

No. 12-16084

**IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

Samuel Lopez, Plaintiff-Appellant,
vs.
Janice K. Brewer, et al., Defendants-Appellees.

* * * CAPITAL CASE * * *
EXECUTION SET MAY 16, 2012, at 10AM MST

Appeal from United States District Court for the District of Arizona
Hon. Neil V. Wake, District Judge, Presiding
Dist. Ct. No. 2:12-cv-00245-NVW

EXCERPTS OF RECORD
VOLUME 1: ERs 001 through 088

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Excerpts of Record

Volume 1 (ERs 001-088):

- ER 001: Notice of Preliminary Injunction Appeal, filed May 7, 2012 [USDC ECF No. 67]
- ER 003: Order Denying Motion for Preliminary Injunction, filed May 7, 2012 [USDC ECF No. 66]
- ER 023: Reply to Response to Motion for Preliminary Injunction (including Exhibits KK-OO), filed May 5, 2012 [USDC ECF No. 65]
- ER 032: Exhibit KK: Email from Eric D. Peters, M.D., to Robin Konrad, dated May 4, 2012
- ER 034: Exhibit LL: Summary Statement of Joseph I. Cohen, M.D., dated May 5, 2012
- ER 036: Exhibit MM: Nembutal Sodium, FDA Label
- ER 048: Exhibit NN: Excerpt Transcript Testimony of Mark Dershwitz, M.D., pp. 89-96, dated December 9, 2008
- ER 052: Exhibit OO: Autopsy Report of Robert C. Comer, dated May 23, 2007
- ER 069: Answer to Second Amended Complaint, filed May 2, 2012 [USDC ECF No. 63]

Volume 2 (ERs 089-243):

- ER 089: Motion by Plaintiff Samuel Lopez for Preliminary Injunction (including Exhibits X-JJ), filed May 2, 2012 [USDC ECF No. 62]
- ER 121: Exhibit X: Declaration of Timothy M. Gabrielsen, dated April 30, 2012
- ER 125: Exhibit Y: Declaration of Dale A. Baich, dated April 30, 2012
- ER 129: Exhibit Z: Private Autopsy Examination of Thomas Kemp, Declaration of Joseph I. Cohen, M.D., dated April 30, 2012
- ER 132: Exhibit AA: Declaration of Eric D. Katz, M.D., dated April 30, 2012
- ER 135: Exhibit BB: Excerpt Transcript Testimony of Eric Katz, M.D., pp. 19-25, 50-51, *West v. Brewer*, No. 2:11-cv-01409 (D. Ariz.), December 7, 2011

- ER 147: Exhibit CC: Excerpt Transcript Testimony of Medical Team Leader, pp. 32-33, *West v. Brewer*, No. 2:11-cv-01409 (D. Ariz.), December 6, 2011
- ER 152: Exhibit DD: Declaration of Angela Fairchild, dated April 30, 2012 (including Attachments 1-6)
- ER 154: Attachment 1: ADC Correctional Service Log, Housing Unit 9 Section Leader, dated March 8, 2012
- ER 163: Attachment 2: ADC Correctional Service Log, Housing Unit 9 Special Operations, dated March 8, 2012
- ER 166: Attachment 3: Execution Log, Towery, ADC #051550
- ER 169: Attachment 4: ADC Correctional Service Log, Housing Unit 9 Section Leader, dated February 29, 2012
- ER 176: Attachment 5: ADC Correctional Service Log, Housing Unit 9 Special Operations, dated February 29, 2012
- ER 180: Attachment 6: Execution Log, Moormann, ADC # 31293
- ER 183: Exhibit EE: Letter from Charles Ryan to the Arizona Supreme Court, dated February 9, 2012, Re: Execution of Robert Moormann
- ER 185: Exhibit FF: Letter from Charles Ryan to the Arizona Supreme Court, dated February 17, 2012, Re: Execution of Robert Towery
- ER 187: Exhibit GG: Letter from Charles Ryan to the Arizona Supreme Court, dated March 28, 2012, Re: Execution of Thomas Kemp
- ER 190: Exhibit HH: Letter from Charles Ryan to the Arizona Supreme Court, dated April 16, 2012, Re: Execution of Samuel Lopez
- ER 192: Exhibit II: Letter from Charles Ryan to Samuel Villegas Lopez, dated April 20, 2012, Re: Choice of Protocol
- ER 194: Exhibit JJ: Letter from Charles Ryan to Dale Baich, dated April 2, 2012, Re: Attorney Visitation
- ER 196: Second Amended Complaint, filed April 19, 2012 [USDC ECF No. 58]
- ER 227: Exhibits U and W to Reply to Response to Motion for Court-Ordered Settlement Conference Pursuant to Local Civil Rule 83.10, and Motion for Stay of Proceedings, filed April 2, 2012 [USDC ECF No. 54-1]
- ER 227: Exhibit U: Letter from Charles Ryan to Dale Baich, March 22, 2012

ER 229: Exhibit W: Private Autopsy Examination of Robert Charles Towery, Performed by Joseph I. Cohen, M.D., dated April 2, 2012

ER 236: Motion for Leave to File Second Amended Complaint, filed April 2, 2012 [USDC ECF No. 53]

ER 239: Exhibits O and P to Reply to Response to Motion for Preliminary Injunction, filed February 20, 2012 [USDC ECF No. 30-1]

ER 239: Exhibit O: Declaration of Michael L. Burke

ER 241: Exhibit P: Declaration of Ashley J. McDonald

Volume 3 (ERs 244-296):

ER 244: Arizona Department of Corrections Department Order 710, Execution Procedures Protocol, dated January 25, 2012 [Exhibit 1, admitted February 22, 2012]

ER 280: Autopsy Photos from Execution of Thomas Kemp

ER 280: Photo No. C4U52904

ER 281: Photo No. C4U52906

ER 282: Photo No. C4U52908

ER 283: Docket

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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA**

Towery, et al.,

Plaintiffs,

v.

Brewer, et al.,

Defendants.

Case No. 2:12-CV-00245-NVW

NOTICE OF PRELIMINARY
INJUNCTION APPEAL

DEATH-PENALTY CASE

**Execution Scheduled
May 16, 2012 at 10 a.m.**

Plaintiff Samuel Lopez hereby gives notice of his appeal to the Ninth Circuit Court
of Appeals from the order entered in this action on May 7, 2012. (Dkt. No. 66.)

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Respectfully submitted this 7th day of May, 2012.

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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA**

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9 Robert Towery, et al.,

10 Plaintiffs,

11 vs.

12 Janice K. Brewer, et al.,

13 Defendants.

14

) No. CV-12-245-PHX-NVW

) DEATH PENALTY CASE

) **ORDER DENYING MOTION FOR
PRELIMINARY INJUNCTION**

15 Before the Court is a motion for preliminary injunction filed by Plaintiff Samuel
16 Lopez, who is an Arizona prisoner under sentence of death. (Doc. 62.) Lopez is scheduled
17 to be executed by lethal injection on Wednesday, May 16, 2012. The motion will be denied
18 for the reasons that follow.

19

BACKGROUND

20 In 2007, a group of Arizona death row prisoners filed a § 1983 complaint challenging
21 numerous aspects of Arizona’s then-in-effect lethal injection protocol.¹ That protocol was
22 based on Department Order 710, dated November 1, 2007, and as modified by an exhibit
23 submitted by the parties as part of a joint report to the Court. *See Dickens v. Brewer*, No.
24 CV-07-1770-PHX-NVW, 2009 WL 1904294, at *1 & n.2 (D. Ariz. Jul. 1, 2009)
25 (unpublished order). This Court granted summary judgment in favor of Defendants,
26 concluding that Arizona’s protocol was “substantially similar” to that approved by the
27 Supreme Court in *Baze v. Rees*, 553 U.S. 35 (2008), and thus did not subject inmates to a

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¹ None of the Plaintiffs in this matter were parties to that litigation.

1 substantial risk of serious harm in violation of the Eighth Amendment. The Court of Appeals
2 for the Ninth Circuit affirmed. *Dickens v. Brewer*, 631 F.3d 1139 (9th Cir. 2011).

3 The version of the protocol at issue in *Dickens* required sequential administration of:
4 (1) sodium thiopental (pentothal), an ultra fast-acting barbiturate that induces
5 unconsciousness; (2) pancuronium bromide, a paralytic neuromuscular blocking agent that
6 prevents any voluntary muscle contraction; and (3) potassium chloride, which causes skeletal
7 muscle paralysis and cardiac arrest. “It is uncontested that, failing a proper dose of sodium
8 thiopental that would render [a] prisoner unconscious, there is a substantial, constitutionally
9 unacceptable risk of suffocation from the administration of pancuronium bromide and pain
10 from the injection of potassium chloride.” *Baze*, 553 U.S. at 53.

11 In October 2010, on the eve of his execution, Arizona prisoner Jeffrey Landrigan filed
12 a § 1983 complaint describing a nationwide shortage of sodium thiopental and alleging that
13 the Arizona Department of Corrections (“ADC”) had imported the drug from a non-FDA-
14 approved foreign manufacturer. The district court granted a temporary restraining order to
15 permit further discovery regarding efficacy of the drug. *Landrigan v. Brewer*, No. CV-10-
16 2246-PHX-ROS, 2010 WL 4269559 (D. Ariz. Oct. 25, 2010) (unpublished order). The
17 Supreme Court reversed, noting that there was “no evidence in the record to suggest that the
18 drug obtained from a foreign source is unsafe” and “no showing that the drug was unlawfully
19 obtained.” *Brewer v. Landrigan*, 131 S. Ct. 445 (2010) (Mem.).

20 Subsequently, Arizona prisoner Daniel Cook filed a complaint similar to that of
21 Landrigan, alleging an unconstitutional risk of serious pain from use of non-FDA approved
22 sodium thiopental. The district court dismissed the complaint, finding that it failed to
23 sufficiently state a claim for relief. *Cook v. Brewer*, No. CV-10-2454-PHX-RCB, 2011 WL
24 251470 (D. Ariz. Jan. 26, 2011) (unpublished order). The Ninth Circuit affirmed and noted
25 that Arizona’s protocol contains safeguards that would prevent the administration of the
26 second and third drugs if the prisoner were not sufficiently anesthetized. *Cook v. Brewer*,
27 637 F.3d 1002, 1007-08 (9th Cir. 2011) (*Cook I*). Based on newly-discovered evidence
28 surrounding the foreign-manufactured sodium thiopental and ADC’s acquisition thereof,

1 Cook refiled a complaint on the eve of his execution. The district court summarily dismissed
2 the complaint, and the Ninth Circuit affirmed. *Cook v. Brewer*, No. CV-11-557-PHX-RCB,
3 2011 WL 1119641 (D. Ariz. Mar. 28, 2011) (unpublished order), *aff'd*, 649 F.3d 915 (9th
4 Cir.) (*Cook II*), *cert. denied*, 131 S. Ct. 2465 (2011).

5 On May 24, 2011, the night before the scheduled execution of Arizona prisoner
6 Donald Beaty, ADC notified Beaty and the Arizona Supreme Court that it intended to
7 substitute pentobarbital for sodium thiopental in carrying out Beaty's execution but that the
8 remaining aspects of the lethal injection protocol would be followed. In this notice, ADC
9 also stated that the change was necessitated by information it had received that day from the
10 United States Department of Justice, indicating that ADC's supply of sodium thiopental was
11 imported without compliance with the Controlled Substances Act and could not be used.

12 Beaty filed a § 1983 complaint, asserting a due process violation from insufficient
13 notice and arguing that a last-minute drug substitution would make it impossible for ADC
14 to comply with the protocol's training requirement, thus subjecting him to a substantial risk
15 of pain and suffering. This Court denied injunctive relief, concluding that the lack of
16 practice with pentobarbital was insufficient to demonstrate a risk of serious harm in light of
17 the protocol's safeguards ensuring the prisoner's anesthetization prior to administration of
18 pancuronium bromide and potassium chloride. *Beaty v. Brewer*, 791 F.Supp.2d 678, 684 (D.
19 Ariz. 2011). The Ninth Circuit affirmed. *Beaty v. Brewer*, 649 F.3d 1071 (9th Cir.), *cert.*
20 *denied*, 131 S. Ct. 2929 (2011).

21 On June 10, 2011, ADC amended Department Order 710 to provide for the
22 administration of sodium thiopental or pentobarbital as the first of the three sequentially-
23 administered drugs in its lethal injection protocol.

24 On July 15, 2011, Thomas West, along with the plaintiffs in *Dickens*, filed a § 1983
25 complaint challenging ADC's implementation of its lethal injection protocol. Specifically,
26 the plaintiffs alleged that ADC's failure to follow its written protocol and the addition of
27 pentobarbital created a substantial risk of unnecessary pain and violated their rights to due
28 process and equal protection. West also sought emergency injunctive relief to enjoin his

1 impending execution, which was denied. *See West v. Brewer*, CV-11-1409-PHX-NVW,
2 2011 WL 2836754 (D. Ariz. Jul. 18, 2011) (unpublished order), *aff'd*, 652 F.3d 1060 (9th
3 Cir.), *cert. denied*, 131 S. Ct. 3092 (2011). Thereafter, this Court denied a motion for
4 summary dismissal and ordered expedited discovery.

5 Following a bench trial in December 2011, the Court entered judgment against the
6 *West* plaintiffs, finding no constitutional infirmities from ADC's implementation of its lethal
7 injection protocol. *West v. Brewer*, No. CV-11-1409-PHX-NVW, 2011 WL 6724628 (D.
8 Ariz. Dec. 21, 2011) (unpublished order), *appeal docketed*, No. 12-15009 (9th Cir. Jan. 3,
9 2012). In particular, the Court determined that none of the complained-of
10 deviations—default use of a femoral central intravenous (“IV”) line; failure to conduct
11 required background checks of the IV team members, document their qualifications, and
12 ensure IV-setting as part of their current professional duties; and failure to affix multiple
13 labels on syringes and accurately document disposal of unused drugs—created a substantial
14 risk the plaintiffs would be improperly anesthetized or otherwise suffer needless suffering
15 and severe pain. The Court noted that ADC Director Charles L. Ryan has “discretion to
16 deviate from the written protocol when safety, security, or medical issues in individual
17 circumstances require temporary deviation from the written protocol.” *Id.* at *11. However,
18 the Court further observed that the written protocol should reflect actual practice and should
19 be amended if “ADC no longer intends to follow the protocol as currently written.” *Id.*

20 On January 25, 2012, ADC again amended Department Order 710 (“the January 2012
21 Protocol”). The revised protocol permits execution using either a three-drug or one-drug
22 protocol and requires ADC's director to choose between these two protocols at least seven
23 days prior to a scheduled execution. Ariz. Dep't Corr., Dep't Order 710, § 710.01, ¶ 1.1.2.4
24 & Attach. D, § C.1 (Jan. 25, 2012) (hereinafter “DO 710 (Jan. 2012)”). The protocol further
25 directs that the director, upon consultation with the IV team leader, shall determine the
26 catheter sites and that a central femoral venous line may not be utilized unless placed by a
27 medically-licensed physician with relevant experience. DO 710 (Jan. 2012), § 710.02, ¶
28 1.2.5.4 & Attach. D, § E.1.

1 The January 2012 Protocol also changed the composition and experience requirements
2 for the IV (Medical) team:

3 The IV Team will consist of any two or more of the following: physician(s),
4 physician assistant(s), nurse(s), emergency medical technician(s),
5 paramedic(2), military corpsman, phlebotomist(s) *or other appropriately*
6 *trained personnel* including those trained in the United States Military. All
7 team members shall have at least one year of relevant experience in placing
8 either peripheral or central femoral intravenous lines.

9 DO 710 (Jan. 2012), § 710.02, ¶ 1.2.5.1 (emphasis added). The previous version used the
10 phrase “or other medically trained personnel” instead of “other appropriately trained
11 personnel” and required one year of “*current* and relevant *professional* experience in their
12 assigned duties on the Medical Team” rather than just one year of “relevant experience.”
13 Ariz. Dep’t Corr., Dep’t Order 710, Attach. D, § B.1 (Sept. 12, 2011) (hereinafter “DO 710
14 (Sept. 2011)”). In addition, the revised protocol requires IV team members to participate in
15 “at least one training session with multiple scenarios within one day prior to a scheduled
16 execution” rather than ten execution “rehearsals” annually as previously required. DO 710
17 (Jan. 2012), §§ 710.02, ¶ 1.1.2, 710.02, ¶ 1.2.5.5; DO 710 (Sept. 2011), Attach. D, § B.5.
18 Finally, the revised protocol permits only telephonic contact between an inmate and his
19 attorney after 9:00 p.m. the night before a scheduled execution, whereas previously counsel
20 were permitted unlimited non-contact visitation. DO 710 (Jan. 2012), § 710.11, ¶ 1.5; DO
21 710 (Sept. 2011), § 710.09, ¶ 1.5.

22 On February 6, 2012, Plaintiffs filed a complaint pursuant to 42 U.S.C. § 1983,
23 challenging the manner and means by which ADC intends to execute condemned inmates by
24 lethal injection. (Doc. 1.) Specifically, Plaintiffs alleged that on its face ADC’s revised
25 protocol impermissibly eliminates safeguards, increases the ADC director’s discretion, and
26 codifies arbitrary and disparate treatment of capital prisoners, in violation of the Eighth and
27 Fourteenth Amendments. Plaintiffs further alleged constitutional violations from ADC’s
28 intent to execute them using the three-drug protocol, including use of pancuronium bromide
imported from a foreign source, instead of the one-drug option. Finally, Plaintiffs alleged
that the January 2012 Protocol violates their due process right to notice concerning the

1 specific drugs and venous access to be used during execution and their right of access to
2 counsel and the courts.

3 On February 14, 2012, Plaintiffs Moormann and Towery, who had been notified
4 pursuant to the January 2012 Protocol that ADC intended to execute them using the three-
5 drug protocol, moved for a preliminary injunction to enjoin their impending executions.
6 Following a hearing, at which neither party presented witnesses, the Court denied injunctive
7 relief. (Doc. 42.) On February 27, less than 48 hours before the first scheduled execution
8 and immediately preceding oral argument before the Ninth Circuit, ADC discovered
9 belatedly that its foreign-supplied pancuronium bromide had expired the previous month and
10 filed notice of intent to administer the one-drug protocol using domestically-obtained
11 pentobarbital. *Towery v. Brewer*, 672 F.3d 650, 657 (9th Cir. 2012). During argument to the
12 Ninth Circuit, counsel for ADC made representations regarding the qualifications of the IV
13 Team in place for the impending executions, preparation of backup syringes, and attorney-
14 client visitation the morning of the executions. *Id.* at 658. The appellate court ultimately
15 determined that Plaintiffs had failed to establish a likelihood of success on the merits of their
16 Eighth Amendment and equal protection challenges. *Id.* at 659-61.

17 Between February 29 and April 25, 2012, ADC carried out the executions of Plaintiffs
18 Moormann, Towery, and Kemp using the one-drug protocol. Each had either a peripheral
19 catheter, femoral catheter, or both inserted as the primary and backup IV lines during the
20 execution process. With regard to Towery, the IV Team made numerous unsuccessful
21 attempts to set a primary peripheral catheter, ultimately inserting a femoral central line for
22 the primary IV and a peripheral catheter in the prisoner's hand as the backup line.

23 On April 19, 2012, Plaintiffs filed a second amended complaint, alleging new claims
24 based on application of the January 2012 Protocol and withdrawing the claim concerning
25 foreign-imported pancuronium bromide. Specifically, the amended complaint alleged that
26 ADC treated Towery differently from other prisoners by spending nearly an hour to set the
27 IV catheters and that this differential treatment burdened Towery's fundamental right to be
28 free from cruel and unusual punishment. Plaintiffs also alleged that Towery was denied

1 access to counsel during ADC's attempts to set the IV catheters and thus, as applied, the
2 January 2012 Protocol prevents Plaintiffs from asserting legal claims based on their right to
3 be free from torture or a lingering death.

4 Plaintiff Lopez filed the instant motion for preliminary injunctive relief on May 1,
5 2012. Defendants filed a response, and Lopez filed a reply. (Docs. 64, 65.)

6 DISCUSSION

7 A preliminary injunction is "an extraordinary and drastic remedy, one that should not
8 be granted unless the movant, *by a clear showing*, carries the burden of persuasion." *Mazurek*
9 *v. Armstrong*, 520 U.S. 968, 972 (1997) (per curiam) (citation omitted). An injunction may
10 be granted only where the movant shows that "he is likely to succeed on the merits, that he
11 is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of
12 equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural*
13 *Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *see also Beardslee v. Woodford*, 395 F.3d
14 1064, 1067 (9th Cir. 2005). Under the "serious questions" version of the sliding-scale test,
15 a preliminary injunction is appropriate when a plaintiff demonstrates that "serious questions
16 going to the merits were raised and the balance of hardships tips sharply in the plaintiff's
17 favor." *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1135 (9th Cir. 2011)
18 (citation omitted). This approach requires that the elements of the preliminary injunction test
19 be balanced, so that a stronger showing of one element may offset a weaker showing of
20 another. "[S]erious questions going to the merits' and a balance of hardships that tips
21 sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the
22 plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is
23 in the public interest." *Id.*

24 In the context of a capital case, the Supreme Court has emphasized that these
25 principles apply when a condemned prisoner asks a federal court to enjoin his impending
26 execution because "[f]iling an action that can proceed under § 1983 does not entitle the
27 complainant to an order staying an execution as a matter of course." *Hill v. McDonough*, 547
28 U.S. 573, 583-84 (2006). Rather, "a stay of execution is an equitable remedy" and "equity

1 must be sensitive to the State’s strong interest in enforcing its criminal judgments without
2 undue interference from the federal courts.” *Id.* at 584.

3 **I. Merits of Claims**

4 Lopez asserts that he can meet the preliminary injunction standard on each of the
5 claims raised in his second amended complaint. His motion is based in large measure on
6 ADC’s implementation of the January 2012 Protocol in the Moormann, Towery, and Kemp
7 executions.

8 **A. Eighth Amendment**

9 The Eighth Amendment “prohibits punishments that involve the unnecessary and
10 wanton inflictions of pain, or that are inconsistent with evolving standards of decency that
11 mark the progress of a maturing society.” *Cooper v. Rimmer*, 379 F.3d 1029, 1032 (9th Cir.
12 2004). That prohibition necessarily applies to the punishment of death, precluding
13 executions that “involve torture or a lingering death, or do not accord with the dignity of
14 man.” *Beardslee v. Woodford*, 395 F.3d at 1070 (internal citations omitted). A violation of
15 the Eighth Amendment can be established by demonstrating there is a “substantial risk of
16 serious harm” that is sure or very likely to cause pain and needless suffering. *Dickens v.*
17 *Brewer*, 631 F.3d at 1144-46 (adopting *Baze* plurality); *see also Brewer v. Landrigan*, 131
18 S. Ct. at 445. The risk must be an “‘objectively intolerable risk of harm’ that prevents prison
19 officials from pleading that they were ‘subjectively blameless for purposes of the Eighth
20 Amendment.’” *Baze*, 553 U.S. at 50 (citing *Farmer v. Brennan*, 511 U.S. 825, 842 (1994)).

21 Lopez argues that ADC’s actions surrounding the insertion of IV catheters in
22 condemned prisoners demonstrates an objectively intolerable risk of harm. (Doc. 62 at 24-
23 25.) Specifically, Lopez asserts that Towery was subjected to a risk of “pain and discomfort”
24 from the placement of a backup IV line in one of his hands after the IV Team was unable to
25 place a line in either of his arms, and that Kemp was subjected to an increased risk of pain
26 and suffering from placement of a femoral central line. (*Id.* at 25.) This Court previously
27 rejected the argument that use of a femoral central line creates a risk of constitutionally
28 unacceptable pain and suffering:

1 In *Baze*, the Court stated, “Simply because an execution method may
2 result in pain, either by accident or as an inescapable consequence of death,
3 does not establish the sort of ‘objectively intolerable risk of harm’ that
4 qualifies as cruel and unusual.” 553 U.S. at 50. In addition, “a condemned
5 prisoner cannot successfully challenge a State’s method of execution merely
6 by showing a slightly or marginally safer alternative.” *Id.* at 51. “To qualify,
7 the alternative procedure must be feasible, readily implemented, and in fact
8 significantly reduce a substantial risk of severe pain.” *Id.* at 52 (emphasis
9 added).

6 At trial Plaintiffs’ expert described the process involved in placing a
7 femoral central line. Unlike a peripheral IV, for which the needle and catheter
8 are one unit and are placed just below the surface of the skin into a visible
9 vein, a central line requires use of a larger needle to go through skin,
10 subcutaneous tissue, and muscle to reach the larger femoral vein. An
11 ultrasound is used to locate the vein and a local anesthetic (lidocaine) is
12 applied. Once the needle reaches the vein, a guide wire is threaded into the
13 vein, the needle is removed, the skin next to the wire is incised with a scalpel
14 to enlarge the opening, a dilator slightly larger than the catheter is used to clear
15 a wider path, and then the catheter is placed and secured with two sutures or
16 staples. Unlike a peripheral IV, the placement of a central line requires an
17 advanced level of training and is ordinarily undertaken only by a physician.

13 At most, the evidence at trial showed that a prisoner may experience
14 some pain and discomfort during placement of a central line if the topical
15 anesthetic is improperly administered before the skin is punctured. However,
16 this pain, as Plaintiffs’ own expert conceded, is difficult to quantify. The
17 evidence at trial also demonstrated that none of the prisoners during the past
18 five executions verbally complained of, or appeared to experience, any pain
19 while [the Medical Team Leader] placed the central line.

17 Therefore, the Court finds that any pain attendant to placement of a
18 central line, beyond that likely to accompany placement of a peripheral IV
19 line, falls far short of the severity needed to trigger an Eighth Amendment
20 violation. *Cf. Baze*, 553 U.S. at 53 (describing the “constitutionally
21 unacceptable” pain from suffocation and cardiac arrest a prisoner would
22 experience if not fully anesthetized prior to administration of pancuronium
23 bromide and potassium chloride). Accordingly, the Eighth Amendment does
24 not require that ADC administer the drugs through a peripheral vein whenever
25 feasible. To find otherwise would in effect turn this Court into a “board[] of
26 inquiry charged with determining ‘best practices’ for executions.” *Id.* at 51.

22 *West*, 2011 WL 6724628, at *17-18.

23 Lopez has not cited any legal authority or alleged any facts that bring into question
24 the prior conclusion in *West* that the Eighth Amendment is not offended by administration
25 of lethal chemicals through a femoral central line. Nor is there any persuasive or even
26 colorable reason to think that placement of a peripheral IV line in a prisoner’s hand, while
27 possibly more uncomfortable than other peripheral sites, poses an objectively intolerable risk
28 of severe pain that qualifies as cruel and unusual. Indeed, the IV line was placed in Tower’s

1 hand only after placement at all preferable peripheral sites had failed. The contention that
2 Towery was thus subjected to cruel and unusual punishment because it was necessary to
3 place the backup IV in his hand is meritless.

4 Therefore, Lopez’s assertion that the IV-placement process in the Towery execution
5 gives rise to an objectively intolerable risk of serious harm in future executions is also
6 meritless. Again, an objectively intolerable risk of pain for purposes of the Eighth
7 Amendment is not established “[s]imply because an execution method *may result in pain*,
8 either by accident or as an inescapable consequence of death.” *Baze*, 553 U.S. at 50
9 (emphasis added). Repeated punctures in IV-placement attempts are not uncommon in the
10 execution context, as shown by the evidence in the *West* litigation, and do not result in the
11 type of pain prohibited by the Eighth Amendment. Nor is it rare in therapeutic medicine.
12 Lopez asserts that both the femoral artery and the femoral vein were punctured and that
13 Towery likely experienced pain as a result. (Doc. 65 at 3.) He further asserts that ADC
14 administered lethal chemicals to Robert Comer through his femoral artery. (*Id.*) Accepting
15 these allegations as true, they fall far short of showing that arterial administration results in
16 a constitutionally unacceptable level of pain. Moreover, the Supreme Court has emphasized
17 that “an isolated mishap alone does not give rise to an Eighth Amendment violation,
18 precisely because such an event, while regrettable, does not suggest cruelty, or that the
19 procedure at issue gives rise to a substantial risk of serious harm.” *Baze*, 553 U.S. at 50
20 (internal citation omitted). The difficulty and delay in placing two working IV lines in
21 Towery appears to be atypical and may very well have been a result of his having been a
22 habitual intravenous drug user. *See Towery v. Ryan*, 641 F.3d 300, 313 (9th Cir. 2010).
23 While undoubtedly disquieting to a condemned inmate awaiting execution, repeated efforts
24 to set IV lines do not, in and of themselves, suggest malevolence from Defendants, extreme
25 pain, or even unnecessary pain. For these reasons Lopez has failed to show either “serious
26 questions” or a likelihood of success on the merits of an Eighth Amendment claim based on
27 placement of IV lines in past executions.

28 Lopez also asserts that Defendants “have designed a protocol that permits unfettered

1 discretion at the very points where *Baze* sought to limit the potential for error through
2 safeguards” and thus Arizona’s lethal injection protocol is “outside the constitutional
3 framework constructed in *Baze*.” (Doc. 62 at 25.) However, Lopez acknowledges that *Baze*
4 considered the risk of pain only in the context of administering a three-drug protocol. (*Id.*
5 at 24.) In *Baze*, the safeguards against maladministration of the first anesthetic drug were
6 found important because there is no dispute that administration of pancuronium bromide and
7 potassium chloride to a conscious individual will cause excruciating pain and suffering.
8 *Baze*, 553 U.S. at 53-56. Here, ADC has notified Lopez that it intends to administer the one-
9 drug protocol, the same method of execution advocated by both the plaintiff in *Baze* and the
10 plaintiffs in *Dickens* and *West*. Under Arizona’s one-drug protocol, ADC will administer
11 only a lethal dose of anesthetic; it will not administer either pancuronium bromide or
12 potassium chloride. Thus, Lopez’s concern that Arizona’s one-drug protocol is “outside the
13 constitutional framework” of *Baze* does not survive scrutiny.

14 A one-drug protocol using a lethal dose of barbiturate is not immune from attack
15 under the Eighth Amendment. However, in the context of the complaint in this case,
16 Plaintiffs have not asserted that maladministration of the lethal chemical used in Arizona’s
17 one-drug regimen will cause substantial pain.² Rather, the Eighth Amendment claim
18 presented in the complaint is that a condemned inmate may not be sufficiently unconscious
19 when receiving a dose of pancuronium bromide and potassium chloride. (*See* Doc. 58 at 22
20 (“The January 2012 Protocol no longer has constitutionally adequate protections to ensure
21 that a prisoner will not suffer from the second and third drugs.”); *see also* Doc. 8 at 8 (“[U]se
22 of a barbiturate-only protocol would eliminate the risk of substantial pain that would occur
23 if pancuronium bromide and potassium chloride were administered to an improperly
24

25 ²Although he does not directly assert that Kemp experienced substantial pain as a
26 result of being injected with pentobarbital, Lopez references a witness’s statement that Kemp
27 shook “violently” for five or six seconds, possibly as a result of a partial seizure. (Doc. 62
28 at 13.) If in fact Lopez is asserting that execution using only a lethal dose of pentobarbital
results in constitutionally unacceptable pain, there is insufficient evidence in the record to
establish a likelihood of success on such a claim.

1 anesthetized prisoner.”.) Lopez has not demonstrated any objectively intolerable risk of
2 pain from administration of the one-drug protocol.

3 **B. Disparate Treatment**

4 Lopez argues that, on its face and as applied, the January 2012 Protocol violates his
5 right to equal protection. (Doc. 62 at 20.) The Equal Protection Clause of the Fourteenth
6 Amendment commands that no State shall “deny to any person within its jurisdiction the
7 equal protection of the laws.” U.S. Const. amend. XIV, § 1. A state practice that
8 discriminates against a suspect class of individuals or interferes with a fundamental right is
9 subject to strict scrutiny. *Massachusetts Bd. of Ret. v. Murgia*, 427 U.S. 307, 312 (1976).
10 Lopez asserts that Defendants’ disparate treatment of different condemned inmates burdens
11 his right to be free from cruel and unusual punishment.³

12 In *Towery*, the Ninth Circuit observed that a prisoner’s right to be free from cruel and
13 unusual punishment “is not affected simply because that prisoner is treated less favorably
14 than another, where one means of execution is no more likely to create a risk of cruel and
15 unusual punishment than the other, and both are constitutionally available.” *Towery*, 672
16 F.3d at 660. However, a risk of being subjected to cruel and unusual punishment may be
17 implicated if plaintiffs show an actual pattern of treating prisoners differently in ways that
18 “affect the *risk* of pain to which they would be subjected.” *Id.* Lopez argues that each of the
19 prisoners that have been executed since adoption of the January 2012 Protocol have been
20 treated differently with respect to placement of the IV catheters and that these variances
21 affected the risk of pain to which each was subjected. (Doc. 62 at 23.) That is mistaken.

22 First, the Ninth Circuit has recognized that the task of selecting which IV site to use
23 may appropriately be made on a case-by-case basis, based on “individualized and changing
24 factors” such as the condition of a prisoner’s veins. *Towery*, 672 F.3d at 661. Second, in
25 *Towery*, the Ninth Circuit found that Plaintiffs had failed to show a pattern of treating

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27 ³Lopez does not urge the class-of-one equal protection theory advanced by Moormann
28 and *Towery* in their motion for preliminary injunction. It is difficult to see how any such
claim could survive after *Towery*. 672 F.3d at 660-61 (rejecting class-of-one argument).

1 prisoners differently in ways that affected the risk of pain, either generally or with respect
2 to the planned application of the January 2012 Protocol to Moormann and Towery, including
3 the fact that ADC’s Director had the discretion to decide whether to use peripheral or central
4 femoral IV access after consultation with the IV Team Leader. *Id.* at 659-60. There is no
5 dispute that at the time of the *Towery* decision, ADC had utilized either peripheral or femoral
6 (or both) IV lines in carrying out each of the previous 26 executions by lethal injection.
7 Third, as already addressed above, use of a femoral catheter is no more likely to create a risk
8 of cruel and unusual punishment than use of a peripheral catheter. For these reasons, Lopez
9 has not raised serious questions or shown a likelihood of success on the merits of his equal
10 protection claim.

11 C. Lack of Notice

12 Lopez argues that the January 2012 Protocol fails to provide reasonable notice of
13 “critical aspects” of the mode and manner in which Defendants will carry out executions,
14 including the method of IV access and the qualifications of the individuals placing the IV
15 catheters. (Doc. 62 at 16.) He asserts that failing to provide this information and preventing
16 access to counsel during the insertion of IV lines deprives him of his right to notice and an
17 opportunity to be heard under the Due Process Clause of the Fourteenth Amendment.⁴
18 Plaintiffs Moormann and Towery raised a similar claim in their motion for preliminary
19 injunction, which the Court found wanting.⁵ (Doc. 42 at 24-26.) Lopez has provided no new
20 authority that was not previously considered by the Court.

21 To establish a procedural due process violation, Plaintiffs must show that (1) they had
22 a property or liberty interest with which Defendants interfered, and (2) Defendants failed to
23 use constitutionally sufficient procedures in depriving Plaintiffs of that right. *Kentucky Dep’t*
24 *of Corrections v. Thompson*, 490 U.S. 454, 460 (1989). “[A]n individual claiming a
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26 ⁴The access-to-counsel issue is discussed next in Section I.D.

27 ⁵Plaintiffs did not appeal this aspect of the Court’s ruling. *See Towery*, 672 F.3d at
28 656 n.3.

1 protected interest must have a legitimate claim of entitlement to it. Protected liberty interests
2 ‘may arise from two sources—the Due Process Clause itself and the laws of the States.’” *Id.*
3 (citing *Hewitt v. Helms*, 459 U.S. 460, 466 (1983)).

4 Lopez does not allege that Arizona law creates an enforceable liberty interest. Indeed,
5 as explained in the Court’s prior order, Arizona’s lethal injection protocol is not statutory—it
6 is issued by ADC and sets out technical procedures for carrying out lethal injection. (Doc.
7 42 at 18.) Rather, Lopez relies on a district court ruling in *Oken v. Sizer*, 321 F.Supp. 2d 658,
8 664 (D. Md.), *stay vacated*, 542 U.S. 916 (2004) (Mem.), in which the court stated:
9 “Fundamental fairness, if not due process, requires that the execution protocol that will
10 regulate an inmate’s death be forwarded to him in prompt and timely fashion.” However,
11 there is no dispute that Lopez has access to ADC’s protocol. The issue is whether he has a
12 due process right to advance notice of the intended method of IV access and the
13 qualifications of the IV Team who will be placing the IV catheters. He does not.

14 First, Lopez has pointed to no authority suggesting he has a right, prior to an
15 execution, to challenge the qualifications of the IV Team or the method of intravenous
16 access. *See Clemons v. Crawford*, 585 F.3d 1119, 1129 n.9 (8th Cir. 2009) (noting lack of
17 authority indicating due process right to probe into backgrounds of execution personnel).
18 Second, Lopez has not shown that lack of such notice will impair consideration of a colorable
19 Eighth Amendment claim. To require the requested notice would in effect permit
20 constitutional challenges based on speculative injuries and the possibility of negligent
21 administration. The Sixth Circuit has recognized that such actions are

22 not only unsupported by Supreme Court precedent but [are] also beyond the
23 scope of our judicial authority. *See, e.g., Gregg v. Georgia*, 428 U.S. 153,
24 174-75 (1976) (“[W]hile we have an obligation to insure that constitutional
25 bounds are not overreached, we may not act as judges as we might as
26 legislators.”). While the Eighth Amendment does provide a necessary and not
27 insubstantial check on states’ authority to devise execution protocols, its
28 purpose is not to substitute the court’s judgment of best practices for each
detailed step in the procedure for that of corrections officials. *See Baze*, 128
S. Ct. at 1537 (“[A]n inmate cannot succeed on an Eighth Amendment claim
simply by showing one more step the State could take as a failsafe for other,
independently adequate measures. This approach would serve no meaningful
purpose and would frustrate the State’s legitimate interest in carrying out a
sentence of death in a timely manner.”).

1 *Cooey v. Strickland*, 589 F.3d 210, 225 (6th Cir. 2009).

2 Lopez has not shown any credible prospect that information concerning venous access
3 and the IV Team will lead to presentation of a viable Eighth Amendment claim. Specifically,
4 Lopez has not alleged any facts to support the inference that the risk of pain and suffering
5 during a lethal injection execution changes substantially based on the siting of the
6 intravenous access, and the Court has rejected the argument that use of a femoral central line
7 creates a risk of constitutionally unacceptable pain and suffering. *See West*, 2011 WL
8 6724628, at *17-18. Therefore, due process does not require advance notice of intended
9 venous access sites.

10 Similarly, any pre-execution challenge based on qualifications of the IV Team would
11 likely fail to establish a substantial risk of serious harm. Before both this Court and the Ninth
12 Circuit, Defendants asserted that the “relevant experience” necessary for selection to the IV
13 Team under the revised protocol “means that IV Team members must have no less than the
14 training that is traditionally given for people to be licensed to place IVs.” *Towery*, 672 F.3d
15 at 658. This representation is “binding” as to the meaning of “appropriately trained” and
16 “relevant experience” in the context of the January 2012 Protocol. *Id.* Moreover, the
17 protocol requires that a central femoral line be placed only by a medically-licensed physician
18 with at least one year of relevant experience placing such lines. DO 710 (Jan. 2012), §
19 710.02, ¶ 1.2.5.1, ¶ 1.2.5.4 & Attach. D, § E.1. Given these requirements, any pre-execution
20 challenge to the qualifications of individual IV Team members would necessarily be based
21 on speculation as to their ability to set IV catheters. Consequently, due process does not
22 demand more notice than is already set forth in the protocol concerning the qualifications of
23 the IV Team.

24 The lack of correlation between the due process right alleged in this case and the
25 ability to pursue a claim of cruel and unusual punishment is even more pronounced here
26 because Lopez will be executed using a one-drug protocol, and he has not alleged or
27 identified the harm that would result from faulty IV siting or deficient IV Team
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1 qualifications. Again, implementation of a one-drug protocol is not immune from attack
2 under the Eighth Amendment. However, Lopez simply has not articulated any specific harm
3 from the risk of maladministration of a barbiturate in the absence of pancuronium bromide
4 and potassium chloride also being administered as part of the execution protocol.

5 In substance, the relief Plaintiffs seek under the guise of due process is a right to
6 judicial pre-clearance in every execution regarding whether ADC will comply with its
7 protocol and how it will deal with contingencies. This is simply not a proper role for the
8 judiciary in the absence of a demonstrated likely deprivation of constitutional rights.
9 Admittedly, ADC does not have a perfect track record in the way it has administered and
10 changed its protocol since resumption of executions in October 2010. *See Towerly*, 672 F.3d
11 at 653. Most recently, ADC's failure to discover until the last minute the expiration of its
12 supply of pancuronium bromide, forcing an unexpected, eve-of-execution switch to the one-
13 drug protocol, is inexplicable. On the other hand, at least one last-minute change—the
14 switch to pentobarbital on the eve of Beaty's execution—was driven by inmate litigation, not
15 caprice.

16 In *West*, testimony was heard concerning the importation of sodium thiopental and the
17 Department of Justice's eve-of-execution request that the imported drug not be used in
18 Beaty's execution. The evidence showed that it was reasonable for ADC to believe the FDA
19 had "approved" the drug's importation, that ADC was unaware of certain DEA requirements
20 for importing sodium thiopental, and that ADC did not intentionally or knowingly import
21 drugs unlawfully. *West*, 2011 WL 6724628, at *19. Although ADC had deviated from its
22 protocol either inadvertently or by design, such deviations were not undertaken in bad faith
23 and none subjected condemned inmates to an objectively intolerable risk of harm. *Id.* at *17.
24 Consequently, the plaintiffs' contentions that ADC could not be trusted to adhere to its
25 protocol and that judicial oversight was necessary to ensure protocol compliance were
26 unpersuasive. Similarly, nothing in the instant motion carries the burden of persuasion.

27 **D. Access to Counsel and Courts**

28 The January 2012 Protocol precludes in-person legal visitation after 9:00 p.m. the day

1 before a scheduled execution, instead permitting only telephonic contact with attorneys of
2 record. Lopez alleges such calls will take place in a holding cell where ADC officers will
3 be present and thus there will be “no opportunity for privileged communication.” (Doc. 62
4 at 18.) This restriction, Lopez asserts, violates his rights to meaningful access to counsel and
5 the courts under the First, Fifth, Eighth, and Fourteenth Amendments.

6 In its prior order denying injunctive relief for Moormann and Towery, the Court
7 addressed this claim and determined that Plaintiffs had failed to establish a likelihood of
8 success on the merits. (Doc. 42 at 26-28.) During oral argument before the Ninth Circuit,
9 counsel for Defendants agreed to the panel’s request to permit counsel for Towery and
10 Moormann to meet in person with their clients the morning of each execution, thus mooting
11 appeal of the issue for Towery and Moormann. *Towery*, 672 F.3d at 658. The court
12 referenced ADC’s “long-standing” practice of permitting such visitation. *Id.*

13 Although Lopez asserts he has no reason to believe ADC will permit similar access,
14 Defendants state in their response that counsel for Lopez will be permitted in-person
15 visitation the morning of the execution up to 7:00 a.m. (Doc. 64 at 13.) Defendants assert
16 that morning-of visitation was permitted from 6:00 to 7:00 a.m. for the Landrigan, King,
17 Beaty, Bible, and West executions, and that, notwithstanding the terms of the current
18 protocol, ADC intends to offer the same visitation terms to counsel for Lopez. Lopez asserts
19 that he should be permitted visitation at least until 45 minutes before the start of the 10:00
20 a.m. execution, as directed by the Ninth Circuit for the executions of Moormann and Towery.
21 *See Towery*, 672 F.3d at 658 (referencing 2004 version of Department Order 710). The issue
22 of meeting in person with counsel up to 7:00 a.m. may not be technically moot, but Lopez’s
23 fear that ADC will dishonor its commitment to allow such access is unpersuasive, especially
24 in light of ADC’s honoring its commitment made to the Ninth Circuit concerning the Towery
25 and Moormann executions.

26 The dispute remains concerning in-person meeting with counsel from 7:00 a.m. up to
27 and during the execution. This Court previously determined that Plaintiffs had not shown a
28 likelihood of success on their access-to-courts claim based on the visitation policy change

1 enacted by the January 2012 Protocol. The Court adopts its previous conclusion, which
2 applies with stronger force the closer the time of execution approaches. Communication with
3 counsel by telephone is still permitted past 7:00 a.m. It is difficult to see how Lopez could
4 speak in confidence with his lawyer in person, but not in confidence on the telephone, as he
5 conclusorily asserts. Like Towery and Moorman before him, Lopez makes no attempt to
6 show that confidential telephone communication cannot be effective in the three hours before
7 execution. The legitimate purpose of access to courts is served by telephonic contact.
8 Moreover, after the exhaustive and repetitive litigations that Lopez’s counsel have conducted
9 in numerous prior executions, the chance of anything happening in the last minutes that could
10 result in successful immediate litigation attenuates well below the threshold for injunctive
11 relief.

12 Lopez also argues that he is entitled to have counsel observe the IV-placement
13 procedure. (Doc. 62 at 19; Doc. 65 at 4 n.3.) He alleges that ADC refused Towery’s request
14 to meet with counsel during the hour it took to set functioning IV lines and that without such
15 access he will be denied meaningful access to the courts.

16 Prisoners have a constitutional right of access to the courts that is “adequate, effective,
17 and meaningful.” *Bounds v. Smith*, 430 U.S. 817, 822 (1977). However, this right
18 “guarantees no particular methodology but rather the conferral of a capability—the capability
19 of bringing contemplated challenges to sentences or conditions of confinement before the
20 courts.” *Lewis v. Casey*, 518 U.S. 343, 354 (1996). Consequently, an inmate who brings a
21 § 1983 claim based on his right of access to the courts must be able to show that the
22 infringing act somehow defeated his ability to pursue a legal claim. That is, a prisoner must
23 show he suffered an “actual injury” as a result of the defendant’s actions. *Id.* at 348-49. An
24 “actual injury” is “actual prejudice with respect to contemplated or existing litigation, such
25 as the inability to meet a filing deadline or to present a claim.” *Id.* at 348. The right of
26 access does not create “an abstract, freestanding right,” but exists to vindicate other rights.
27 *Id.* at 351.

28 Lopez does not identify any contemplated litigation that will be inhibited by the lack

1 of access to counsel during the IV-placement procedure, other than to speculate that some
2 circumstance may arise immediately prior to his execution that presents a constitutional
3 concern. This is insufficient to demonstrate actual injury under *Lewis v. Casey*. Moreover,
4 as discussed above, repeated attempts to place an IV line do not raise a *per se* claim of cruel
5 and unusual punishment. If the IV Team is unable to place a functioning IV line, Arizona’s
6 protocol provides that the Director may restart the procedure at a later time within the
7 warrant’s 24-hour period or abandon the effort altogether. DO 710 (Jan. 2012), Attach. D,
8 § I.3. In such event, nothing in Arizona’s protocol precludes the prisoner from access to
9 counsel and, consequently, pursuit of any appropriate judicial remedies.

10 Lopez’s argument from the circumstances of the Towery execution especially fails.
11 Even with after-the-fact examination, there was nothing in the Towery execution that would
12 have warranted judicial proceedings. The difficulty of finding IV access sites required
13 immediate further effort by the IV Team, not intervention by this Court.

14 **II. Irreparable Harm, Balance of Equities, and Public Interest**

15 Although there is a likelihood of irreparable harm in every § 1983 action challenging
16 a proposed method of execution, that factor alone is insufficient to warrant injunctive relief
17 where there is no significant possibility of success on the merits. In *Hill v. McDonough*, the
18 Court recognized the “important interest in the timely enforcement of a sentence” and
19 cautioned that federal courts “can and should protect States from dilatory or speculative
20 suits.” 547 U.S. at 584-85. Given the State’s “strong interest in enforcing its criminal
21 judgments without undue interference from the federal courts,” and because “the victims of
22 crime have an important interest in the timely enforcement of a sentence,” the Court
23 concludes that the balance of equities favors Defendants and that a stay of execution to
24 resolve Lopez’s speculative allegations is not in the public interest. *Id.* at 584.

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IT IS THEREFORE ORDERED that the Motion by Plaintiff Lopez for Preliminary Injunction (Doc. 62) is **DENIED**.

DATED this 7th day of May, 2012.



Neil V. Wake
United States District Judge

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15 **IN THE UNITED STATES DISTRICT COURT**
16 **FOR THE DISTRICT OF ARIZONA**

17 Towery, et al.,
18 Plaintiffs,
19 v.
20 Brewer, et al.,
21 Defendants.

Case No. 2:12-cv-00245-NVW

DEATH PENALTY CASE
Execution Scheduled
May 16, 2012 at 10:00 a.m.

**Reply to Response to Motion for
Preliminary Injunction**

22
23 In their Response to Plaintiff Samuel Lopez's Motion for Preliminary Injunction,
24 Defendants fail to address factual circumstances and legal arguments that this Court has not
25 yet considered. Instead, they ask this Court to deny the motion based on its previous findings
26 in *Towery v. Brewer*, No. 12-cv-245-PHX-NVW, 2012 WL 592749 (D. Ariz. Feb. 23, 2012).
27 This case presents new factual developments in light of the three most recent executions and
28 presents new legal arguments related, in part, to an as-applied challenge to the January 2012
Protocol. Therefore, this Court should grant the preliminary injunction, stay Lopez's
execution, and allow him to proceed to trial on the merits of his claims.

I. Introduction

Defendants attempt to persuade the Court to deny Lopez’s motion by claiming that the January 2012 Protocol is essentially the same protocol that this Court and the Ninth Circuit reviewed in *Towery v. Brewer*. It is not. In *Towery*, the Ninth Circuit “amended” the protocol based on Defendants’ representations that both IV team members had experience placing IVs within the last twelve months—one was a licensed nurse with seventeen years experience and the other was a medically-licensed physician. *Towery v. Brewer*, 672 F.3d 650, 658 (9th Cir. 2012). And it accepted, for purposes of Moormann’s and Towery’s execution, that the IV team members “must have no less than the training that is traditionally given for people to be licensed to place IVs.” *Id.* The conclusion made by the Ninth Circuit in *Towery* is not based on the written language of the January 2012 Protocol. Rather it is based on the representations that were made by counsel during argument. Those representations are no longer being made by counsel. Thus, the issue regarding the qualifications of IV team members remains unresolved.

In addition to ignoring the qualifications of those retained by ADC to perform executions, Defendants also remain silent regarding Towery’s denial of counsel immediately before his execution. The Ninth Circuit also “amended” the protocol to assure that access to counsel would be permitted the morning of an execution under “long-standing ADC practice.” *Id.* Lopez presented the undisputed declaration of Dale A. Baich as factual support that Towery was denied access to counsel, and in turn, the courts shortly before he was executed. Defendants have done nothing to rebut those facts.

This Court should refrain from following Defendants’ conclusory logic and instead should rely upon the undisputed declarations submitted in support of Lopez’s request for preliminary injunction and grant Lopez relief. *See Ross-Whitney Corp. v. Smith Kline & French Laboratories*, 207 F.2d 190, 198 (9th Cir. 1953) (holding that “a preliminary injunction may be granted upon affidavits”); *International Paper Co. v. Inhabitants of the Town of Jay*, 672 F. Supp. 29, 33 (D. Me. 1987) (“court may rely on affidavits and pleadings alone where basic facts are not disputed”); *Scott & Fetzer Co. v. McCarty*, 450 F. Supp. 274,

1 277, n.4 (N.D. Ohio 1977) (noting that “district court has discretion to forego an evidentiary
2 hearing where undisputed facts, submitted affidavits, or other factors render such a hearing
3 unnecessary”).

4 **II. This Court Should Issue a Preliminary Injunction**

5 In a cursory manner, Defendants simply state that Lopez is not entitled to an
6 injunction because ADC has not deviated from the protocol used in carrying out Towery’s
7 and Moormann’s executions. (ECF No. 64 at 5.) By doing so, they fail to rebut the merits
8 of Lopez’s claims.

9 **First Claim: Eighth Amendment Violation**

10 Defendants assert that Lopez cannot show an Eighth Amendment violation where
11 there was no evidence that Towery or Kemp experienced pain or suffering. (ECF No. 64 at
12 9.)¹ Towery’s autopsies, however, revealed that the both the femoral artery and the femoral
13 vein were punctured. (ECF No. 54-1, attached as Ex. W, at 1; *see also* Email from Eric D.
14 Peters, M.D., to Robin Konrad, dated May 4, 2012, attached as Ex. KK (indicating that
15 medical examiner did not puncture the artery); Summary Statement of Joseph I Cohen, M.D.,
16 dated May 5, 2012, attached as Ex. LL.) If the IV line was placed in the artery and the
17 pentobarbital was administered, then it was likely that Towery experienced pain. (*See*
18 Nembutal Sodium, FDA Label, attached as Ex. MM, at 3 (noting, under precautions, that
19 “extreme care should be taken to avoid . . . intra-arterial injection” because “consequences
20 of intra-arterial injection may vary from transient pain to gangrene of the limb”); *see also*
21 Testimony of Mark Dershwitz, M.D., dated Dec. 9, 2008, attached as Ex. NN, at 93:15-17
22 (noting that thiopental “if injected into an artery” is painful)).

23 Moreover, Defendants also claim that Lopez has not shown that the IV team was
24 unqualified. When Defendants’ expert Mark Dershwitz, M.D., was asked during the *Dickens*
25 *v. Napolitano* proceedings whether it was possible to puncture the femoral artery when
26

27 ¹Defendants state that Kemp’s execution occurred “without incident.” (ECF No. 64
28 at 2.) This, however, is not true. Kemp possibly suffered a seizure, as he convulsed for at
least five seconds. Kemp also had two punctures in his left arm and a femoral catheter.

1 attempting to place a femoral line, he responded: “I will acknowledge that virtually anything
2 is possible. However, because one typically palpates the artery with the fingers of one hand
3 while inserting the needle with the fingers of the other, that’s a relatively uncommon adverse
4 effect in my experience.” Ex. NN at 92:9-14. Even Defendants’ own expert argues that
5 puncturing the femoral artery is uncommon. Yet it happened in one of the three most recent
6 executions under the January 2012 Protocol. And this is not an isolated incident: Defendants
7 executed a prisoner in 2007 by injecting the lethal drugs through the femoral artery instead
8 of the vein.² Defendants have a history of retaining unqualified individuals to participate in
9 executions.

10 In attempting to rebut Lopez’s argument that the IV procedure during Towery’s
11 execution was unreasonable, Defendants “[a]ssum[e] the IV team leader . . . suggested
12 making a final effort to set a peripheral backup line, rather than proceeding straight to setting
13 the backup line in Towery’s hand” (ECF No. 64 at 8 (emphasis added).) Lopez
14 supported his facts with direct citation to the execution logs provided by Defendants. That
15 Defendants would have to “assume” something that it is reflected in their own logs calls into
16 question the reliability of their procedures.³ Defendants likewise have done nothing other
17 than to state that the actions of the IV team leader—which they suggest could be
18 hypothetical—were “not unreasonable.” (ECF No. 64 at 8.) This statement, however, does
19

20 ²Robert Comer’s autopsy report revealed that Defendants administered the lethal drugs
21 through his femoral artery. (See Autopsy Report of Robert C. Comer, dated May 23, 2007,
22 attached as Ex. OO at 5.)

23 ³Equally, if not more, puzzling is Defendants’ Answer to Plaintiffs’ Second Amended
24 Complaint. Many paragraphs of the Second Amended Complaint included facts related to
25 the executions of Towery and Moormann, which involved timing of activities. (See, *i.e.*,
26 ECF No. 58, ¶¶113-16, 118-20, 123-29, 132-33, 135-38.) In their Answer, Defendants admit
27 each of the activities alleged by Plaintiffs, but claim they are “without information or belief
28 as to the exact time alleged.” (ECF No. 63, ¶¶113-16, 118-20, 123-29, 132-33, 135-38.)
Defendants, however, are the ones who provided the execution logs upon which Plaintiffs
have based the times in their complaint. Defendants’ statement that they are “without
information” lends further support for Lopez’s request that counsel be present to observe the
IV procedure.

1 not refute the declaration of Eric Katz, M.D., submitted by Lopez in support of his motion.
2 Dr. Katz explains that it was “unreasonable to suggest setting a peripheral line (back-up or
3 otherwise) in a vein in which IV personnel were demonstrably unable to set an IV after
4 multiple attempts.” (Ex. AA, ¶ 7.)

5 **Second and Third Claims: Equal Protection Violation**

6 Defendants flippantly assert that Lopez has offered “nothing new, other than the
7 information regarding the executions of Moormann, Towery, and Kemp, to show that the
8 execution protocol violates Equal Protection.” (ECF No. 64 at 10.) But the past several
9 executions, and the circumstances surrounding them, are critical. Indeed, Defendants’ only
10 legal argument is that Lopez cannot show that the three most recently executed prisoners
11 were treated differently such that they were subjected to a “substantial risk of pain.” (ECF
12 No. 64 at 11.) Defendants position, however, ignores the recent Ninth Circuit opinion in
13 *Towery v. Brewer*, which indicated that there could be an equal-protection violation requiring
14 strict-scrutiny analysis where a prisoner shows that state action *burdens* fundamental rights.
15 672 F.3d at 660. The *Towery* court found that such burden could be shown through a
16 “pattern of treating prisoners differently in ways that [] affect[ed] the *risk* of pain to which
17 they would be subjected.” *Id.* at 660 (citation omitted). Defendants disregard that holding
18 and present no compelling state interest for the varying treatment of prisoners.

19 **Fourth Claim: Due Process Violation**

20 Defendants argue that Lopez is not entitled to notice regarding where the IV
21 catheter(s) will be placed, and they argue the January 2012 Protocol provides sufficient
22 notice regarding the qualifications of the IV team members. (ECF No. 64 at 11.) Defendants
23 cannot prevent a prisoner from knowing in advance information regarding his execution and
24 when something goes awry during the process, prevent him access to counsel and the courts.
25 Furthermore, Defendants cite to the written terms of the January 2012 Protocol to satisfy this
26 Court that prisoners are provided notice of the qualifications of the persons performing the
27 surgical incision or setting peripheral IVs—which he will find out only minutes before his
28 death. The Ninth Circuit was concerned about the vague terms related to the training and

1 qualifications of individuals, and it therefore explained the “amended” terms of the protocol.
2 *Towery*, 672 F.3d at 658. The detailed information provided by the Ninth Circuit is not
3 written in the protocol, and Defendants have not represented that they intend to follow that
4 aspect of the *Towery* opinion. To the contrary, they all but ignore the IV team qualifications
5 as modified by *Towery*.⁴ Without further information, this Court should not allow an
6 execution to go forward where Lopez is denied access to information in violation of due
7 process.

8 **Fifth and Sixth Claims: Access to Courts and Counsel**

9 Defendants’ silence regarding Lopez’s access to counsel during the IV procedure is
10 telling. They say nothing to refute the now uncontested facts surrounding the circumstances
11 of *Towery*’s execution and Defendants’ blatant disregard for his request for counsel and, in
12 turn, his fundamental right to access the courts. The facts, as presented by Lopez and
13 supported with declarations from Plaintiffs and documents from Defendants, demonstrate
14 that ADC violated *Towery*’s right to counsel and right to access the courts.

15 Moreover, Defendants’ response to Lopez’s argument that he should have access to
16 counsel on the morning of his execution is factually inaccurate. Defendants claim that the
17 “requirement” that a condemned prisoner’s in-person visitation with his attorney cease after
18 9:00 p.m., the day before an execution was “in place during the Landrigan, King, Beaty,
19 Bible, and West executions.” (ECF No. 12.) This statement misrepresents the written
20 protocol in place during those five executions. The version of Department Order 710 that
21 was in effect for those prisoners’ executions states: “The inmate’s visitation privileges shall
22 be terminated at 2100 hours the day prior to the execution, *excluding* non-contact visits with
23 the inmate’s Attorney of Record and facility chaplain as approved by the Division Director
24 for Offender Operations.” (Dept. Order 710.09, § 1.5.2, *available at West v. Brewer*, No. 12-

25
26
27 ⁴Indeed, ADC will make any representations necessary to allow an execution to go
28 forward, but then it backs away from those representations after the urgency of the situation
has passed. *See, e.g., Ex. JJ.*

1 245-NVW, ECF No. 1-2, Ex. C) (emphasis added).⁵ Up until the January 2012 Protocol,
2 attorneys were excluded from the blanket rule ending visitation at 9:00 p.m. on the evening
3 before an execution. Thus, Defendants representation to the contrary is wrong.⁶

4 Perhaps in attempt to suggest Lopez has waived this argument, Defendants assert that
5 Kemp made no objection to the change in visitation hours on the morning of his execution.
6 (ECF No. 64 at 2.) First, Kemp's actions, or inactions, are irrelevant to this Court's
7 determination of Lopez's motion. Second, Defendants, once again, are mistaken. Their
8 statement ignores a letter that Kemp's attorney wrote to Director Ryan after the Director
9 informed him that his legal visit would only be from 6:00 a.m. until 7:00 a.m. the morning
10 of his execution. (Letter from Baich to Ryan, dated March 28, 2012 (ECF No. 54-1, attached
11 as Ex. V).) In the letter, Kemp's attorney requested explanation from the Director on his
12 change in requiring in-person legal visits to end three hours prior to the scheduled execution,
13 rather than 45-minutes as required by the *Towery* court. (*Id.*)

14 Finally, Defendants represent to this Court that "ADC has communicated to Lopez's
15 attorney that contact visitation will be allowed the morning of the execution between 6 and
16

17 ⁵The Department Order cited became effective May 12, 2011, and governed the
18 executions of Beauty, Bible, and West. The Department Order in place for the executions of
19 Landrigan and King had the same language in Department Order 710, but it was in Section
20 710.09, §1.6.1. *See West*, Trial Ex. 85.

21 ⁶Moreover, Defendants disregard the written protocols from over the past twenty years
22 that allowed (*without* the Director's discretion) attorney-client visitation up until anywhere
23 between 30 minutes and 2 hours before an execution. *See, e.g.*, ADC Internal Management
24 Procedure 500.4 (Feb. 4, 1986) Section 4.4.5 ("Visits from the Attorney of Record and a
25 Chaplain of condemned inmate's choice shall be permitted up to ½ hour prior to the
26 scheduled time of the execution."); Internal Management Procedure 500 (Mar. 10, 1993)
27 Section 5.6.3.6 ("Non-Contact Visits from the Attorney of Record and a Chaplain of
28 condemned inmate's choice shall be permitted up to two hours prior to the scheduled
execution."); Internal Management Procedure 500.4 (Dec. 24, 1994) Section 5.2.1.2.4
("Visits from the Attorney of Record and a Chaplain of condemned inmate's choice shall be
permitted up to one-half hour before the scheduled execution time."); Department Order 710-
IO-F (Nov. 5, 2004) Section 1.3.3.5 ("Visits from the Attorney of Record and a Department
Chaplain of condemned inmate's choice are permitted up to forty-five (45) minutes prior to
the scheduled execution.").

1 7.” (ECF No. 64 at 13.) As of this filing, neither of Lopez’s attorneys have been provided
2 this information.

3 **Conclusion**

4 For the reasons in this Reply and in his Motion, Lopez respectfully requests that this
5 Court grant him relief on based on the undisputed evidence presented to this Court. In the
6 alternative, Lopez requests that the Court grant him discovery, a hearing, and ultimately a
7 preliminary injunction.

8 Respectfully submitted this 5th day of May, 2012.

9 Jon M. Sands
10 Federal Public Defender
11 Dale A. Baich
12 Robin C. Konrad
13 Cary Sandman

14 David J. Sepanik
15 Flora F. Vigo
16 Amanda R. Conley
17 O’Melveny & Myers LLP

18 By: s/Dale A. Baich
19 Counsel for Plaintiffs Rogovich,
20 Stanley, Cook, and Stokley

21 Kelley J. Henry
22 Denise I. Young
23 By: s/Kelley J. Henry (with permission)
24 Counsel for Plaintiff Lopez
25
26
27
28

Towery v. Brewer
No. 2:12-cv-00245-NVW

Exhibits to Reply by Plaintiff Samuel Lopez for Preliminary Injunction

- KK. Email from Eric D. Peters, M.D., to Robin Konrad, dated May 4, 2012
- LL. Summary Statement of Joseph I Cohen, M.D., dated May 5, 2012
- MM. Nembutal Sodium, FDA Label
- NN. Testimony of Mark Dershwitz, M.D., dated Dec. 9, 2008
- OO. Autopsy Report of Robert C. Comer, dated May 23, 2007

EXHIBIT KK

EXHIBIT KK



RE: Autopsy Information
Eric Peters to: 'Robin Konrad'

05/04/2012 12:25 PM

Concerning the autopsy examinations of Thomas Kemp and Robert Towery:

Blood samples were drawn from deep veins. Specifically, the lower portion of the inferior vena cava. No additional transdermal punctures are made to acquire these specimens; they are drawn after the incision into the body cavities.

Eric D. Peters, MD
Forensic Pathologist
Deputy Chief Medical Examiner
Pima County Office of the Medical Examiner
2825 East District Street
Tucson, AZ 85714
520-243-8600
520-243-8610 (fx)
Mail Stop: CM-DIST-2825-1

-----Original Message-----

From: Robin Konrad [mailto:Robin_Konrad@fd.org]
Sent: Friday, May 04, 2012 12:21 PM
To: Eric Peters
Subject: Autopsy Information

Dr. Peters,

Thank you for speaking with me regarding the autopsies of Robert Towery and Thomas Kemp. Please feel free to email the letter regarding the blood sample or, if you prefer, you may fax to the number below.

If you have questions, please call me.

Thank you,

Robin C. Konrad
Assistant Federal Public Defender
Capital Habeas Unit

Federal Public Defender for the District of Arizona
850 West Adams Street, Suite 201, Phoenix, AZ 85007 v. (602) 382.2734 / f.
(602) 889.3960 e. robin_konrad@fd.org

NOTICE: This communication may contain privileged or other confidential information. If you have received it in error, please advise the sender by reply email and immediately delete the message and any attachments without copying or disclosing the contents. Thank you.

EXHIBIT LL

EXHIBIT LL

United Forensic Services, P.C.

Professional Forensic Autopsy & Consultation

Joseph I. Cohen, M.D., Forensic Pathologist | drcohen@forensiconline.com | www.forensiconline.com
448 Ignacio Blvd., Suite 325, Novato, California 94949 | 877.372.6436 Toll Free | 951.346.3245 Fax

Private Autopsy Examination of Robert Charles Towery
(Summary Statement of Joseph I. Cohen, M.D., May 5, 2012)

I, Joseph I. Cohen, M.D., Forensic Pathologist, having previously performed an autopsy examination (comment: please refer to autopsy report P12-031612, United Forensic Services, dated April 2, 2012) on the body of Robert Charles Towery, on March 16, 2012, hereby state that the needle puncture produced in the right femoral artery of Mr. Towery was performed in the antemortem state, on his living body.

The aforementioned conclusion is strengthened by the assumption that the medical examiner of record did not create any needle punctures in the right femoral region of Mr. Towery, during the postmortem examination of his body.



Joseph I. Cohen, M.D.
Forensic Pathologist

05-05-12

Date

EXHIBIT MM

EXHIBIT MM

NEMBUTAL SODIUM - pentobarbital sodium injection, solution

Lundbeck Inc.

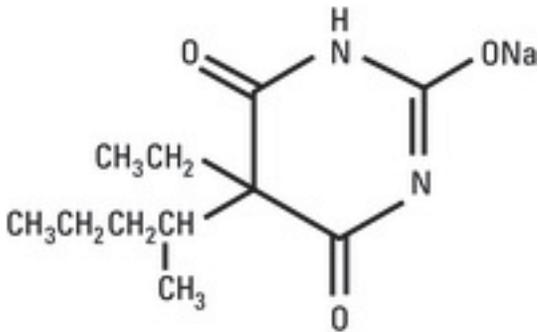
DESCRIPTION

The barbiturates are nonselective central nervous system depressants which are primarily used as sedative hypnotics and also anticonvulsants in subhypnotic doses. The barbiturates and their sodium salts are subject to control under the Federal Controlled Substances Act (See "[Drug Abuse and Dependence](#)" section).

The sodium salts of amobarbital, pentobarbital, phenobarbital, and secobarbital are available as sterile parenteral solutions. Barbiturates are substituted pyrimidine derivatives in which the basic structure common to these drugs is barbituric acid, a substance which has no central nervous system (CNS) activity. CNS activity is obtained by substituting alkyl, alkenyl, or aryl groups on the pyrimidine ring.

NEMBUTAL Sodium Solution (pentobarbital sodium injection) is a sterile solution for intravenous or intramuscular injection. Each mL contains pentobarbital sodium 50 mg, in a vehicle of propylene glycol, 40%, alcohol, 10% and water for injection, to volume. The pH is adjusted to approximately 9.5 with hydrochloric acid and/or sodium hydroxide.

NEMBUTAL Sodium is a short-acting barbiturate, chemically designated as sodium 5-ethyl-5-(1-methylbutyl) barbiturate. The structural formula for pentobarbital sodium is:



The sodium salt occurs as a white, slightly bitter powder which is freely soluble in water and alcohol but practically insoluble in benzene and ether.

CLINICAL PHARMACOLOGY

Barbiturates are capable of producing all levels of CNS mood alteration from excitation to mild sedation, to hypnosis, and deep coma. Overdosage can produce death. In high enough therapeutic doses, barbiturates induce anesthesia.

Barbiturates depress the sensory cortex, decrease motor activity, alter cerebellar function, and produce drowsiness, sedation, and hypnosis.

Barbiturate-induced sleep differs from physiological sleep. Sleep laboratory studies have demonstrated that barbiturates reduce the amount of time spent in the rapid eye movement (REM) phase of sleep or dreaming stage. Also, Stages III and IV sleep are decreased. Following abrupt cessation of barbiturates used regularly, patients may experience markedly increased dreaming, nightmares, and/or insomnia. Therefore, withdrawal of a single therapeutic dose over 5 or 6 days has been recommended to lessen the REM rebound and disturbed sleep which contribute to drug withdrawal syndrome (for example, decrease the dose from 3 to 2 doses a day for 1 week). In studies, secobarbital sodium and pentobarbital sodium have been found to lose most of their effectiveness for both inducing and maintaining sleep by the end of 2 weeks of continued drug administration at fixed doses. The short-, intermediate-, and, to a lesser degree, long-acting barbiturates have been widely prescribed for treating insomnia. Although the clinical literature abounds with claims that the short-acting barbiturates are superior for producing sleep while the intermediate-acting compounds are more effective in maintaining sleep, controlled studies have failed to demonstrate these differential effects. Therefore, as sleep medications, the barbiturates are of limited value beyond short-term use.

Barbiturates have little analgesic action at subanesthetic doses. Rather, in subanesthetic doses these drugs may increase the reaction to painful stimuli. All barbiturates exhibit anticonvulsant activity in anesthetic doses. However, of the drugs in this class, only phenobarbital, mephobarbital, and metharbital have been clinically demonstrated to be effective as oral anticonvulsants in subhypnotic doses.

Barbiturates are respiratory depressants. The degree of respiratory depression is dependent upon dose. With hypnotic doses, respiratory depression produced by barbiturates is similar to that which occurs during physiologic sleep with slight decrease in blood pressure and heart rate.

Studies in laboratory animals have shown that barbiturates cause reduction in the tone and contractility of the uterus, ureters, and urinary bladder. However, concentrations of the drugs required to produce this effect in humans are not reached with sedative-hypnotic doses.

Barbiturates do not impair normal hepatic function, but have been shown to induce liver microsomal enzymes, thus increasing and/or altering the metabolism of barbiturates and other drugs. (See "[Precautions - Drug Interactions](#)" section).

Pharmacokinetics

Barbiturates are absorbed in varying degrees following oral, rectal, or parenteral administration. The salts are more rapidly absorbed than are the acids.

The onset of action for oral or rectal administration varies from 20 to 60 minutes. For IM administration, the onset of action is slightly faster. Following IV administration, the onset of action ranges from almost immediately for pentobarbital sodium to 5 minutes for phenobarbital sodium. Maximal CNS depression may not occur until 15 minutes or more after IV administration for phenobarbital sodium.

Duration of action, which is related to the rate at which the barbiturates are redistributed throughout the body, varies among persons and in the same person from time to time.

No studies have demonstrated that the different routes of administration are equivalent with respect to bioavailability.

Barbiturates are weak acids that are absorbed and rapidly distributed to all tissues and fluids with high concentrations in the brain, liver, and kidneys. Lipid solubility of the barbiturates is the dominant factor in their distribution within the body. The more lipid soluble the barbiturate, the more rapidly it penetrates all tissues of the body. Barbiturates are bound to plasma and tissue proteins to a varying degree with the degree of binding increasing directly as a function of lipid solubility.

Phenobarbital has the lowest lipid solubility, lowest plasma binding, lowest brain protein binding, the longest delay in onset of activity, and the longest duration of action. At the opposite extreme is secobarbital which has the highest lipid solubility, plasma protein binding, brain protein binding, the shortest delay in onset of activity, and the shortest duration of action. Butabarbital is classified as an intermediate barbiturate.

The plasma half-life for pentobarbital in adults is 15 to 50 hours and appears to be dose dependent.

Barbiturates are metabolized primarily by the hepatic microsomal enzyme system, and the metabolic products are excreted in the urine, and less commonly, in the feces. Approximately 25 to 50 percent of a dose of aprobarbital or phenobarbital is eliminated unchanged in the urine, whereas the amount of other barbiturates excreted unchanged in the urine is negligible. The excretion of unmetabolized barbiturate is one feature that distinguishes the long-acting category from those belonging to other categories which are almost entirely metabolized. The inactive metabolites of the barbiturates are excreted as conjugates of glucuronic acid.

INDICATIONS AND USAGE

Parenteral

1. Sedatives.
2. Hypnotics, for the short-term treatment of insomnia, since they appear to lose their effectiveness for sleep induction and sleep maintenance after 2 weeks (See "[Clinical Pharmacology](#)" section).
3. Preanesthetics.
4. Anticonvulsant, in anesthetic doses, in the emergency control of certain acute convulsive episodes, e.g., those associated with status epilepticus, cholera, eclampsia, meningitis, tetanus, and toxic reactions to strychnine or local anesthetics.

CONTRAINDICATIONS

Barbiturates are contraindicated in patients with known barbiturate sensitivity. Barbiturates are also contraindicated in patients with a history of manifest or latent porphyria.

WARNINGS

1. *Habit forming*: Barbiturates may be habit forming. Tolerance, psychological and physical dependence may occur with continued use. (See "[Drug Abuse and Dependence](#)" and "[Pharmacokinetics](#)" sections). Patients who have psychological dependence on barbiturates may increase the dosage or decrease the dosage interval without consulting a physician and may subsequently develop a physical dependence on barbiturates. To minimize the possibility of overdose or the development of dependence, the prescribing and dispensing of sedative-hypnotic barbiturates should be limited to the amount required for the interval until the next appointment. Abrupt cessation after prolonged use in the dependent person may result in withdrawal symptoms, including delirium, convulsions, and possibly death. Barbiturates should be withdrawn gradually from any patient known to be taking excessive dosage over long periods of time. (See "[Drug Abuse and Dependence](#)" section).
2. *IV administration*: Too rapid administration may cause respiratory depression, apnea, laryngospasm, or vasodilation with fall in blood pressure.
3. *Acute or chronic pain*: Caution should be exercised when barbiturates are administered to patients with acute or chronic pain, because paradoxical excitement could be induced or important symptoms could be masked. However, the use of barbiturates as sedatives in the postoperative surgical period and as adjuncts to cancer chemotherapy is well established.
4. *Use in pregnancy*: Barbiturates can cause fetal damage when administered to a pregnant woman. Retrospective, case-controlled studies have suggested a connection between the maternal consumption of barbiturates and a higher than expected incidence of

fetal abnormalities. Following oral or parenteral administration, barbiturates readily cross the placental barrier and are distributed throughout fetal tissues with highest concentrations found in the placenta, fetal liver, and brain. Fetal blood levels approach maternal blood levels following parenteral administration.

Withdrawal symptoms occur in infants born to mothers who receive barbiturates throughout the last trimester of pregnancy. (See "[Drug Abuse and Dependence](#)" section). If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

5. *Synergistic effects*: The concomitant use of alcohol or other CNS depressants may produce additive CNS depressant effects.

PRECAUTIONS

General

Barbiturates may be habit forming. Tolerance and psychological and physical dependence may occur with continuing use. (See "[Drug Abuse and Dependence](#)" section). Barbiturates should be administered with caution, if at all, to patients who are mentally depressed, have suicidal tendencies, or a history of drug abuse.

Elderly or debilitated patients may react to barbiturates with marked excitement, depression, and confusion. In some persons, barbiturates repeatedly produce excitement rather than depression.

In patients with hepatic damage, barbiturates should be administered with caution and initially in reduced doses.

Barbiturates should not be administered to patients showing the premonitory signs of hepatic coma.

Parenteral solutions of barbiturates are highly alkaline. Therefore, extreme care should be taken to avoid perivascular extravasation or intra-arterial injection. Extravascular injection may cause local tissue damage with subsequent necrosis; consequences of intra-arterial injection may vary from transient pain to gangrene of the limb. Any complaint of pain in the limb warrants stopping the injection.

Information for the patient

Practitioners should give the following information and instructions to patients receiving barbiturates.

1. The use of barbiturates carries with it an associated risk of psychological and/or physical dependence. The patient should be warned against increasing the dose of the drug without consulting a physician.
2. Barbiturates may impair mental and/or physical abilities required for the performance of potentially hazardous tasks (e.g., driving, operating machinery, etc.).
3. Alcohol should not be consumed while taking barbiturates. Concurrent use of the barbiturates with other CNS depressants (e.g., alcohol, narcotics, tranquilizers, and antihistamines) may result in additional CNS depressant effects.

Laboratory tests

Prolonged therapy with barbiturates should be accompanied by periodic laboratory evaluation of organ systems, including hematopoietic, renal, and hepatic systems. (See "[Precautions - General](#)" and "[Adverse Reactions](#)" sections).

Drug interactions

Most reports of clinically significant drug interactions occurring with the barbiturates have involved phenobarbital. However, the application of these data to other barbiturates appears valid and warrants serial blood level determinations of the relevant drugs when there are multiple therapies.

1. *Anticoagulants*: Phenobarbital lowers the plasma levels of dicumarol (name previously used: bishydroxycoumarin) and causes a decrease in anticoagulant activity as measured by the prothrombin time. Barbiturates can induce hepatic microsomal enzymes resulting in increased metabolism and decreased anticoagulant response of oral anticoagulants (e.g., warfarin, acenocoumarol, dicumarol, and phenprocoumon). Patients stabilized on anticoagulant therapy may require dosage adjustments if barbiturates are added to or withdrawn from their dosage regimen.
2. *Corticosteroids*: Barbiturates appear to enhance the metabolism of exogenous corticosteroids probably through the induction of hepatic microsomal enzymes. Patients stabilized on corticosteroid therapy may require dosage adjustments if barbiturates are added to or withdrawn from their dosage regimen.
3. *Griseofulvin*: Phenobarbital appears to interfere with the absorption of orally administered griseofulvin, thus decreasing its blood level. The effect of the resultant decreased blood levels of griseofulvin on therapeutic response has not been established. However, it would be preferable to avoid concomitant administration of these drugs.
4. *Doxycycline*: Phenobarbital has been shown to shorten the half-life of doxycycline for as long as 2 weeks after barbiturate therapy is discontinued.
This mechanism is probably through the induction of hepatic microsomal enzymes that metabolize the antibiotic. If phenobarbital and doxycycline are administered concurrently, the clinical response to doxycycline should be monitored closely.

5. *Phenytoin, sodium valproate, valproic acid*: The effect of barbiturates on the metabolism of phenytoin appears to be variable. Some investigators report an accelerating effect, while others report no effect. Because the effect of barbiturates on the metabolism of phenytoin is not predictable, phenytoin and barbiturate blood levels should be monitored more frequently if these drugs are given concurrently. Sodium valproate and valproic acid appear to decrease barbiturate metabolism; therefore, barbiturate blood levels should be monitored and appropriate dosage adjustments made as indicated.
6. *Central nervous system depressants*: The concomitant use of other central nervous system depressants, including other sedatives or hypnotics, antihistamines, tranquilizers, or alcohol, may produce additive depressant effects.
7. *Monoamine oxidase inhibitors (MAOI)*: MAOI prolong the effects of barbiturates probably because metabolism of the barbiturate is inhibited.
8. *Estradiol, estrone, progesterone and other steroidal hormones*: Pretreatment with or concurrent administration of phenobarbital may decrease the effect of estradiol by increasing its metabolism. There have been reports of patients treated with antiepileptic drugs (e.g., phenobarbital) who became pregnant while taking oral contraceptives. An alternate contraceptive method might be suggested to women taking phenobarbital.

Carcinogenesis

1. *Animal data*. Phenobarbital sodium is carcinogenic in mice and rats after lifetime administration. In mice, it produced benign and malignant liver cell tumors. In rats, benign liver cell tumors were observed very late in life.
2. *Human data*. In a 29-year epidemiological study of 9,136 patients who were treated on an anticonvulsant protocol that included phenobarbital, results indicated a higher than normal incidence of hepatic carcinoma. Previously, some of these patients were treated with thorotrast, a drug that is known to produce hepatic carcinomas. Thus, this study did not provide sufficient evidence that phenobarbital sodium is carcinogenic in humans.
Data from one retrospective study of 235 children in which the types of barbiturates are not identified suggested an association between exposure to barbiturates prenatally and an increased incidence of brain tumor. (Gold, E., et al., "Increased Risk of Brain Tumors in Children Exposed to Barbiturates," *Journal of National Cancer Institute*, 61:1031-1034, 1978).

Pregnancy

1. *Teratogenic effects*. Pregnancy Category D - See "Warnings - Use in Pregnancy" section.
2. *Nonteratogenic effects*. Reports of infants suffering from long-term barbiturate exposure in utero included the acute withdrawal syndrome of seizures and hyperirritability from birth to a delayed onset of up to 14 days. (See "Drug Abuse and Dependence" section).

Labor and delivery

Hypnotic doses of these barbiturates do not appear to significantly impair uterine activity during labor. Full anesthetic doses of barbiturates decrease the force and frequency of uterine contractions. Administration of sedative-hypnotic barbiturates to the mother during labor may result in respiratory depression in the newborn. Premature infants are particularly susceptible to the depressant effects of barbiturates. If barbiturates are used during labor and delivery, resuscitation equipment should be available. Data are currently not available to evaluate the effect of these barbiturates when forceps delivery or other intervention is necessary. Also, data are not available to determine the effect of these barbiturates on the later growth, development, and functional maturation of the child.

Nursing mothers

Caution should be exercised when a barbiturate is administered to a nursing woman since small amounts of barbiturates are excreted in the milk.

Pediatric Use

No adequate well-controlled studies have been conducted in pediatric patients; however, safety and effectiveness of pentobarbital in pediatric patients is supported by numerous studies and case reports cited in the literature. Pediatric dosing information for Nembutal is described in the DOSAGE and ADMINISTRATION section.

Geriatric Use

Clinical studies of Nembutal have not included sufficient numbers of subjects aged 65 and over to determine whether elderly subjects respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal or cardiac function, and of concomitant disease or other drug therapy.

Elderly patients may react to barbiturates with marked excitement, depression, and confusion. In some persons, barbiturates repeatedly produce excitement rather than depression. Dosage should be reduced in the elderly because these patients may be more sensitive to barbiturates.

ADVERSE REACTIONS

The following adverse reactions and their incidence were compiled from surveillance of thousands of hospitalized patients. Because such patients may be less aware of certain of the milder adverse effects of barbiturates, the incidence of these reactions may be somewhat higher in fully ambulatory patients.

More than 1 in 100 patients. The most common adverse reaction estimated to occur at a rate of 1 to 3 patients per 100 is:

Nervous System: Somnolence.

Less than 1 in 100 patients. Adverse reactions estimated to occur at a rate of less than 1 in 100 patients listed below, grouped by organ system, and by decreasing order of occurrence are:

Nervous system: Agitation, confusion, hyperkinesia, ataxia, CNS depression, nightmares, nervousness, psychiatric disturbance, hallucinations, insomnia, anxiety, dizziness, thinking abnormality.

Respiratory system: Hypoventilation, apnea.

Cardiovascular system: Bradycardia, hypotension, syncope.

Digestive system: Nausea, vomiting, constipation.

Other reported reactions: Headache, injection site reactions, hypersensitivity reactions (angioedema, skin rashes, exfoliative dermatitis), fever, liver damage, megaloblastic anemia following chronic phenobarbital use.

To report SUSPECTED ADVERSE REACTIONS, contact Lundbeck Inc. at 1-800-455-1141 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG ABUSE AND DEPENDENCE

Pentobarbital sodium injection is subject to control by the Federal Controlled Substances Act under DEA schedule II.

Barbiturates may be habit forming. Tolerance, psychological dependence, and physical dependence may occur especially following prolonged use of high doses of barbiturates. Daily administration in excess of 400 milligrams (mg) of pentobarbital or secobarbital for approximately 90 days is likely to produce some degree of physical dependence. A dosage of from 600 to 800 mg taken for at least 35 days is sufficient to produce withdrawal seizures. The average daily dose for the barbiturate addict is usually about 1.5 grams. As tolerance to barbiturates develops, the amount needed to maintain the same level of intoxication increases; tolerance to a fatal dosage, however, does not increase more than two-fold. As this occurs, the margin between an intoxicating dosage and fatal dosage becomes smaller.

Symptoms of acute intoxication with barbiturates include unsteady gait, slurred speech, and sustained nystagmus. Mental signs of chronic intoxication include confusion, poor judgment, irritability, insomnia, and somatic complaints.

Symptoms of barbiturate dependence are similar to those of chronic alcoholism. If an individual appears to be intoxicated with alcohol to a degree that is radically disproportionate to the amount of alcohol in his or her blood the use of barbiturates should be suspected. The lethal dose of a barbiturate is far less if alcohol is also ingested.

The symptoms of barbiturate withdrawal can be severe and may cause death. Minor withdrawal symptoms may appear 8 to 12 hours after the last dose of a barbiturate. These symptoms usually appear in the following order: anxiety, muscle twitching, tremor of hands and fingers, progressive weakness, dizziness, distortion in visual perception, nausea, vomiting, insomnia, and orthostatic hypotension. Major withdrawal symptoms (convulsions and delirium) may occur within 16 hours and last up to 5 days after abrupt cessation of these drugs. Intensity of withdrawal symptoms gradually declines over a period of approximately 15 days. Individuals susceptible to barbiturate abuse and dependence include alcoholics and opiate abusers, as well as other sedative-hypnotic and amphetamine abusers. Drug dependence to barbiturates arises from repeated administration of a barbiturate or agent with barbiturate-like effect on a continuous basis, generally in amounts exceeding therapeutic dose levels. The characteristics of drug dependence to barbiturates include: (a) a strong desire or need to continue taking the drug; (b) a tendency to increase the dose; (c) a psychic dependence on the effects of the drug related to subjective and individual appreciation of those effects; and (d) a physical dependence on the effects of the drug requiring its presence for maintenance of homeostasis and resulting in a definite, characteristic, and self-limited abstinence syndrome when the drug is withdrawn.

Treatment of barbiturate dependence consists of cautious and gradual withdrawal of the drug. Barbiturate-dependent patients can be withdrawn by using a number of different withdrawal regimens. In all cases withdrawal takes an extended period of time. One method involves substituting a 30 mg dose of phenobarbital for each 100 to 200 mg dose of barbiturate that the patient has been taking. The total daily amount of phenobarbital is then administered in 3 to 4 divided doses, not to exceed 600 mg daily. Should signs of withdrawal occur on the first day of treatment, a loading dose of 100 to 200 mg of phenobarbital may be administered IM in addition to the oral dose. After stabilization on phenobarbital, the total daily dose is decreased by 30 mg a day as long as withdrawal is proceeding smoothly. A modification of this regimen involves initiating treatment at the patient's regular dosage level and decreasing the daily dosage by 10 percent if tolerated by the patient.

Infants physically dependent on barbiturates may be given phenobarbital 3 to 10 mg/kg/day. After withdrawal symptoms (hyperactivity, disturbed sleep, tremors, hyperreflexia) are relieved, the dosage of phenobarbital should be gradually decreased and completely withdrawn over a 2-week period.

OVERDOSAGE

The toxic dose of barbiturates varies considerably. In general, an oral dose of 1 gram of most barbiturates produces serious poisoning in an adult. Death commonly occurs after 2 to 10 grams of ingested barbiturate. Barbiturate intoxication may be confused with alcoholism, bromide intoxication, and with various neurological disorders.

Acute overdosage with barbiturates is manifested by CNS and respiratory depression which may progress to Cheyne-Stokes respiration, areflexia, constriction of the pupils to a slight degree (though in severe poisoning they may show paralytic dilation), oliguria, tachycardia, hypotension, lowered body temperature, and coma. Typical shock syndrome (apnea, circulatory collapse, respiratory arrest, and death) may occur.

In extreme overdose, all electrical activity in the brain may cease, in which case a "flat" EEG normally equated with clinical death cannot be accepted. This effect is fully reversible unless hypoxic damage occurs. Consideration should be given to the possibility of barbiturate intoxication even in situations that appear to involve trauma.

Complications such as pneumonia, pulmonary edema, cardiac arrhythmias, congestive heart failure, and renal failure may occur. Uremia may increase CNS sensitivity to barbiturates. Differential diagnosis should include hypoglycemia, head trauma, cerebrovascular accidents, convulsive states, and diabetic coma. Blood levels from acute overdosage for some barbiturates are listed in Table 1.

Table 1. Concentration of Barbiturate in the Blood Versus Degree of CNS Depression

		Blood barbiturate level in ppm ($\mu\text{g/mL}$)				
		Degree of depression in nontolerant persons*				
Barbiturate	Onset/duration	1	2	3	4	5
Pentobarbital	Fast/short	≤ 2	0.5 to 3	10 to 15	12 to 25	15 to 40
Secobarbital	Fast/short	≤ 2	0.5 to 5	10 to 15	15 to 25	15 to 40
Amobarbital	Intermediate/ intermediate	≤ 3	2 to 10	30 to 40	30 to 60	40 to 80
Butobarbital	Intermediate/ intermediate	≤ 5	3 to 25	40 to 60	50 to 80	60 to 100
Phenobarbital	Slow/long	≤ 10	5 to 40	50 to 80	70 to 120	100 to 200

* Categories of degree of depression in nontolerant persons:

1. Under the influence and appreciably impaired for purposes of driving a motor vehicle or performing tasks requiring alertness and unimpaired judgment and reaction time.
2. Sedated, therapeutic range, calm, relaxed, and easily aroused.
3. Comatose, difficult to arouse, significant depression of respiration.
4. Compatible with death in aged or ill persons or in presence of obstructed airway, other toxic agents, or exposure to cold.
5. Usual lethal level, the upper end of the range includes those who received some supportive treatment.

Treatment of overdosage is mainly supportive and consists of the following:

1. Maintenance of an adequate airway, with assisted respiration and oxygen administration as necessary.
2. Monitoring of vital signs and fluid balance.
3. Fluid therapy and other standard treatment for shock, if needed.
4. If renal function is normal, forced diuresis may aid in the elimination of the barbiturate. Alkalinization of the urine increases renal excretion of some barbiturates, especially phenobarbital, also aprobarbital and mephobarbital (which is metabolized to phenobarbital).
5. Although not recommended as a routine procedure, hemodialysis may be used in severe barbiturate intoxications or if the patient is anuric or in shock.
6. Patient should be rolled from side to side every 30 minutes.
7. Antibiotics should be given if pneumonia is suspected.
8. Appropriate nursing care to prevent hypostatic pneumonia, decubiti, aspiration, and other complications of patients with altered states of consciousness.

DOSAGE AND ADMINISTRATION

Dosages of barbiturates must be individualized with full knowledge of their particular characteristics and recommended rate of administration. Factors of consideration are the patient's age, weight, and condition. Parenteral routes should be used only when oral administration is impossible or impractical.

Intramuscular Administration

IM injection of the sodium salts of barbiturates should be made deeply into a large muscle, and a volume of 5 mL should not be exceeded at any one site because of possible tissue irritation. After IM injection of a hypnotic dose, the patient's vital signs should be monitored. The usual adult dosage of NEMBUTAL Sodium Solution is 150 to 200 mg as a single IM injection; the recommended pediatric dosage ranges from 2 to 6 mg/kg as a single IM injection not to exceed 100 mg.

Intravenous Administration

NEMBUTAL Sodium Solution should not be admixed with any other medication or solution. IV injection is restricted to conditions in which other routes are not feasible, either because the patient is unconscious (as in cerebral hemorrhage, eclampsia, or status epilepticus), or because the patient resists (as in delirium), or because prompt action is imperative. Slow IV injection is essential, and patients should be carefully observed during administration. This requires that blood pressure, respiration, and cardiac function be maintained, vital signs be recorded, and equipment for resuscitation and artificial ventilation be available. The rate of IV injection should not exceed 50 mg/min for pentobarbital sodium.

There is no average intravenous dose of NEMBUTAL Sodium Solution (pentobarbital sodium injection) that can be relied on to produce similar effects in different patients. The possibility of overdose and respiratory depression is remote when the drug is injected slowly in fractional doses.

A commonly used initial dose for the 70 kg adult is 100 mg. Proportional reduction in dosage should be made for pediatric or debilitated patients. At least one minute is necessary to determine the full effect of intravenous pentobarbital. If necessary, additional small increments of the drug may be given up to a total of from 200 to 500 mg for normal adults.

Anticonvulsant use

In convulsive states, dosage of NEMBUTAL Sodium Solution should be kept to a minimum to avoid compounding the depression which may follow convulsions. The injection must be made slowly with due regard to the time required for the drug to penetrate the blood-brain barrier.

Special patient population

Dosage should be reduced in the elderly or debilitated because these patients may be more sensitive to barbiturates. Dosage should be reduced for patients with impaired renal function or hepatic disease.

Inspection

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution containers permit. Solutions for injection showing evidence of precipitation should not be used.

HOW SUPPLIED

NEMBUTAL Sodium Solution (pentobarbital sodium injection, USP) is available in the following sizes:

20-mL multiple-dose vial, 1 g per vial (NDC 67386-501-52); and 50-mL multiple-dose vial, 2.5 g per vial (NDC 67386-501-55).

Each mL contains:

Pentobarbital Sodium, derivative of barbituric acid - 50 mg

Propylene glycol - 40% v/v

Alcohol - 10%

Water for Injection - qs

(pH adjusted to approximately 9.5 with hydrochloric acid and/or sodium hydroxide.)

Vial stoppers are latex free.

Exposure of pharmaceutical products to heat should be minimized. Avoid excessive heat. Protect from freezing. It is recommended that the product be stored at 20-25°C (68-77°F), however, brief excursions are permitted between 15-30°C (59-86°F). See USP controlled room temperature.

Manufactured by: Hospira, Inc.

Lake Forest, IL 60045, U.S.A.

For: Lundbeck Inc.

Deerfield, IL 60015, U.S.A.

® Trademark of Lundbeck Inc.

Revised: May 2009

PRINCIPAL DISPLAY PANEL

NDC 67386-501-52

20-mL Label:

Bar Code Area

NDC 67386-501-52 20 mL Sterile Solution
Nembutal®
Sodium Solution
(pentobarbital sodium injection, USP)

50 mg/mL



For Intravenous or Intramuscular Use.
Multiple-dose Vial. LATEX-FREE.
Rx only



Lundbeck Inc.
Deerfield, IL 60015, U.S.A.

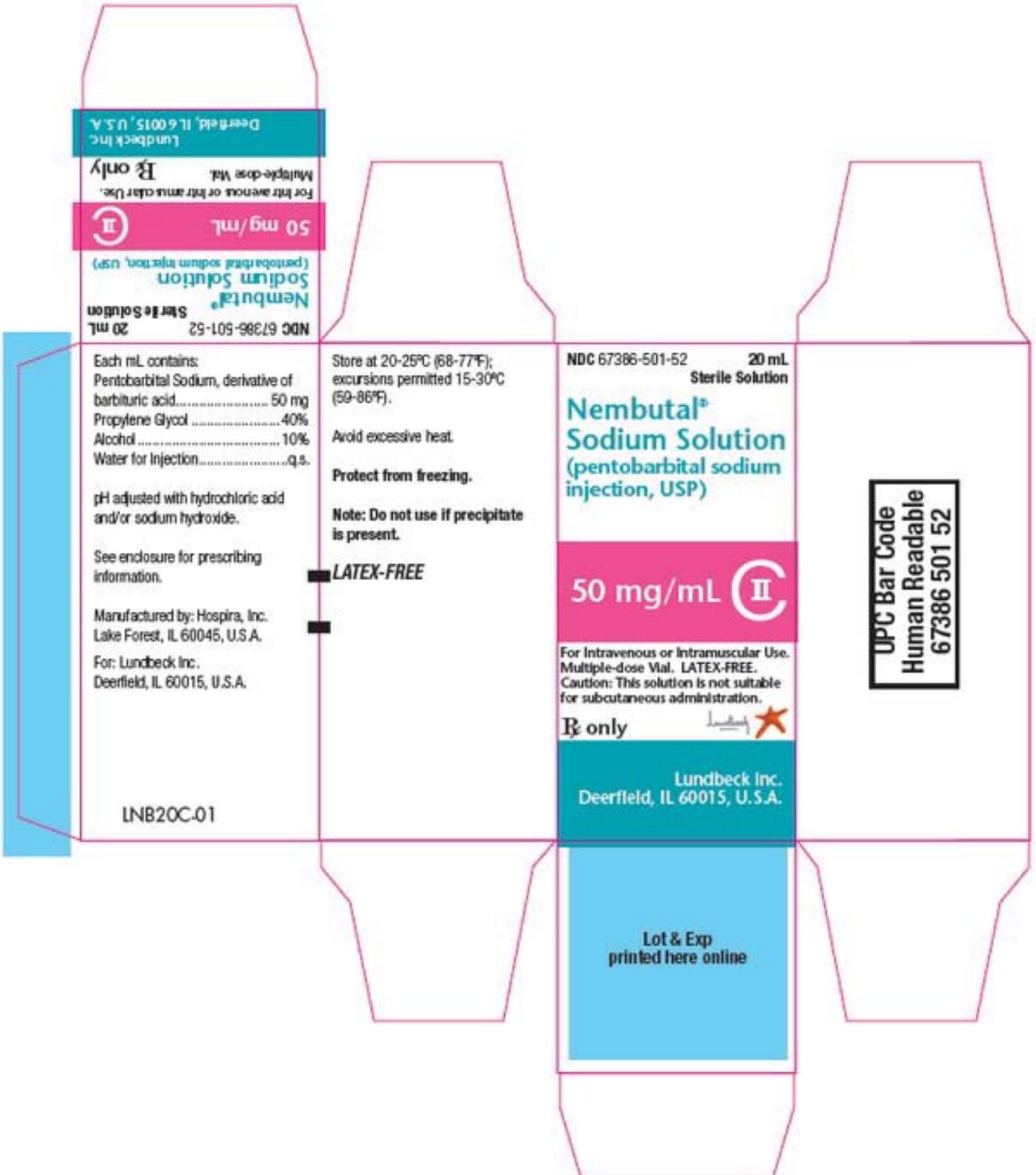
Each mL contains:
Nembutal Sodium (Pentobarbital Sodium, derivative of barbituric acid)..... 50 mg
Propylene Glycol..... 40%
Alcohol..... 10%
Water for injection..... q.s.
pH adjusted with hydrochloric acid and/or sodium hydroxide. See enclosure for prescribing information.
Note: Do not use if precipitate is present. Store at 20-25°C (68-77°F); excursions permitted 15-30°C (59-86°F). Avoid excessive heat. Protect from freezing.
Manufactured by: Hospira, Inc. Lake Forest, IL 60045, U.S.A.
For: Lundbeck Inc. Deerfield, IL 60015, U.S.A.

RSS Code
(01) 00067386501521

LNB20L-01

Lot & Exp
printed here online

20-mL Carton:



NDC 67386-501-55
50-mL Label:

NDC 67386-501-55 50 mL Sterile Solution

Nembutal® Sodium Solution (pentobarbital sodium injection, USP)

50 mg/mL



For Intravenous or Intramuscular Use.
Multiple-dose Vial. LATEX-FREE.
Rx only



Lundbeck Inc.
Deerfield, IL 60015, U.S.A.

Each mL contains:
Nembutal Sodium (Pentobarbital Sodium, derivative of barbituric acid)50 mg
Propylene Glycol..... 40%
Alcohol..... 10%
Water for injection..... q.s.
pH adjusted with hydrochloric acid and/or sodium hydroxide. See enclosure for prescribing information.

Note: Do not use if precipitate is present. Store at 20-25°C (68-77°F); excursions permitted 15-30°C (59-86°F). Avoid excessive heat.

Protect from freezing.
Manufactured by: Hospira, Inc.
Lake Forest, IL 60045, U.S.A.
For: Lundbeck Inc.
Deerfield, IL 60015, U.S.A.

Bar Code Area

RSS Code
67386 501 55

INB501-01

Lot & Exp
printed here online

50-mL Carton:

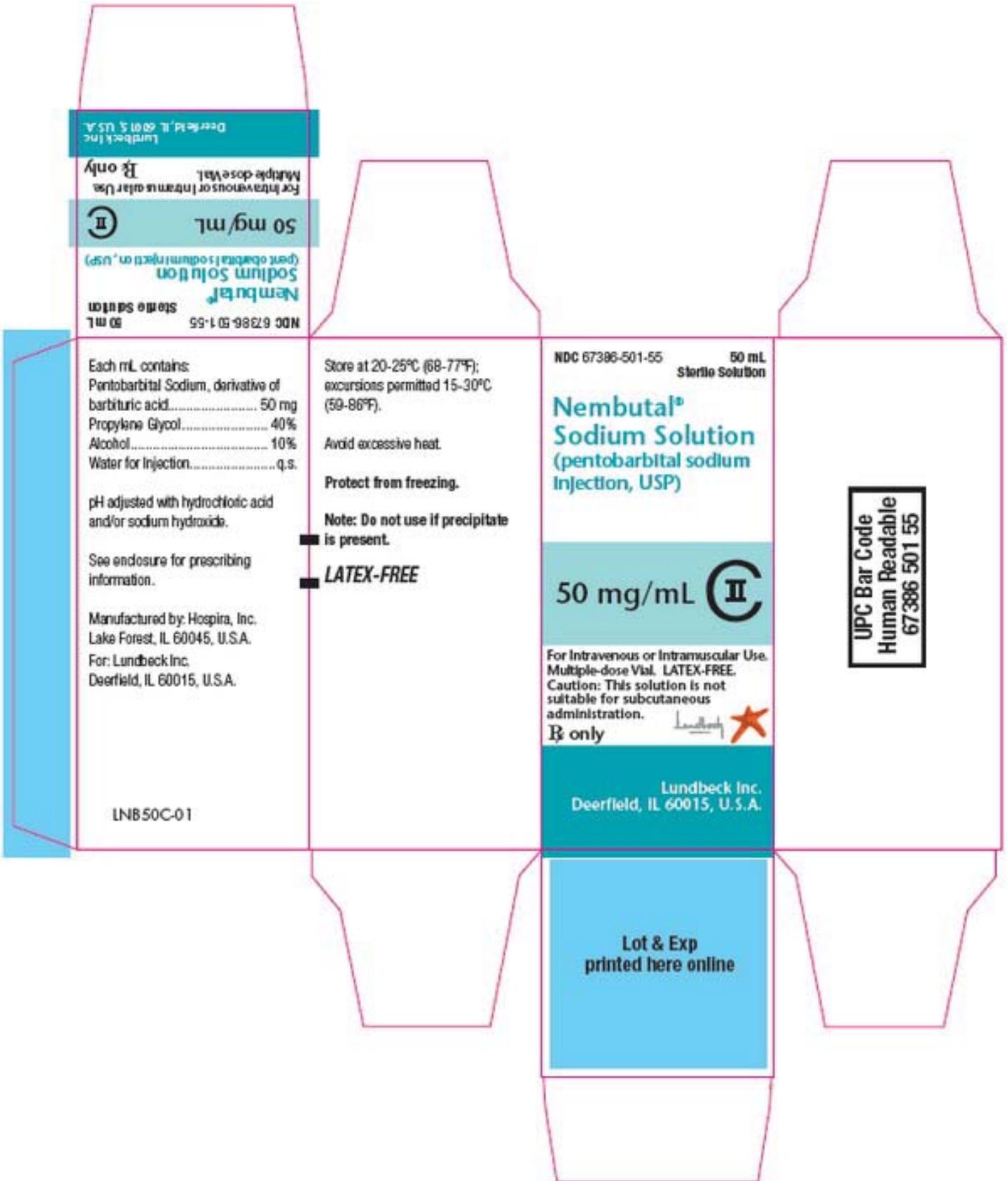


EXHIBIT NN

EXHIBIT NN

1

1 IN THE UNITED STATES DISTRICT COURT

2 FOR THE DISTRICT OF ARIZONA

3

4

5 GREGORY DICKENS, ET AL,
Plaintiffs

6 vs. C.A. NO. 07-cv-01770NVS)

7 JANET NAPOLITANO, ET AL,
Defendants

8

9

10

11

12 VIDEOTAPE DEPOSITION of MARK DERSHWITZ,
13 M. D., taken at the request of the plaintiffs
14 pursuant to Rule 30 of the Federal Rules of
15 Civil Procedure before Nancy A. Diemdowicz,
16 Registered Merit Reporter, a notary public in
17 and for the Commonwealth of Massachusetts, on
18 December 9, 2008, commencing at 12:14 P.M. at
19 the offices of McCarthy Reporting Service,
20 12 Harvard Street, Worcester, Massachusetts.

21

22

23

24

3

1 I N D E X

2 DEPONENT: MARK DERSHWITZ, M. D.

3 PAGE

4

5 EXAMINATION BY MR. ROSENSTEIN 5

6 EXAMINATION BY MR. TODD 180

7 FURTHER EXAMINATION BY MR. ROSENSTEIN 181

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9 FURTHER EXAMINATION BY MR. ROSENSTEIN 183

10

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15 1. Expert Report 6

16 2. Copy of Protocol 65

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2

1 A P P E A R A N C E S:

2

3 FOR THE PLAINTIFFS:

4 STEVEN A. ROSENSTEIN, ESQ.
5 BENJAMIN D. PETROSKY, ESQ.
6 O'MELVENY & MYERS LLP
7 Times Square Tower
8 7 Times Square
9 New York, New York 10036
- and -

10 DALE A. BAICH, ESQ.
11 FEDERAL PUBLIC DEFENDER
12 DISTRICT OF ARIZONA
13 850 West Adams Street
14 Phoenix, Arizona 85007-2730

15 FOR THE DEFENDANTS:

16 JOHN PRESSLEY TODD, ESQ.
17 ATTORNEY GENERAL'S OFFICE
18 1275 West Washington Street
19 Phoenix, Arizona 85007

20

21 ALSO PRESENT: SUSAN LANDA ROGERS, ESQ.
22 ARIZONA DEPARTMENT OF CORRECTIONS

23

24 THE VIDEOGRAPHER: Sean McDonald

4

1 THE VIDEOGRAPHER: This is the

2 videotape deposition of Dr. Mark Dershwitz,

3 M. D., taken by the plaintiffs in the matter

4 of Gregory Dickens, et al versus Janet

5 Napolitano, et al, pending in the United

6 States District Court for the District of

7 Arizona, Case No. 07-cv-1770 (PHX) being held

8 today, December 9, 2008, in the offices of

9 McCarthy Reporting Service, 12 Harvard Street,

10 Worcester, Massachusetts, commencing at

11 12:14 P. M.

12 The court reporter's name is Nancy

13 Diemdowicz. She is from the firm of McCarthy

14 Reporting Service. I am the videotape

15 specialist, my name is Sean McDonald, and I

16 represent McCarthy Reporting Service of

17 Worcester, Massachusetts.

18 Counselors, if you would introduce

19 yourselves, please.

20 MR. ROSENSTEIN: Hi. Steve

21 Rosenstein of O'Melveny & Myers. I'm here

22 with Benjamin Petrosky for the plaintiffs.

23 MR. TODD: John Todd with the

24 Attorney General's Office representing the

1 to be a medical team member in the protocol is
2 in Section B(1) which just says they're a
3 physician, a nurse and/or an EMT; is that
4 correct?

5 A. Well, it also says that those
6 people must be selected by the director of the
7 Department of Corrections, which in and of
8 itself is a qualification.

9 Q. Okay. So they have to be a
10 physician, a nurse, or an EMT that is selected
11 by the director of the Department of
12 Corrections?

13 A. Correct.

14 Q. The only -- so the director has
15 final selection criteria, and the eligible
16 pool is anybody who's a physician, a nurse, or
17 an EMT, as the protocol reads?

18 A. Correct.

19 Q. So under the protocol, medical team
20 member number three could, if designated by
21 the department director, be responsible for
22 inserting the catheter?

23 A. I guess so.

24 Q. And other -- and there's nothing in

1 go back and look specifically. I never got
2 the impression that he considered himself
3 qualified to do the procedure independently
4 without assistance.

5 Q. Okay. And do you recall in -- come
6 back to that later. When you -- strike that.

7 Are there any other risks attendant
8 to the placement of a femoral line -- or
9 strike that.

10 Are there any risks attendant to
11 the placement of a femoral line?

12 A. In general, the risks that are
13 associated with placement of an IV catheter,
14 in general, are pain, infection, bleeding.

15 As I mentioned, pain can usually be
16 mitigated by the appropriate use of local
17 anesthesia, infection is probably not a
18 relevant risk factor considering the time
19 course that this particular line is going to
20 be in place, and bleeding is a theoretical
21 risk.

22 However, the location of this
23 particular line in contrast to others that may
24 be put in the body lends itself to external

1 the protocol itself that guarantees or even
2 implies that -- strike that.

3 There's nothing in the protocol
4 that requires that the person who is
5 responsible for a particular task the medical
6 team has engages in that task as part of their
7 day job or is otherwise qualified beyond the
8 minimum qualification as a physician, nurse or
9 EMT and ultimate selection by the director,
10 correct?

11 A. Correct. One hopes that the
12 director exercises appropriate selection
13 criteria.

14 Q. You -- you did note in your opinion
15 -- in your report that medical team member
16 number one, based on his deposition, had said
17 that he regularly inserts such catheters as a
18 part of his practice.

19 Do you recall whether medical team
20 member number three regularly inserted central
21 lines as part -- femoral lines as part of his
22 practice?

23 A. My recollection is he said he
24 assisted with them somewhere, but I'd have to

1 compression. So, for example, if a pass of
2 the needle entered the vein and did not result
3 in a successful cannulation, then one could
4 put pressure on the area to decrease the
5 likelihood of there being any bleeding.

6 Q. Is it possible to puncture the
7 femoral artery that is next to the femoral
8 vein in attempting to place a femoral line?

9 A. I will acknowledge that virtually
10 anything is possible. However, because one
11 typically palpates the artery with the fingers
12 of one hand while inserting the needle with
13 the fingers of the other, that's a relatively
14 uncommon adverse effect in my experience.

15 Q. I guess, is it a -- is there a
16 universe of known medical risks that you would
17 be careful of and train new doctors, you know,
18 to guard against when it comes to placement of
19 a femoral line?

20 A. Well, certainly, if one
21 accidentally entered the artery instead of the
22 vein before threading the wire, one would see
23 pulsatile blood that's bright red as opposed
24 to non-pulsatile blood that's dark. That

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1 basically is the best evidence of one versus
 2 the other.

3 If one accidentally enters the
 4 artery, one would remove the needle and hold
 5 pressure for a while and then reinsert the
 6 needle a little bit more to the side so that
 7 you're more likely to enter the vein the next
 8 time, not the artery.

9 Q. If you didn't realize --
 10 hypothetically, someone didn't realize and
 11 actually put the placement in the artery, what
 12 would the effect be if drugs were administered
 13 through an IV in the artery?

14 A. Well, Thiopental, unfortunately,
 15 has been associated with vasospasm when
 16 accidentally injected into an artery, and in
 17 the short term that's painful.

18 And in the long term, although I
 19 don't recall any cases involving the leg,
 20 Thiopental has been accidentally injected into
 21 an arterial catheter in the hand and that has
 22 resulted in gangrene of the digits.

23 But, obviously, not that day,
 24 sometime down the road. But, in the short

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1 term, it hurts.

2 Q. How does it affect the distribution
 3 of the drug into the body and the reaction of
 4 the body to the drug after that initial pain?

5 A. Some Thiopental will circulate and
 6 cause a pharmacological effect; but because of
 7 the intense vasospasm in the distal arterial
 8 supply, the onset will be slowed.

9 Q. Would the -- in addition to the
 10 onset being slowed, would there be any kind of
 11 reduced effectiveness or reduced length of the
 12 drug's effectiveness?

13 A. Well, actually -- and this is the
 14 sort of theoretical question that, as a
 15 pharmacologist, it's kind of silly to
 16 describe.

17 Because any attempt to discuss the
 18 duration of Thiopental assumes that the person
 19 continues to breathe and have a blood
 20 pressure. After five grams of Thiopental, the
 21 patient will have neither.

22 But let us assume the person
 23 continued to breathe and have a blood
 24 pressure, hypothetically speaking. If the

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1 onset were delayed, the duration would
 2 theoretically increase, but not in a
 3 meaningful way because we're talking about
 4 hours.

5 Q. It would -- so would the same
 6 amount of drug -- is there a particular, you
 7 know, organ or body part that gets affected by
 8 Thiopental to create a state of
 9 unconsciousness?

10 A. Well, parts of the brain.

11 Q. So would the same amount of drug
 12 eventually get to the brain if it was in the
 13 artery, or would a reduced amount get to the
 14 brain?

15 A. If one deposited five grams of
 16 Thiopental in an artery, assuming that it
 17 didn't leak out directly, sooner or later it
 18 will circulate assuming that the person also
 19 continued to breathe and have a blood
 20 pressure, but that assumption is virtually
 21 impossible for those of us who have considered
 22 this to imagine. But it would be a bad idea
 23 to put this stuff into an artery, to begin
 24 with.

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1 I would also say that the chances
 2 of depositing all five grams into the artery,
 3 I think, are small, because before the person
 4 fell asleep they would scream, and that would
 5 probably, I would anticipate, cause the
 6 medical team and those witnesses present and
 7 who's ever responsible here to realize
 8 something is amiss, because Thiopental
 9 properly administered into a vein is
 10 absolutely painless.

11 Q. Okay. So if it was in the vein, it
 12 would be absolutely painless. If it's in the
 13 artery, it would be painful?

14 A. Very painful. And if it
 15 extravasates, meaning it goes outside of the
 16 vein into the subcutaneous tissue because it's
 17 a pH-11, which is four pH units away from
 18 physiologic, approximately, it also burns due
 19 to its direct basic effect on tissue.

20 So any voicing of discomfort on the
 21 part of the inmate during the injection
 22 process should let those responsible realize
 23 that something is not right.

24 Q. Do you understand that the Arizona

EXHIBIT 00

EXHIBIT 00

ROBERT C. COMER
ML 07-0898
AUTOPSY REPORT
PINAL COUNTY, ARIZONA
DEPARTMENT OF CORRECTIONS
CASE #2007020168
MAY 23, 2007



Page 1

053

08/20/07
DM

ML 07-0898

Re: Robert C. Comer

Page 2

PATHOLOGIC DIAGNOSES AND FINDINGS:

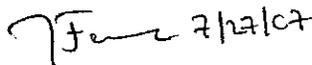
1. Lethal injection performed at Florence prison
2. Cardiac hypertrophy and slight dilatation
3. Focal coronary atherosclerosis, slight
4. Pulmonary congestion
5. Enlarged liver and spleen
6. Thiopental detected in postmortem central blood (1.2 mg/L)*

OPINION:

In consideration of the known circumstances surrounding this death, the available medical history, and the examination of the remains, the cause of death is ascribed to **judicial execution by lethal injection.**

The manner of death is **homicide.**

***Note:** The tissue and body fluid samples in this case were obtained about 22 hours after death was pronounced following the lethal injection procedure. Thiopental is highly lipophilic and has the potential to undergo significant postmortem redistribution. The detection cut-off level of AIT Laboratories was reported to me as ≥ 1.0 mg/L.



Michael J. Ferenc, M.D.
Forensic Pathologist

MJF/aef

ML 07-0898

Re: Robert C. Comer

Page 3

MEDICOLEGAL INVESTIGATION

AUTHORIZATION:

The postmortem examination is performed under the authorization of the Pinal County Medical Examiner's Office.

IDENTIFICATION:

The body is identified by Department of Corrections.

ML 07-0898

Re: Robert C. Comer

Page 4

POSTMORTEM EXAMINATION

CIRCUMSTANCES OF THE EXAMINATION:

The postmortem examination of Robert Comer is performed at the Forensic Science Center, 2825 East District Street, Tucson, Arizona at about 0730 hours on May 23, 2007. Assisting in the examination: Sam Cook, Mark Glenn, Louie Goad, Chuck Harding, and Krystal Poulin.

GENERAL DESCRIPTION:

The unembalmed body of a middle-aged man is received inside a sealed plastic pouch, is dressed in prison clothing, and has a properly labeled identification tag present. No significant recent trauma is seen.

RECENT MEDICAL THERAPY:

There are ECG pads present on the torso. There is a vascular line present in the right groin area.

CLOTHING AND PERSONAL EFFECTS:

The decedent is dressed in orange-colored prison-style clothing including a shirt, pants, and socks. The clothing is held in place by Velcro seals. A pair of disposable-type plastic underpants is present. Please refer to personal effects receipt for details of clothing and any personal items.

RECENT INJURY:

None.

IDENTIFYING SCARS, MARKS, AND TATTOOS:

Please refer below to external examination section.

EXTERNAL EXAMINATION:

The body is that of a well-developed, well nourished, middle-aged, fair complexion man who is 73-1/2 inches and weighs 222 pounds. Rigor mortis is moderate. Livor mortis is red-blue, moderate, posterior, and fixed.

ML 07-0898

Re: Robert C. Comer

Page 5

EXTERNAL EXAMINATION (Continued):

There are multiple tattoos over the body including on either side of the eyelids, the right earlobe, much of the torso, all four limbs, and the tip of the penis. Many of the tattoos have complex patterns with some of the tattoos including Nazi-style swastikas.

That head is symmetrical and shows no significant trauma or scars. The head hair is brown and gray, straight, and about 1/16 inch. A mustache is present. The face is otherwise shaven. The eyelids, sclerae, and conjunctivae show no hemorrhage. The irides are brown with arcus, and the pupils are roughly equal and round. The nose shows no lesions. The mouth and oral cavity show no lesions. The teeth are in poor condition. The external ears are normally formed.

The neck is symmetrical without significant trauma or scars. The chest is symmetrical without significant trauma or scars. The breasts are those of a man. The abdomen is not distended and shows no significant trauma. There is a 5 inch linear scar in the right lower quadrant. The external genitalia are those of a circumcised man.

The forearms and upper arms are symmetrical without significant trauma or scars. The hands, fingers, and fingernails are intact. The legs and feet are symmetrical without significant trauma or scars.

Incision into the right groin area reveals the catheter tip to be inserted within the proximal right femoral artery.

The posterior body surfaces show no significant trauma or scars. The anus is unremarkable.

INTERNAL EXAMINATION:

Body walls and cavities:

The abdominal fat pad, measured just below the umbilicus, is 1 inch. The subcutaneous and breast tissues are unremarkable. The pleural cavities contain minimal serous fluid and no adhesions. The pericardial sac shows moderate diffuse fibrous adhesions. The mediastinal soft tissues show no lesions or hemorrhage. The diaphragm is intact. The abdominal cavity contains minimal serous fluid and occasional fibrous adhesions. The major thoracic and abdominal organs are in their normal anatomic positions.

ML 07-0898

Re: Robert C. Comer

Page 6

Head and cranial contents:

The scalp shows no hemorrhage or trauma. The skull shows no fractures. The dura mater and leptomeninges show no lesions or hemorrhages. The dural sinuses and floor of the skull are intact. The circle of Willis shows no aneurysms and minimal to slight atherosclerosis focally. The brain weighs 1,460 grams. Externally, the cerebral hemispheres, cerebellum, and brain stem show no diffuse or focal lesions. Internally, the grey and white matter, nuclei, ventricles, cerebellum, and brain stem show no diffuse or focal lesions. The pituitary gland is unremarkable.

Neck:

The superficial and deep muscles of the anterior neck show no hemorrhage or trauma. The thyroid gland is red-brown, normal texture, slightly larger than normal, and symmetrical. The parathyroid glands are not identified. The hyoid bone, thyroid cartilages, and cricoid cartilage are intact. The epiglottic and laryngeal mucosa is not edematous and does not contain significant aspirated matter. The mucosa is tan. The tongue is unremarkable. The posterior pharynx is not obstructed. The prevertebral fascia shows no hemorrhage. The cervical vertebrae are unremarkable on palpation.

Cardiovascular system:

The epicardium is smooth and glistening. The coronary arteries follow a right predominant distribution. The right coronary artery shows two focal regions of 40% narrowing by yellow-tan atherosclerotic plaque one just distal to the coronary ostium and the other in the vessel after the origin of the posterior descending branch. The remainder the coronary artery system shows minimal atherosclerotic change. The heart weighs 570 grams. The myocardium is red-brown, normal texture, and uniform. No increased fatty infiltration or increased fibrous tissue is seen in the right ventricle. The left and right ventricles are of normal thickness. The chambers are all slightly dilated. The endocardium, coronary sinus, chordae, and papillary muscles are intact and unremarkable for age without evidence of hemorrhage. The foramen ovale is closed. The atrioventricular and semilunar valves are normally formed, show no significant lesions, and are appropriate for age. The aorta shows no atherosclerosis. The venae cavae and great vessels show no thrombi, emboli, or trauma.

Dissection of the right femoral vein at the catheter site does not reveal any hemorrhage for abnormality of the vessel.

Pulmonary system:

The right lung weighs 990 grams and the left lung weighs 910 grams. The pulmonary parenchyma varies from pink-red to dark red, is partially to fully aerated, normal texture, and without focal lesions. The tracheobronchial tree shows no lesions or hemorrhage. The mucosa is red-tan. The pulmonary vessels show no thrombi, emboli, or trauma.

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Re: Robert C. Comer

Page 7

Hepatobiliary system:

The liver is red-brown to dark red-brown, normal texture, uniform, and 2,520 grams. The biliary tract is intact. The gallbladder contains 20 cc of green thick bile. The pancreas is tan, lobulated, normal texture, and without focal lesions.

Hematopoietic system:

The spleen is dark red, normal texture, uniform, and 450 grams. The thymus gland is unremarkable for age. The lymph nodes are tan, normal texture, and not enlarged. The bone marrow of the ribs and skull are unremarkable for age.

Gastrointestinal system:

The oropharynx, esophagus, and stomach show no lesions. The stomach contains less than 15 cc of tan mucoid material. No pills or granular material is seen. The duodenum, jejunum, ileum, and large bowel show no mucosal, mural, or serosal lesions or hemorrhage. The mesentery is intact. The appendix is not identified.

Genitourinary system:

The adrenal cortices and medullae show no lesions or hemorrhages. The renal capsule strips with moderate difficulty. The right kidney weighs 210 grams, and the left kidney weighs 230 grams. The cortices are red-brown, slightly granular, normal thickness, and uniform. The calyces and pelves are not dilated. The pyramids and papillae are intact. The ureters are patent to the bladder that contains about 50 cc of cloudy yellow urine. The bladder wall and mucosa are unremarkable. The prostate gland is unremarkable for age on sectioning. The testes are unremarkable for age on sectioning.

Musculoskeletal system:

The muscles show no focal or diffuse lesions. The skeleton is well developed and appropriate for age with slight osteophytic lipping of the vertebral column. Fractures and focal trauma are not identified.

TOXICOLOGY (PLEASE SEE ATTACHED REPORT)

HISTOLOGY:

BRAIN: Sections from the medulla, pons, cerebellum, hippocampus, basal ganglia, and random cortex are examined. No neoplasia, inflammatory infiltrates, or trauma are seen. Some of the neurons in Sommer sector are slightly shrunken and hyperchromatic with darkened nuclei.

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HISTOLOGY (Continued):

HEART: Left and right ventricle sections show intact myocytes and no significant inflammatory infiltrates. Epicardial and endocardial surfaces and vessels are unremarkable.

LUNGS: Sections show congested parenchyma with slight emphysematous change and no significant acute inflammatory infiltrates. Patches of anthracotic pigment are seen. Bronchial elements are intact. No foreign polarizable material is seen.

LIVER: Section shows unremarkable hepatocytes and portal areas. The sinusoids are congested.

PANCREAS: Section shows intact islets and acini, ducts, and vessels.

ADRENAL GLAND: Section shows intact cortex with congestion of the zona reticularis. A small area of unremarkable medulla is seen.

SPLEEN: Section shows unremarkable red and white pulp, capsule, and vessels.

KIDNEY: Section shows intact glomeruli, tubules, and vessels. The interstitium is congested. No foreign polarizable material is seen.

THYROID GLAND: Section shows variable-sized, pink colloid-filled follicles lined by cuboidal to flattened epithelium.

FEMORAL VEINS: Sections from right femoral vein at the injection site and the corresponding left femoral veins do not reveal any abnormalities of the vessel surfaces or walls. The adventitial tissue on the right shows focal slight recent hemorrhage.

OTHER LABORATORY TESTING:

None.



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 Robert Foery, Ph.D., DABCC/DABTC

LABORATORY CASE NUMBER: 329520	Subject's Name: COMER, ROBERT
Client Account: 11565 / FSC01	Agency Case #: ML 07-0898
Physician: DR.FERENC	Date Of Death: Not Given
Report To: FORENSIC SCIENCE CENTER	Test Reason: Other
ATTN: Patti Nelson	Investigator:
2825 E. District St.	Date Received: 05/24/2007
Tucson, AZ 85714	Date Reported: 06/05/2007
Fx: 520-243-8610	

Laboratory Specimen No: 40037732	Date Collected: 05/23/2007
Container(s) : 01: Red Top Bottle Blood, PERIPHERAL	Test(s) : 70510 Comprehensive Drug Panel (550B)
	44660 Thiopental

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
AMPHETAMINES	Negative				
BARBITURATES	Negative				
BENZODIAZEPINES	Negative				
CANNABINOIDS	Negative				
COCAINE/METABOLITES	Negative				
FENTANYL	Negative				
METHADONE	Negative				
OPIATES	Negative				
PHENCYCLIDINE	Negative				
PROPOXYPHENE	Negative				
SALICYLATES	Negative				
TRICYCLIC ANTIDEPRESSANTS	Negative				
ALCOHOLS	Negative				
STIMULANTS	POSITIVE				
Caffeine	POSITIVE				
NARCOTICS	Negative				
SEDATIVES/HYPNOTICS	Negative				
Thiopental	Negative				
ANTIDEPRESSANTS	Negative				
ANALGESICS	Negative				
ANESTHETICS	Negative				
CARDIOVASCULAR AGENTS	Negative				
ANTIHISTAMINES	Negative				
ANTICONVULSANTS	Negative				
ANTIPSYCHOTICS	Negative				

Specimens will be kept for one year from the date received.

JUN 07 09 124 ONE

COMER, ROBERT

Laboratory Case #: 329520

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Laboratory Specimen No: 40037733	Date Collected: 05/23/2007
Container(s) : 01: Red Top Tube Blood, CENTRAL	Test(s) : 44660 Thiopental

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
Thiopental Thiopental, Quant	POSITIVE	1.2	ug/mL	4-7	

COMER, ROBERT

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Laboratory Specimen No:	40037738	Date Collected:	05/23/2007
Container(s) : 01: Orange Top	Tissue, BRAIN	Test(s) : 44660	Thiopental

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
Thiopental	Negative				

COMER, ROBERT

Laboratory Case #: 329520

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Laboratory Specimen No: 40037734	Date Collected: 05/23/2007
Container(s) : 01: Bottle-Yellow Urine, Random	Test(s) : 70080 Drugs of Abuse Panel (900U)

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
AMPHETAMINES	Negative				
BARBITURATES	Negative				
BENZODIAZEPINES	Negative				
CANNABINOIDS	Negative				
COCAINE/METABOLITES	Negative				
METHADONE/METABOLITE	Negative				
OPIATES	Negative				
OXYCODONE/METABOLITE	Negative				
PHENCYCLIDINE	Negative				
ALCOHOLS	Negative				

COMER, ROBERT

Laboratory Case #: 329520

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Laboratory Specimen No:	40037735	Date Collected:	05/23/2007
Container(s) :01: Tube	Fluid, VITREOUS	Test(s) : 32400	Electrolytes Panel (910COR)

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
Chloride		128	MMOL/L		
Creatinine		0.3	mg/dL		
Glucose		<25	mg/dL		
Potassium		7.7	MMOL/L		
Sodium		146	MMOL/L		
Urea Nitrogen		11	mg/dL		

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 Robert Foery, Ph.D., DABCC/DABTC

Laboratory Specimen No: 40037736 Date Collected: 05/23/2007
 Container(s) : 01: Red Top Tube Vitreous, EYE Test(s): 70570 Autopsy Panel, Volatiles (550V1)

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
ALCOHOLS	Negative				
Methanol	Negative				
Ethanol	Negative				
Acetone	Negative				
Isopropanol	Negative				

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Robert Foery, Ph.D., DABCC/DABTC

Laboratory Specimen No:	40037737	Date Collected:	05/23/2007
Container(s) : 01: Orange Top	Tissue, LIVER	Test(s) : 49900	Not Tested (NT)

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
< No Testing Performed	>				

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Robert Foery, Ph.D., DABCC/DABTC

Laboratory Specimen No:	40037739	Date Collected:	05/23/2007
Container(s) : 01: Tube	Fluid, CSF	Test(s) : 49900	Not Tested (NT)

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
< No Testing Performed	>				

The Specimen identified by this Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

COMER, ROBERT

Laboratory Case #: 329520

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068 Foery, Robert
Signature of Certifying Scientist

1 Thomas C. Horne
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 2
 3 Kent Cattani, State Bar No. 010806
 Jeffrey A. Zick, State Bar No. 018712
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8 *Attorneys for Defendants*

9 **UNITED STATES DISTRICT COURT**
 10 **DISTRICT OF ARIZONA**

11 Robert Towery, Robert Moorman and Pete
 12 Rogovich,

13 Plaintiffs,

14 v.

15 Janice K. Brewer, Governor of Arizona,
 16 *et al.*,

17 Defendants.

No. CV 12-00245-PHX-NVW

**ANSWER TO SECOND AMENDED
 COMPLAINT**

18 Defendants Janice K. Brewer, Director Charles L. Ryan, Warden Lance Hetmer,
 19 and Warden Ron Credio, through undersigned counsel, hereby answer the Second
 20 Amended Complaint as follows:

21 **Nature of the Action**

22 1. Defendants admit this Court has jurisdiction over this 42 U.S.C. § 1983
 23 lawsuit and deny the remaining allegations of paragraph 1 of the Amended Complaint.

24 2. Defendants admit the allegation of paragraph 2 of the Amended
 25 Complaint.

26 3. Defendants admit the allegation of paragraph 3 of the Amended
 27 Complaint.

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Jurisdiction and Venue

4. Defendants admit the allegation of paragraph 4 of the Amended Complaint.

5. Defendants admit the allegation of paragraph 5 of the Amended Complaint.

The Parties

6. Defendants admit the allegation of paragraph 6 of the Amended Complaint.

7. Defendants admit the allegation of paragraph 7 of the Amended Complaint.

8. Defendants admit the allegation of paragraph 8 of the Amended Complaint.

9. Defendants admit the allegation of paragraph 9 of the Amended Complaint.

10. Defendants admit the allegation of paragraph 10 of the Amended Complaint.

11. Defendants admit the allegation of paragraph 11 of the Amended Complaint and affirmatively allege that multiple defendants need not be named in their official capacity to obtain injunctive relief.

12. Defendants admit the allegation of paragraph 12 of the Amended Complaint and affirmatively allege that multiple defendants need not be named in their official capacity to obtain injunctive relief.

13. Defendants deny the allegation of paragraph 13 of the Amended Complaint as they are hypothetical and affirmatively allege that multiple defendants need not be named in their official capacity to obtain injunctive relief.

1 24. Defendants admit the allegation of paragraph 24 of the Amended
2 Complaint.

3 25. Defendants deny the allegation of paragraph 25 of the Amended
4 Complaint.

5 26. Defendants admit the allegation of paragraph 26 of the Amended
6 Complaint.

7 27. In respect to paragraph 27 of the Amended Complaint, Defendants
8 affirmatively allege that the document speaks for itself.

9 28. Defendants admit the allegation of paragraph 28 of the Amended
10 Complaint.

11 29. Defendants admit the allegation of paragraph 29 of the Amended
12 Complaint.

13 30. Defendants deny the allegation of paragraph 30 of the Amended
14 Complaint.

15 31. Defendants deny the allegation of paragraph 31 of the Amended
16 Complaint.

17 32. Defendants deny the allegation of paragraph 32 of the Amended
18 Complaint.

19 33. Defendants admit the allegation of paragraph 33 of the Amended
20 Complaint.

21 34. Defendants deny the allegation of paragraph 34 of the Amended
22 Complaint.

23 35. Defendants deny the allegation of paragraph 35 of the Amended
24 Complaint.

25 36. Defendants deny the allegation of paragraph 36 of the Amended Complaint
26 that “the January 2012 Protocol contains significant departures from the previous
27 version.”

28

1 37. Defendants deny the allegation of paragraph 37 of the Amended
2 Complaint.

3 38. Defendants deny the allegation of paragraph 38 of the Amended
4 Complaint.

5 39. Defendants deny the allegation of paragraph 39 of the Amended
6 Complaint.

7 40. Defendants deny the allegation of paragraph 40 of the Amended
8 Complaint.

9 41. Defendants deny the allegation of paragraph 41 of the Amended
10 Complaint.

11 **A. In 2009, ADC Added Safeguards to its Lethal-Injection Protocol in
12 Response to Litigation**

13 42. Defendants admit the allegation of paragraph 42 of the Amended
14 Complaint.

15 43. Defendants admit the Protocol was amended, but deny the remaining
16 allegation of paragraph 43 of the Amended Complaint.

17 44. Defendants deny the allegation of paragraph 44 of the Amended
18 Complaint.

19 45. Defendants deny the allegation of paragraph 45 of the Amended
20 Complaint.

21 46. Defendants deny the allegation of paragraph 46 of the Amended
22 Complaint.

23 47. Defendants deny the allegation of paragraph 47 of the Amended
24 Complaint.

25 48. Defendants deny the allegation of paragraph 48 of the Amended
26 Complaint.

27 49. Defendants admit the allegation of paragraph 49 of the Amended
28 Complaint.

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B. The *West v. Brewer* Trial Revealed That ADC Has Not Followed the Safeguards That It Adopted to Obtain a Favorable Outcome in *Dickens*

50. Defendants admit the allegation of paragraph 50 of the Amended Complaint.

51. Defendants deny the allegation of paragraph 51 of the Amended Complaint.

52. Defendants deny the allegation of paragraph 52 of the Amended Complaint.

53. Defendants deny the allegation of paragraph 53 of the Amended Complaint.

54. Defendants deny the allegation of paragraph 54 of the Amended Complaint.

55. Defendants deny the allegation of paragraph 55 of the Amended Complaint.

56. Defendants admit the allegation of paragraph 56 of the Amended Complaint that the District Court found no constitutional violations.

57. Defendants admit the allegation of paragraph 57 of the Amended Complaint.

C. ADC Subsequently Adopted a Protocol that Eliminates Safeguards, Increases the Director's Discretion, and Codifies Arbitrary and Disparate Treatment

58. Defendants admit the allegation of paragraph 58 of the Amended Complaint.

59. Defendants deny the allegation of paragraph 59 of the Amended Complaint.

60. Defendants admit the allegation of paragraph 60 of the Amended Complaint.

61. Defendants deny the allegation of paragraph 61 of the Amended Complaint.

1 62. Defendants deny the allegation of paragraph 62 of the Amended Complaint
2 that “other appropriately trained personnel” are not defined.

3 63. Defendants deny the allegation of paragraph 63 of the Amended
4 Complaint.

5 64. Defendants deny the allegation of paragraph 64 of the Amended
6 Complaint.

7 65. Defendants deny the allegation of paragraph 65 of the Amended
8 Complaint.

9 66. Defendants admit the allegation of paragraph 66 of the Amended
10 Complaint.

11 67. Defendants admit the allegation of paragraph 67 of the Amended
12 Complaint that the word “current” is not in the 2012 Protocol.

13 68. Defendants deny the allegation of paragraph 68 of the Amended
14 Complaint.

15 69. Defendants deny the allegation of paragraph 69 of the Amended
16 Complaint.

17 70. Defendants deny the allegation of paragraph 70 of the Amended
18 Complaint.

19 71. Defendants deny the allegation of paragraph 71 of the Amended
20 Complaint.

21 72. As to the allegation of paragraph 72 of the Amended Complaint,
22 Defendants allege that the document speaks for itself.

23 73. As to the allegation of paragraph 73 of the Amended Complaint,
24 Defendants allege that the document speaks for itself.

25 74. As to the allegation of paragraph 74 of the Amended Complaint,
26 Defendants allege that the document speaks for itself.

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1 75. As to the allegation of paragraph 75 of the Amended Complaint,
2 Defendants allege that the document speaks for itself.

3 76. Defendants deny the allegation of paragraph 76 of the Amended
4 Complaint.

5 77. As to the allegation of paragraph 77 of the Amended Complaint,
6 Defendants allege that the document speaks for itself.

7 78. As to the allegation of paragraph 78 of the Amended Complaint,
8 Defendants allege that the document speaks for itself.

9 79. As to the allegation of paragraph 79 of the Amended Complaint,
10 Defendants allege that the document speaks for itself.

11 80. As to the allegation of paragraph 80 of the Amended Complaint,
12 Defendants allege that the document speaks for itself.

13 81. As to the allegation of paragraph 81 of the Amended Complaint,
14 Defendants allege that the document speaks for itself.

15 82. As to the allegation of paragraph 82 of the Amended Complaint,
16 Defendants allege that the document speaks for itself.

17 83. As to the allegation of paragraph 83 of the Amended Complaint,
18 Defendants allege that the document speaks for itself.

19 84. As to the allegation of paragraph 84 of the Amended Complaint,
20 Defendants allege that the document speaks for itself.

21 85. As to the allegation of paragraph 85 of the Amended Complaint,
22 Defendants allege that the document speaks for itself.

23 86. As to the allegation of paragraph 86 of the Amended Complaint,
24 Defendants allege that the document speaks for itself.

25 87. As to the allegation of paragraph 87 of the Amended Complaint,
26 Defendants allege that the document speaks for itself.

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1 88. Defendants deny the allegation of paragraph 88 of the Amended
2 Complaint.

3 89. Defendants deny the allegation of paragraph 89 of the Amended
4 Complaint.

5 90. Defendants deny the allegation of paragraph 90 of the Amended
6 Complaint.

7 91. Defendants deny the allegation of paragraph 91 of the Amended
8 Complaint.

9 92. Defendants admit the allegation of paragraph 92 of the Amended
10 Complaint.

11 93. Defendants deny the allegation of paragraph 93 of the Amended
12 Complaint.

13 94. Defendants deny the allegation of paragraph 94 of the Amended
14 Complaint.

15 95. Defendants deny the allegation of paragraph 95 of the Amended
16 Complaint.

17 96. Defendants deny the allegation of paragraph 96 of the Amended
18 Complaint.

19 97. As to the allegation of paragraph 97 of the Amended Complaint,
20 Defendants allege that the document speaks for itself.

21 98. As to the allegation of paragraph 98 of the Amended Complaint,
22 Defendants allege that the document speaks for itself.

23 99. As to the allegation of paragraph 99 of the Amended Complaint,
24 Defendants allege that the document speaks for itself.

25 100. Defendants deny the allegation of paragraph 100 of the Amended
26 Complaint.

27
28

1 101. As to the allegation of paragraph 101 of the Amended Complaint,
2 Defendants allege that the document speaks for itself.

3 102. As to the allegation of paragraph 102 of the Amended Complaint,
4 Defendants allege that the document speaks for itself.

5 **D. Executions of Robert Moorman and Robert Towery**

6 103. Defendants admit the allegation of paragraph 103 of the Amended
7 Complaint.

8 104. Defendants admit the allegation of paragraph 104 of the Amended
9 Complaint.

10 105. As to the allegation of paragraph 105 of the Amended Complaint,
11 Defendants allege that the document speaks for itself.

12 106. As to the allegation of paragraph 106 of the Amended Complaint,
13 Defendants allege that the document speaks for itself.

14 107. Defendants deny the allegation of paragraph 104 of the Amended
15 Complaint.

16 108. As to the allegation of paragraph 108 of the Amended Complaint,
17 Defendants allege that the document speaks for itself.

18 109. Defendants admit the allegation of paragraph 109 of the Amended
19 Complaint.

20 110. Defendants deny the allegation of paragraph 110 of the Amended
21 Complaint.

22 111. Defendants admit the allegation of paragraph 111 of the Amended
23 Complaint.\

24 112. Defendants admit the allegation of paragraph 112 of the Amended
25 Complaint, but is without information or belief as to the exact time alleged.

26 113. Defendants admit the allegation of paragraph 113 of the Amended
27 Complaint, but is without information or belief as to the exact time alleged.

28

1 114. Defendants admit the allegation of paragraph 114 of the Amended
2 Complaint, but is without information or belief as to the exact time alleged.

3 115. Defendants admit the allegation of paragraph 115 of the Amended
4 Complaint, but is without information or belief as to the exact time alleged.

5 116. Defendants admit the allegation of paragraph 116 of the Amended
6 Complaint, but is without information or belief as to the exact time alleged.

7 117. Defendants admit the allegation of paragraph 117 of the Amended
8 Complaint, but is without information or belief as to the exact time alleged.

9 118. Defendants admit the allegation of paragraph 118 of the Amended
10 Complaint, but is without information or belief as to the exact time alleged.

11 119. Defendants admit the allegation of paragraph 119 of the Amended
12 Complaint, but is without information or belief as to the exact time alleged.

13 120. Defendants admit the allegation of paragraph 120 of the Amended
14 Complaint, but is without information or belief as to the exact time alleged.

15 121. Defendants admit the allegation of paragraph 121 of the Amended
16 Complaint.

17 122. Defendants admit the allegation of paragraph 122 of the Amended
18 Complaint, but is without information or belief as to the exact time alleged.

19 123. Defendants admit the allegation of paragraph 123 of the Amended
20 Complaint, but is without information or belief as to the exact time alleged.

21 124. Defendants deny the allegation of paragraph 124 of the Amended
22 Complaint.

23 125. Defendants admit the allegation of paragraph 125 of the Amended
24 Complaint, but is without information or belief as to the exact time alleged.

25 126. Defendants admit the allegation of paragraph 126 of the Amended
26 Complaint, but is without information or belief as to the exact time alleged.

27
28

1 127. Defendants admit the allegation of paragraph 127 of the Amended
2 Complaint, but is without information or belief as to the exact time alleged.

3 128. Defendants admit the allegation of paragraph 128 of the Amended
4 Complaint, but is without information or belief as to the exact time alleged.

5 129. Defendants admit the allegation of paragraph 129 of the Amended
6 Complaint, but is without information or belief as to the exact time alleged.

7 130. Defendants deny the allegations of paragraph 130 of the Amended
8 Complaint.

9 131. Defendants are without information and belief as to the truth or falsity of
10 the allegations of paragraph 131 of the Amended Complaint and therefore deny the
11 allegations.

12 132. Defendants admit the allegation of paragraph 132 of the Amended
13 Complaint, but is without information or belief as to the exact time alleged.

14 133. Defendants admit the allegation of paragraph 133 of the Amended
15 Complaint, but is without information or belief as to the exact time alleged.

16 134. Defendants admit the allegation of paragraph 134 of the Amended
17 Complaint, but is without information or belief as to the exact time alleged.

18 135. Defendants admit the allegation of paragraph 135 of the Amended
19 Complaint, but is without information or belief as to the exact time alleged.

20 136. Defendants admit the allegation of paragraph 136 of the Amended
21 Complaint, but is without information or belief as to the exact time alleged.

22 137. Defendants admit the allegation of paragraph 137 of the Amended
23 Complaint, but is without information or belief as to the exact time alleged.

24 138. Defendants admit the allegation of paragraph 138 of the Amended
25 Complaint, but is without information or belief as to the exact time alleged.

26 139. Defendants deny the allegations of paragraph 139 of the Amended
27 Complaint.

28

1 140. Defendants are without information and belief as to the truth or falsity of
2 the allegations of paragraph 140 of the Amended Complaint and therefore deny the
3 allegations.

4 **E. Scheduled Executions of Thomas Kemp and Samuel Lopez**

5 141. Defendants admit the allegation of paragraph 141 of the Amended
6 Complaint.

7 142. Defendants admit the allegation of paragraph 142 of the Amended
8 Complaint.

9 143. As to the allegation of paragraph 143 of the Amended Complaint,
10 Defendants allege that the document speaks for itself.

11 144. As to the allegation of paragraph 144 of the Amended Complaint,
12 Defendants allege that the document speaks for itself.

13 145. As to the allegation of paragraph 145 of the Amended Complaint,
14 Defendants allege that the document speaks for itself.

15 **F. Defendants Unlawfully Imported Lethal-Injection Drugs**

16 146. Defendants deny the allegation of paragraph 146 of the Amended
17 Complaint.

18 147. Defendants deny the allegation of paragraph 147 of the Amended
19 Complaint.

20 148. Defendants deny the allegation of paragraph 148 of the Amended
21 Complaint.

22 149. Defendants deny the allegation of paragraph 149 of the Amended
23 Complaint.

24 150. Defendants deny the allegation of paragraph 150 of the Amended
25 Complaint.

26 151. Defendants deny the allegation of paragraph 151 of the Amended
27 Complaint.

28

1 152. Defendants deny the allegation of paragraph 152 of the Amended
2 Complaint.

3 153. Defendants deny the allegation of paragraph 153 of the Amended
4 Complaint.

5 **FIRST CLAIM FOR RELIEF**

6 154. Defendants repeat and restate the answers contained in paragraphs 1-153 of
7 this Answer as if fully set forth herein.

8 155. This is a statement of law, not fact, and thus no response is required to
9 paragraph 155 of the Amended Complaint.

10 156. This is a statement of law, not fact, and thus no response is required to
11 paragraph 156 of the Amended Complaint.

12 157. Defendants deny the allegation of paragraph 157 of the Amended
13 Complaint.

14 158. Defendants deny the allegation of paragraph 158 of the Amended
15 Complaint.

16 159. This is a statement of law, not fact, and thus no response is required to
17 paragraph 159 of the Amended Complaint.

18 160. This is a statement of law, not fact, and thus no response is required to
19 paragraph 160 of the Amended Complaint.

20 161. This is a statement of law, not fact, and thus no response is required to
21 paragraph 161 of the Amended Complaint.

22 162. This is a statement of law, not fact, and argument and thus no response is
23 required to paragraph 162 of the Amended Complaint.

24 163. This is a statement of law, not fact, and argument and thus no response is
25 required to paragraph 163 of the Amended Complaint.

26 164. This is a statement of law, not fact, and argument and thus no response is
27 required to paragraph 164 of the Amended Complaint.
28

1 178. Defendants deny the allegation of paragraph 178 of the Amended
2 Complaint.

3 179. Defendants deny the allegation of paragraph 179 of the Amended
4 Complaint.

5 180. Defendants deny the allegation of paragraph 180 of the Amended
6 Complaint.

7 181. Defendants deny the allegation of paragraph 181 of the Amended
8 Complaint.

9 182. Defendants deny the allegation of paragraph 182 of the Amended
10 Complaint.

11 183. Defendants deny the allegation of paragraph 183 of the Amended
12 Complaint.

13 184. Defendants deny the allegation of paragraph 184 of the Amended
14 Complaint.

15 185. Defendants deny the allegation of paragraph 185 of the Amended
16 Complaint.

17 186. Defendants deny the allegation of paragraph 186 of the Amended
18 Complaint.

19 187. Defendants deny the allegation of paragraph 187 of the Amended
20 Complaint.

21 **THIRD CLAIM FOR RELIEF**

22 188. Defendants repeat and restate the answers contained in paragraphs 1-187 of
23 this Answer as if fully set forth herein.

24 189. Defendants deny the allegation of paragraph 189 of the Amended
25 Complaint.

26 190. Defendants deny the allegation of paragraph 190 of the Amended
27 Complaint.
28

1 191. Defendants deny the allegation of paragraph 191 of the Amended
2 Complaint.

3 192. Defendants deny the allegation of paragraph 192 of the Amended
4 Complaint.

5 193. Defendants deny the allegation of paragraph 193 of the Amended
6 Complaint.

7 194. Defendants admit the allegation of paragraph 194 of the Amended
8 Complaint.

9 195. Defendants deny the allegation of paragraph 195 of the Amended
10 Complaint.

11 196. Defendants deny the allegation of paragraph 196 of the Amended
12 Complaint.

13 197. Defendants deny the allegation of paragraph 197 of the Amended
14 Complaint.

15 **FOURTH CLAIM FOR RELIEF**

16 198. Defendants repeat and restate the answers contained in paragraphs 1-197 of
17 this Answer as if fully set forth herein.

18 199. This is a statement of law, not fact and thus no response is required to
19 paragraph 199 of the Amended Complaint.

20 200. This is a statement of law, not fact and thus no response is required to
21 paragraph 200 of the Amended Complaint.

22 201. Defendants deny the allegation of paragraph 201 of the Amended
23 Complaint.

24 202. Defendants admit the allegation of paragraph 202 of the Amended
25 Complaint.

26 203. Defendants deny the allegation of paragraph 203 of the Amended
27 Complaint.
28

AFFIRMATIVE DEFENSES

1
2 1. Affirmatively allege that Plaintiffs have failed to state any claim upon
3 which relief can be granted;

4 2. Affirmatively allege that Defendants, at all times alleged herein, acted
5 professionally and pursuant to legitimate penological interest and in compliance with all
6 constitutional amendments;

7 3. Affirmatively allege that Plaintiffs failed to exhaust prison administrative
8 remedies as are available; and therefore, their claims are barred by 42 U.S.C. § 1997e(a)
9 whether denominated as an affirmative defense, subject matter jurisdiction, quasi-
10 jurisdictional, abatement or a condition precedent;

11 4. Affirmatively allege that these claims are barred by res judicata and/or
12 collateral estoppel; and

13 5. At the time of this Answer, Defendants do not know which, if any,
14 additional affirmative defenses may be supported by the facts developed through
15 discovery. Accordingly, Defendants allege, as though set forth herein *in haec verba*, all
16 affirmative defenses set forth in Rule 8 of the Federal Rules of Civil Procedure.

17 WHEREFORE, it is respectfully requested that the Court

18 1. Dismiss Plaintiffs’ Second Amended Complaint in its entirety with
19 prejudice;

20 2. Award Defendants their attorneys fees and costs as allowed by law; and

21 3. Award such other and further relief as the Court deems just and proper.

22 RESPECTFULLY SUBMITTED this 2nd of May, 2012.

23 Thomas C. Horne
24 Attorney General

25 s/Michael E. Gottfried
26 Michael E. Gottfried
27 Assistant Attorney General
28 *Attorneys for Defendants*