facts only slightly more developed than those in *Baze*. In *Dickens*, this Court was presented with the early development of a one-drug protocol. According to the petitioner's reply brief in that case, only five executions had occurred in Ohio between January and May, 2010, and none had occurred in Washington. *Dickens v. Brewer*, 09-16539, Reply Brief of Petitioner-Appellants at 30-31 & n.5, 2010 WL 4471069 (9th Cir. May 20, 2010). Since that time, nine more people have been executed without incident, and South Dakota has adopted a one-drug protocol.

Ohio and Washington have executed a total of 14 inmates with one-drug barbiturate injections of either pentobarbital or thiopental without any pain. ER Vol. I, pp. 32-41. These one-drug executions used the first drug required in the IDOC three-drug protocol in exactly the same dose as that protocol contemplates. *See* ER Vol. VI, p. 732. By switching to a one-drug protocol, Ohio and Washington completely eliminated all risk of severe pain from the now omitted, second and third drugs – the acknowledged source of pain in lethal injection executions. *See* ER Vol. VI, pp. 724, 732 (executions with "no potential" for agonizing pain because of removal of second and third drugs). No legitimate penological purpose justifies the continued use of the second and third drugs.

Tolerating a foreseeable torturous mishap *is* cruelty and violates the Eighth Amendment in the face of a history of painful three-drug executions that exists and

continues post-*Baze* as compared to a uniform history of successful, pain-free executions using the one-drug protocol. *See Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459, 464 (1947); *id*. at 471 (Frankfurter, J., concurring). Continued use of three-drug protocols, with their foreseeable inevitable pain in botched executions, does not result in an "innocent misadventure" that can be tolerated, ignored or disregarded. *Cf. Baze*, 553 U.S. at 50.

IDOC argues against adopting a one-drug protocol, showing undisguised contempt for the "humane execution" it professes to espouse and expects to carry out. The foreseeability of a botched painful execution and the ease of avoidance by implementing a now established and successful one-drug protocol adds an element of cruelty to any subsequent three-drug execution. *See Resweber*, 329 U.S. at 464. The *Baze* Court's review of the evolving methods of execution leaves no doubt that the measure against which execution methods must be evaluated has remained constant: is the method more humane than its alternatives? In light of the evidence, continued use of a three-drug protocol presents an objectively intolerable risk of harm and is indicative that IDOC has other reasons to refuse to use the simpler, more humane protocol.

In intentionally choosing a method of execution that presents a demonstrated risk of severe pain, IDOC is not "subjectively blameless." Given a readily available, feasible and less complicated alternative, the choice of a three-drug

protocol amounts to reckless indifference in refusing to "take reasonable measures to abate an intolerable risk." *See Farmer*, 511 U.S. at 846 n.9. Proceeding with a three-drug protocol is akin to Justice Frankfurter's hypothetical that "a series of abortive attempts at electrocution" would violate the Due Process Clause. *See Baze*, 553 U.S. at 50 (quoting. *Resweber*, 329 U.S. at 470-71). These are "matters which depend on 'differences of degree.'" *Resweber*, 329 U.S. at 471 (Frankfurter, J., concurring). The continued pursuit of that method in utter disregard of a humane, pain-free alternative is a difference of a degree that violates the Eighth and Fourteenth Amendments.

When the risk of severe pain can be reduced dramatically, by any measure the reduction in risk is substantial. Complete elimination of the risk of pain is substantial under *Baze*. *Dickens* construes *Baze* to hold that "failure to adopt an alternative protocol establishes an Eighth Amendment violation only if the current protocol creates a substantial risk of serious harm that the alternative protocol will reduce." *Dickens*, 631 F.3d at 1150. *Dickens* strayed from *Baze* in concluding that *Baze* does not allow consideration of a one-drug protocol "even if there is evidence that the [one-drug] protocol is safer and feasible." *Dickens*, 631 F.3d at 1150. A one-drug protocol is a *substantially* safer alternative in that it elimintates any risk of pain from the second and third drug. When an alternative protocol is substantially safer and less complicated, the State's preferred method of execution

necessarily presents a "substantial risk of harm" that is intolerable and violates the Eighth and Fourteenth Amendment. The lower court's finding to the contrary is erroneous.

D. Absent A Stay, Mr. Rhoades Will Suffer Irreparable Harm.

This second factor is incorporated in the *Baze* stay standard. Because the *Baze* safeguards are not incorporated in SOP 135, there is substantial likelihood that Mr. Rhoades will suffer irreparable harm – severe pain and suffering, and an inability to pursue his claims – should his execution move forward. The court found this factor in Mr. Rhoades's favor. ER Vol. II, p. 110.

E. The Balance of Equities Tips in Mr. Rhoades's Favor.

In March, 2011, IDOC refused undersigned counsel's public records request for the IDOC execution protocol. ER Vol. V, p. 592. In May, 2011, IDOC provided to the University of California, Berkeley School of Law, a draft revision of the predecessor to SOP 135, a revision which they disclaimed and stated was not in effect. ER Vol. V, pp. 532, 534-43. Until March of 2011, IDOC continued to review that unpublished draft. ER Vol. VI, p 744. Finally, on October 14, the IDOC adopted and released for publication its final execution procedures. ER Vol. IV, pp. 398-450. IDOC at different times describes SOP 135 as "extensively revised" and "completely revised" from the draft which the IDOC refused to provide undersigned counsel. ER Vol. IV, pp. 350, 357.

Respondents were long aware that they needed to create execution procedures in compliance with *Baze*. ER Vol. VI, p. 742. In October of 2010, Zmuda, Chief of Prisons Sonnen and Wardens Blades and Cluney traveled to Arizona to visit the Arizona execution facilities and discuss "issues related to processes, practices [and] procedures" with Arizona officials. ER Vol. VI, p. 791. Notwithstanding the legal developments of *Baze*, the legislative delegation of authority or a trip to Arizona, the IDOC failed to adopt any specific procedures until October 14, 2011. *See* ER Vol. IV, p. 395 (IDOC Grievance Listing, noting 2009 grievances re execution process). Finally, in late October 2011, IDOC, by Deputy Chief Zmuda, interviewed potential execution team members and began training. ER Vol. VI, p. 755. No reference checks, employment, training qualifications or licensing/certification verification was done for any team member. ER Vol. VI, pp. 752-53, 754-56, 758, 760. Added to this unvetted execution team is a lack of meaningful training and an unfinished execution facility. *See* infra and ER Vol. VI, pp. 769-70. In delaying both the construction of its facility and the drafting and release of SOP 135 until mere days before the execution, IDOC has unclean hands and has waited so long that the balance of equities tips in Mr. Rhoades's favor.

F. A Stay or Injunction Is In the Public Interest.

The court overlooked the strong public interest in the enforcement of the Eighth Amendment rights and against state government violation of those rights. ER Vol. II, p. 111. This was an abuse of discretion. Further, while the State has an interest in carrying out its sentences, the public has an especially strong interest in the government not killing a citizen when the State's delays caused insufficient time for the court to resolve this matter in a deliberate fashion. The strong public interest is in an orderly and deliberate decision of the important issues raised. If Idaho is to exact the ultimate penalty, it should only do so in a humane manner, without inflicting severe and unnecessary pain on the condemned inmate.

IX. CONCLUSION

Mr. Rhoades meets his burden for a stay. He has established that SOP 135 creates a demonstrated risk of severe pain. That risk is substantial when compared to the known and available alternatives. The Court should issue a preliminary injunction or stay of execution pending the resolution of this lawsuit.

Dated this 15th day of November 2011.

Respectfully submitted,

_____/s/_____
Oliver W. Loewy
Teresa A. Hampton
Capital Habeas Unit
Federal Defenders Services of Idaho, Inc.

CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of November, 2011, I electronically filed the foregoing document with the Clerk of the Court using the CM/ECF system which is designed to send a Notice of Electronic Filing to persons including the following:

Krista Howard
khoward@idoc.idaho.gov

/s/
Teresa A. Hampton